

**Analysing Restrictive and Liberal Approaches towards
Assisted Suicide and Euthanasia**

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Abstract

The 'end of life' issue in relation to assisted suicide and euthanasia is one of our prime concerns and a most widely discussed phenomenon not only in academic and official literature, but also in day-to-day life. Some people, who are terminally ill or suffer from degenerative diseases, choose to end their life while they are competent to do so especially when the hope of recovery fades, suffering escalates and the quality of life diminishes. My thesis examines the practice of assisted suicide and euthanasia in: (a) England and Wales where the practice has been strictly prohibited, but is now in a process of liberalisation. The recent guidelines issued by the Director of the public prosecutions pertaining to section 2 (4) of the Suicide Act 1961¹, may permit people assisting suicide to disobey the law on assisted suicide.² (b) The Netherlands, the State of Oregon in the U.S. and Switzerland where the practice is already liberalised under special circumstances. In conclusion, the thesis will discuss liberal regimes to observe which regime would best suit England and Wales position.

¹ S. 2 (4) provide: "[N]o proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions." See 'The Suicide Act 1961'.
<http://www.statutelaw.gov.uk>

² This view was put forth by Prof. David Schiff and Prof. Richard Nobles in the conference held on 'Purdy and Director of the public prosecutions' Guidelines' on 6th November 2009.

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Introduction

Issues surrounding 'end of life' are widely discussed at today, not only in the academic and official literature, but also in day-to-day newspapers, television programmes and general conversation. The most controversial issues concern the areas of assisted suicide and euthanasia. These issues arose with the Greeks and eventually gained prominence in the medical context. Medical and scientific progress has lead to a change in the place and the time of death.³ For example, prior to the 20th century people generally died at home.⁴ It was rare for people to have any medical intervention in the last moments of their lives. Today many people die in hospitals or in hospices under medical supervision.⁵ As a result, there is now a progressive movement that consists of dying patients, as well as their families and physicians. This movement poses the question of whether the artificial extension of the lives of people who are dying is really in their best interest in all cases.⁶ For instance, 'right to die' societies and other such organisations have begun to lobby for change in the law of assisted suicide. These 'right to die' societies and organisations argue that the patient, or the family representative, should have control over the dying process. They aim to ensure patient autonomy in the last moments of his or her life and further to this, they are in favour of allowing the patient to choose the time and the place of his or her death. In other words, as argued by Battin,⁷ death has formed a part of the conception of personal autonomy and self-determination.

³ Ziegler S. J. (2009) 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for its Potential to Enhance Oversight and Demedicalize the Dying Process'. *Journal of Law, Medicine and Ethics*, Vol. 37, p. 318.

⁴ For example, owing either to old age or due to illness or natural calamity.

⁵ Ziegler S. J. (2009) 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for its Potential to Enhance Oversight and Demedicalize the Dying Process'. *Journal of Law, Medicine and Ethics*, Vol. 37, p. 318.

⁶ *Ibid.*

⁷ Battin M.P. (2008) 'Safe, Legal Rare? Physician-Assisted Suicide and Cultural Change in the Future' in Birnbacher Dieter and Dahl Edgar (eds) *Giving Death a Helping Hand: Physician-Assisted Suicide, Terminal Sedation and Public Policy. An International Perspective*. The Netherlands: Springer, Vol. 36.

This thesis examines the law of England and Wales on assisted suicide and euthanasia. As a comparison, the thesis examines the legal and extra-legal regimes of three different jurisdictions where assisted suicide or euthanasia, or both practices, are legalised or permitted officially. These jurisdictions are the Netherlands, the State of Oregon in the U.S. and finally, Switzerland. In the Netherlands, both euthanasia and assisted suicide are permitted under special provisions. In the State of Oregon, only physician-assisted suicide (PAS) is permitted. In Switzerland, assisted suicide is legal as long as the motive of the assistant is altruistic.⁸

The main difference between Switzerland and the other two jurisdictions is that in Switzerland anybody either a physician or non-physician may assist in an act of suicide. On the other hand, in the Netherlands and the State of Oregon only physicians can provide assistance. In Switzerland and the Netherlands in particular, these practices have long been recognised and are now deeply embedded in the culture of these countries. In fact, Switzerland has started to cater for foreigners with this service, resulting in a phenomenon known as ‘suicide tourism’. People from other countries, especially Germany, France, Austria and England, travel to Switzerland in order to die.⁹ As of now, it is the only place in Europe for ‘death refugees’ i.e. travellers who have the aim of ending their lives in a humane and dignified manner through the assistance of ‘right to die’ societies such as Dignitas.¹⁰

⁸ It is relevant to note that apart from these three jurisdictions, places such as Belgium, Luxemburg and the State of Washington and Montana in U.S. also permit one or the other practices. The reason why the subject matter of the thesis is restricted to only the Netherlands, the State of Oregon and Switzerland is because the current position of the practice of assisted suicide and euthanasia in England and Wales has some things in common with the Netherlands and Switzerland. The State of Oregon is of interest because its model is observed abuse free since its inception. Furthermore, Lord Joffe’s ‘*Assisted dying for Terminally Ill Bill*’ was modelled on the Oregon Death with Dignity Act (ODWDA). See Keown J. (2007) ‘Physician Assisted Suicide: Lord Joffe’s Slippery Bill’. *Medical Law Review*, Vol. 15, pp. 126-135.

⁹ ‘Assisted suicide statistics: the numbers Dignitas helps to die, by country’.

<http://www.guardian.co.uk/news/datablog/2010/feb/25/assisted-suicide-dignitas-statistics>

¹⁰ Dignitas is one of the ‘right to die’ societies based in Switzerland which (apart from Exit international) provide assistance in suicide to foreigners apart from Swiss residents, provided that the person assisted suffers from a fatal disease or unacceptable disability.

The thesis is divided into three chapters, followed by an overall conclusion at the end. Chapter 1 sets out the law of England and Wales on assisted suicide. Hence, it provides an overview of the statutory law on assisted suicide¹¹. It also analyses the limited scope of section 1 in the light of section 2 of the Suicide Act 1961. It further examines the possible reasons as to why a special provision - section 2(4) is incorporated in the statute that provides the Director of the Public Prosecutions (DPP) with the power to decide whether to bring prosecution or not against the person alleged to have assisted in the suicide. The role of the DPP is also analysed in this chapter, taking into account the recent landmark decisions in cases of assisted suicide.¹² This is followed by considerations of possible future developments that could potentially follow from the most recent decision in the case of *Debbie Purdy*.¹³

Chapter 2 examines the law of England and Wales on euthanasia. Hence, it is necessary to take into account both acts that kill and omissions that kill. Firstly, the chapter analyses the difference in law between the conduct of a doctor and a layperson that kills. Of particular importance here is the doctrine of double effect. Following this, the chapter will illustrate the discrepancies that are arguably involved in the application of the criminal law in cases of double effect. Secondly, the chapter sets out the duties that potentially can transform omissions into acts. The chapter discusses the ability of doctors to cancel their legal duties under special circumstances and the difficulties faced by laypersons who choose to do the same. The chapter concludes by examining the implications drawn from the relevant acts and omissions that kill.

Chapter 3 sets out the current legal regimes relevant to the Netherlands, the State of Oregon and Switzerland. This comparison with the law of England and Wales is undertaken in order to have an insight into the regimes adopted by these

¹¹ The Suicide Act 1961.

¹² That is the case of *Diane Pretty* and *Debbie Purdy*. The example of Daniel James will also be examined in this chapter.

¹³ *Regina (Purdy) v DPP (Society for the Prosecution of Unborn Children Intervention)* [2009] 3. W.L.R. 403. Hereafter cited as *R (Purdy) v DPP* [2009] 3. W.L.R. 403.

jurisdictions in relation to the 'end of life' issue. Apart from an assessment of these legal regimes, this chapter also sets out the extra-legal regimes adopted by these jurisdictions in order to ensure safe, responsible regulation of the practice of assisted suicide and euthanasia.

The conclusion draws attention to what are arguably the two main reasons why the legislature in England and Wales is still reluctant to liberalise the current strict legal regime. These are the principle of sanctity of life or value of life and the fear of abuse. The thesis examines whether the experiences of these foreign jurisdictions can provide any information that might inform the debate on the law of England and Wales. Furthermore, an attempt is made to ascertain whether the fears regarding the potential for abuse of a more liberal regime are justified. In addition, attention is drawn to further problems that could potentially arise from the liberalisation of the laws on assisted suicide or euthanasia. Similarly, the importance of the sanctity of life or value of life is taken into account in this concluding part. This analysis is undertaken in order to find out whether there is evidence from these countries, as well as the state of Oregon, to show that the public in England and Wales generally holds different views on the sanctity or value of life, when compared to the view of the public in the other jurisdictions noted above.

Chapter 1

The Law of England and Wales on Assisted Suicide

Before 1961, it was a crime under common law to commit suicide or even to attempt to commit suicide. Such a felony was regarded as self-murder. As a result, anyone who assisted or encouraged another person to commit suicide and who was also present at the suicide was guilty of murder as a principle in the second degree; a person who was an accessory before the fact to the suicide¹⁴ was guilty of being an accomplice to murder.¹⁵ In 1961, the law on suicide was changed and liberalised by the Suicide Act, but nevertheless, assisted suicide remained a serious crime under section 2 (1) 'complicity in suicide'.¹⁶ This Act creates a tension between the lawfulness of suicide and the unlawfulness of assisting someone to commit suicide which has become apparent over time. Efforts have been made to shed light on this Act and to clarify the law on suicide and assisted suicide. This chapter sets out the law on suicide and assisted suicide. It examines leading cases focusing on the role of the DPP under section 2 (4) of the Act and consider the likely future developments in this area by taking into account the most recent decision of the House of Lords in the case of *Debbie Purdy*.¹⁷

¹⁴ Accessory before the fact to the suicide was one who did assist in suicide, but was not present at the time of commission of the crime.

¹⁵ *R (Purdy) v DPP* [2009] 3 W.L.R. 403, p. 407.

¹⁶ Williams Glanville. (1973) 'Euthanasia'. *Medico Legal Journal*, Vol. 41, pp. 14-34.

¹⁷ *R (Purdy) v DPP* [2009] 3 W.L.R. 403.

1.1 The Statutory Law on Assisted Suicide: The Suicide Act 1961

a) Outline of the Act's Provisions

In 1961, Parliament enacted the Suicide Act decriminalising suicide under section 1. At the same time, the Act made provision for criminal liability for complicity in the suicide of another under section 2 of the Act.¹⁸

Section 2(1) of the Act

Section 2 (1) proscribes any conduct that would assist in suicide of another person or the attempted suicide of another person.¹⁹ It provides: “A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide” perpetrates a crime under section 2 (1) of the Act.²⁰ On the other hand, a person who attempts to aid, abet, counsel or procure the suicide of another, commits an offence under section 1 (1) of the Criminal Attempts Act 1981.

As of 1st February 2010, the above position of the law on assisted suicide, which comprised of two offences, both the substantive offence and the attempt to commit the substantive offence, has been replaced with a single offence through section 59 (2) of the Coroners and Justice Act 2009.²¹ The new Act substitutes section 2 (1) of the Suicide Act with the following:

“(1) A person (“D”) commits an offence if-

- (a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and
- (b) D’s act was intended to encourage or assist suicide or an attempt at suicide.

¹⁸ *Ibid.*, at p. 407.

¹⁹ *Pretty v United Kingdom* [2002] 35 E.H.R.R. 1; *R v (Purdy) v DPP* [2009] 1 Cr. App. R 32, p. 460; *R (Purdy) v DPP* [2009] 3 W.L.R. 403, p. 409.

²⁰ *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32.

²¹ See ‘Minister of Justice Circular 2010/03’ at URL:

<http://www.justice.gov.uk/publications/docs/circular-02-2010-coroners-justice-act.pdf>.

(1A) The person referred to in subsection (1) (a) need not be a specific person (or class of persons) known to, or identified by, D.

(1B) D may commit an offence under this section whether or not a suicide, or an attempt at suicide, occurs.

(1C) An offence under this section is triable on indictment and a person convicted of such an offence is liable to imprisonment for a term not exceeding 14 years.”²²

In addition, section 59 (4) of the Coroners and Justice Act 2009 inserts two new sections under section 2 of the Suicide Act:

Section 2A of the Act

“2A Act capable of encouraging or assisting

(1) If D arranges for a person (“D2”) to do an act that is capable of encouraging or assisting the suicide or attempted suicide of another person and D2 does that act, D is also to be treated for the purposes of this Act as having done it.

(2) Where the facts are such that an act is not capable of encouraging or assisting suicide or attempted suicide, for the purposes of this Act it is to be treated as so capable if the act would have been so capable had the facts been as D believed them to be at the time of the act or had subsequent events happened in the manner D believed they would happen (or both).

(3) A reference in this Act to a person (“P”) doing an act that is capable of encouraging the suicide or attempted suicide of another person includes a reference to P doing so by threatening another person or otherwise putting pressure on another person to commit or attempt suicide.”²³

²² See section 59 Encouraging and Assisting Suicide (England and Wales) of Coroners and Justice Act 2009 c. 25. <http://login.westlaw.co.uk>

²³ *Ibid.*

Section 2B of the Act

“2B Course of Conduct

A reference in this Act to an act includes a reference to a course of conduct, and a reference to doing an act is to be read accordingly.”²⁴

Implications of the New Provisions

The interpretation of the law on assisted suicide provided by the Criminal law Policy Unit Ministry of Justice circular states that apart from combining two offences into one, and replacing old-fashioned terms such as “aid, abet, counsel or procure” with more modern terms such as “assisting or encouraging”, there is no other change to the existing law on assisted suicide.²⁵ However, the provisions of section 2 (1), (1A) and (1B) of the Act suggest otherwise. Section 2 (1) criminalises the distribution of information without any need to show that any particular person committed suicide or attempted suicide. This is contrary to the interpretation provided in the case of *Abel and Others* based on the old provision under section 2 (1) of the Suicide Act 1961. In this case Woolf J. held that

“...for supply of the booklet [for example,] to amount to an offence under section 2 (1) of the Act of 1961 it had to be proved that the supplier, whilst intending the booklet to be used by a person actually contemplating suicide, and with the object of assisting or otherwise encouraging him, supply the booklet to such a person who then read it and, except in the case of an attempted offence, was assisted or encouraged by reading it to commit or to attempt to commit suicide....”²⁶

The provision regarding substitution under section 2 (1) of the Suicide Act²⁷ makes it clear that the crime of assisted suicide is a ‘conduct’ crime rather than a

²⁴ *Ibid.*

²⁵ See ‘Minister of Justice Circular 2010/03’ at URL: <http://www.justice.gov.uk/publications/docs/circular-02-2010-coroners-justice-act.pdf>.

²⁶ *Attorney-General v Able and Others* [1984] Q.B. 795, p. 796.

²⁷ The Suicide Act 1961 hereafter referred to as the Act.

‘result’ crime.²⁸ Under the Act, it does not matter whether or not a person actually acts on the information that is supplied or provided by another person. If a person distributes information with intent to encourage or assist suicide, and the person is aware that his conduct is capable of providing assistance to any person contemplating suicide, this would fall within the scope of criminal liability under section 2 (1) of the Act. This means any proponent, particularly those directly linked to right-to-die societies, who distributes or publishes information on methods of committing suicide will face criminal liability, irrespective of the use of the information, as much as such a conduct of a person in the circumstances would fulfil the requirements of *actus reus* and *mens rea*.

On the other hand, although section 2A (2) may seem harsh on those people who believe that their actions might assist suicide when there is no real possibility, arguably it provides a better understanding of the existing law on criminal attempts. For example under the law of criminal attempts, even attempting the impossible, such as providing harmless pills to a person ‘to assist in suicide’, would attract criminal liability.²⁹

Similarly, those who escort their loved ones to Switzerland or those who make arrangements with Dignitas on behalf of their loved ones, can be held responsible for their actions in line with Section 2 (1) of the Act.³⁰ The Minister of Justice, in Circular 2010/03, recently confirmed that the new language of ‘encouraging or assisting’ covers essentially the same actions that were previously covered by the

²⁸ See section 2 (1B) above.

²⁹ See ‘Minister of Justice Circular 2010/03’ at URL:

<http://www.justice.gov.uk/publications/docs/circular-02-2010-coroners-justice-act.pdf>.

³⁰ This is explicit from the decision of the DPP in Daniel James’ situation (see pp. 43- 46 of the thesis) and from the most recent (19/03/2010) case of Caractacus Downes who escorted his parents (Sir Edward and Lady Joan Downes) to Dignitas and booked hotel room for their use in Switzerland. The DPP in this matter provided following reasons for holding consent to prosecution of Caractacus Downes. He said although there is sufficient evidence to charge Caractacus Downes with an offence of assisted suicide of his parents, “it is not in the public interest to do so”. The assistance provided can be characterised as minor and Caractacus Downes was “wholly motivated by compassion”. Furthermore his parents had showed a clear and settled decision to end their life. See ‘No Charges following deaths of Sir Edward and Lady Downes’. http://www.cps.gov.uk/news/press_releases/113_10/index.html

old language i.e. to ‘aid, abet, counsel and procure’ under section 2 of the Suicide Act and the Criminal Attempts Act, as applied in case of section 2 of the Suicide Act.³¹

Section 2 (4) of the Act

As has historically been the case,³² the prosecution under section 2(1) can be initiated *only* with the consent of the DPP.³³ Section 2(4) of the Act makes provision for this. It provides: “...no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions.”³⁴ The law under this subsection was clarified recently³⁵ on the basis that it forms an integral part of section 2 (1) of the Act.³⁶ Furthermore, the DPP has published the ‘Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide’, a policy document³⁷ which contains a number of specific factors, both for and against prosecution, in the circumstances of encouraging or assisting suicide.³⁸

Section 3 (3) of the Act

Apart from the above-mentioned provisions, the Act also incorporates a proviso with regard to its jurisdiction. Section 3(3) of the Act provides that it extends *only* to England and Wales.³⁹ The Law Lords in the case of *Debbie Purdy*⁴⁰ were

³¹ ‘Minister of Justice Circular 2010/03’ at URL:

<http://www.justice.gov.uk/publications/docs/circular-02-2010-coroners-justice-act.pdf>.

³² Since the inception of the Act.

³³ Bennion Francis. (2009) ‘Assisted Suicide: A Constitutional Change’. *Criminal Law and Justice Weekly*, Vol. 173, p. 521.

³⁴ The Suicide Act 1961. <http://www.statutelaw.gov.uk>

³⁵ On 25 February 2010.

³⁶ The clarification of the law on encouraging or assisting suicide under subsection (4) of the Act is the outcome of the case of *Debbie Purdy* who claimed that the law under subsection (4) of the Act was unclear (See *R (Purdy) v DPP* [2009] 3 W.L.R. 403). More on this part of the chapter is said under subheading ‘The case of *Debbie Purdy*’. See p. 47 of the thesis.

³⁷ For the sake of brevity in future, this policy will be referred to as ‘offence specific policy’. This policy is annexed as ‘Appendix A’.

³⁸ The detailed analysis of the ‘offence specific policy’ is dealt further in this chapter under subheading, ‘Encouraging or Assisting Suicide: The Offence Specific Policy for Prosecutors’.

³⁹ See ‘The Suicide Act 1961’. <http://www.statutorylaw.gov.uk>

⁴⁰ *Ibid.*, at p. 403. This case is examined little later under subheading ‘Decision in the case of *Debbie Purdy*’.

divided on the issue of jurisdiction.⁴¹ For instance, Lord Phillips showed concern over the probability that section 1 of the Act might not apply to suicide committed abroad, thus it would come under old law i.e., self-murder. As a result, such conduct would then attract a liability “...within section 9 of the Offences Against the Person Act 1861 which gives the English Courts jurisdiction over both principal and accessory liability in case of murder and manslaughter committed abroad”.⁴²

However, Lord Hope on the other hand, reasoned that the language of section 2(1) of the Act

“...suggests that it applies to any acts of the kind it describes that are performed within this jurisdiction, irrespective of where the final act of suicide is to be committed. So acts which help another person to make a journey to another country, in the knowledge that its purpose is to enable the person to end her own life there, are within its reach. Its application cannot be avoided by arranging for the final act of suicide to be performed on the high seas, for example, or in Scotland. Otherwise it would be all too easy to exclude the vulnerable or the easily led from its protection.”⁴³

Perhaps, the meaning of Lord Hope’s statement is that if section 2(1) applies to acts taking place outside of the jurisdiction, then section 1 must similarly apply to acts taking place outside of the jurisdiction, or the greater offence of accessory to murder would leave no room for the offence of complicity to operate.⁴⁴

⁴¹ Heywood Rob. (2010) ‘R. (on the application of Purdy) v DPP: Clarification on Assisted Suicide’. *Law Quarterly Review*, Vol. 126, p. 5; Buxton Richard. (2010) ‘R (on the application of Purdy) v DPP: Complicity in Suicide abroad’. *Law Review*, Vol.126, pp. 1-5.

⁴² Buxton Richard. (2010) ‘R (on the application of Purdy) v DPP: Complicity in Suicide Abroad’. *Law Review*, Vol.126, p. 3.

⁴³ *R (Purdy) v DPP* [2009] 3 W.L.R. 403, p. 409.

⁴⁴ Alternatively, Lord Hope’s observation could mean that since assisted suicide is conduct-based offence, any act performed with intention to encourage or assist suicide or an attempt in suicide within the jurisdiction of England and Wales should be sufficient to hold one responsible for his or her conduct irrespective of the result. However, this could give rise to further concerns raised by Lord Philips. Similarly, this ambiguity could lead one to think that the defendant could be charged

Taking into account the opinion of Lord Phillips, Lord Hope addressed the issue further, stating that the conduct of Debbie Purdy's husband in assisting Debbie Purdy to travel to Switzerland for the purpose of assisted suicide would potentially fall within the parameters of section 2 (1) of the Act. It was this risk that caused Debbie Purdy to seek guidance from the authorities regarding the potential criminal liability her husband could incur in the event of escorting her travel to Switzerland.⁴⁵

On the contrary, Michael Hirst is of the view that it is not an offence for a person to do acts in England and Wales that aided and or abetted a suicide that subsequently took place in a jurisdiction where suicide is lawful.⁴⁶ Although the Appellant Committee took his opinion into account in their oral discussion on this issue,⁴⁷ Lord Philips, who pronounced the judgement in the case, held that the observations made by Lord Hope on the question of jurisdiction should remain valid unless it falls for the determination in the context of a prosecution. In addition, he stated the question should remain open since the interpretation provided by Lord Hope was not challenged and the issue requires a through study.⁴⁸

Accepting the decision to keep the jurisdiction issue open, Hirst argues that the observation made by Lord Philip on the point of jurisdiction is mistaken. "One can, however, state with certainty that the spectre of prosecution for murder in such cases was properly laid to rest in 1961."⁴⁹ In Hirst's view

with two offences, complicity in suicide of another and principal in second degree or an accomplice to murder. Since these possibilities go against the clear and strait forward, view held by Lord Hope it is unlikely that this is what he meant. Hence Lord Hope must mean the above i.e. section 1 must apply beyond the jurisdiction.

⁴⁵ *R (Purdy) v DPP* [2009] 3 W.L.R. 403, p.413.

⁴⁶ Hirst Michael. (2009) 'Suicide in Switzerland: Complicity in England?' *Criminal Law Review*, p. 335.

⁴⁷ Hirst Michael. (2009) 'Assisted Suicide after Purdy: The Unresolved Issue'. *Criminal Law Review*, p. 870.

⁴⁸ *R (Purdy) v DPP* [2009] 3 W.L.R. 403, p.406.

⁴⁹ Hirst Michael. (2009) 'Assisted Suicide after Purdy: The Unresolved Issue'. *Criminal Law Review*, p. 876.

“Section 3(3) indicates that the Suicide Act extends only to the law of England and Wales, and not to those of Scotland or Northern Ireland. But that is all that it does. It does not impose any territorial limitation on the ambit or application of the various provisions of the Act. So, when s. 1 of the Act abrogated the old felony of suicide, it did so for all purposes in English law, but only for the purpose of English law.”⁵⁰

Having outlined the provisions of the Act, the following part of the chapter aims to explore the limited effect of section 1 in the light of section 2 of the Act.

b) Negative and Positive Right to Die: The Limited Effect of Section 1 in the Light of Section 2 of the Act

The law on suicide constitutes a negative, not a positive right to die.⁵¹ A negative right corresponds only to those rights which require a duty or duties of non-interference.⁵² In other words, a negative right calls for non-action from others. A positive right, on the other hand, “is a justified claim to someone’s assistance”⁵³. It entails not only a duty of non-interference, but also “the duty to *help*, at least in the cases where the right-holder would not be able to do the thing without help”⁵⁴. Section 1 of the Act, permits any competent person to choose death over life.⁵⁵ The law “does not penalise the decision... to take their own life ...nor does the law prohibit them from so doing”.⁵⁶ Nonetheless, the language of the Act clearly indicates “...there is no right to be helped to die either by one’s own hand or the

⁵⁰ *Ibid.*, at p. 872.

⁵¹ *R (Pretty) v DPP (Secretary of State for the Home Department intervening)* [2002] 1 A.C. 800, p. 846; Hale Dame Brenda (Lady Justice of Appeal). (2003) ‘A Pretty Pass: When Is There a Right to Die?’ *Comm. L. World Review*, Vol. 1, p. 9.

⁵² Narveson J. (1999) *Moral Matter*. Canada: Broad View Press Ltd. pp. 34-5; Childress J.F. (1980) ‘Negative and Positive Rights’. *The Hastings Center Report*, Vol. 10, No.1, p. 19.

⁵³ Childress J.F. (1980) ‘Negative and Positive Rights’. *The Hastings Center Report*, Vol. 10, No.1, p. 19. *R (Pretty) v DPP (Secretary of State for the Home Department intervening)* [2002] 1 A.C. 800, p. 846; Hale Dame Brenda. (2003) ‘A Pretty Pass: When Is There a Right to Die?’ *Comm. L. World Review*, Vol. 1, p. 9.

⁵⁴ Narveson J. (1999) *Moral Matter*. Canada: Broad View Press Ltd. pp. 34-5.

⁵⁵ *Re Z (Local Authority: Duty)* [2005] 1 W.L.R. 959.

⁵⁶ *Ibid.*

intervention of others.”⁵⁷ In fact, those who encourage or assist the act of suicide *may*⁵⁸ face criminal prosecution under section 2 (1) of the Act which proscribes any such conduct.⁵⁹ As a result, in the light of section 2 (1) of the Act, the outcome of section 1 of the Act is such that a person who chooses to end his life is able to act alone.⁶⁰ This leaves one with *only* two choices: to die unaided within the jurisdiction of England and Wales;⁶¹ or travel abroad unaided for example, to Switzerland to die with the help of Dignitas.⁶²

Taking Life ‘Actively’

In order to benefit from the existing negative right to die, one must be competent to make a decision.⁶³ Further to this, the person should be physically able to carry out the act of suicide.⁶⁴ Therefore, under the Act, a person contemplating suicide should begin and end the whole process by oneself.⁶⁵ Any sort of assistance provided either ‘before the fact’, ‘during the process of attempt to commit suicide’ or ‘after the attempt’⁶⁶, would potentially bring the assistant “...within

⁵⁷ Hale Dame Brenda (2003) ‘A Pretty Pass: When Is There a Right to Die?’ *Comm. L. World Review*, Vol. 1, p. 9.

⁵⁸ The word ‘*may*’ is used to emphasise the requirement of consent for prosecution under subsection (4) of the Act.

⁵⁹ *R v Pitman* (1997) 4 (9) Med L Monitor 2-3. Cited in Huxtable R. (2007). *Euthanasia, Ethics and the Law: From Conflict to Compromise*. New York: Routledge. Cavendish. p. 151; *R v Wallis* [1983] 5 Cr App R (S) 342.

⁶⁰ Freeman Michael. (2002) ‘Denying Death its Dominion: Thoughts on the *Dianne Pretty Case*’. *Medical Law Review*, Vol. 10, p. 246.

⁶¹ Coggon John. (2006) ‘Could the Right to Die with Dignity Represent a New Right to Die in English Law?’ *Medical Law Review*, Vol. 14, p. 228.

⁶² In *Re Z (Local Authority: Duty)* [2005] 1 W.L.R. 959. It is to be noted that although the husband of Ms Z was willing to accompany her, the moot point in this case is the court held that it had no power to stop Ms Z from travelling to Switzerland for the purpose of ‘assisted death’.

⁶³ *Ibid.*

⁶⁴ Without requiring any help from another person who comes within the jurisdiction of the English courts for the purposes of section 2 (1) of the Act. Although the law does not require one to be physically able to attempt to commit suicide, physical disability prevents one from doing so. As a result, such person cannot benefit from the negative right to die unless he depends on another person for assistance which would mean exposing that particular person to criminal liability. Hence, one *should* be physically able to benefit from section 1 of the Act.

⁶⁵ This means not only planning how to go about, but also to make arrangements for the means to end one's life successfully and peacefully. Such course of conduct is necessary in order to prevent another person falling within the scope of section 2(1) of the Act.

⁶⁶ Assistance provided after the attempt here refers to cases in which a person may require more help from the assistant to ensure one's death like in case of Lynn Gilderdale who had to ask her mother to provide her with more morphine. For further details on this case, see footnote 68 and the last part of this chapter.

the meaning of section 2 (1) as an offender and render him [or her] subject to prosecution”⁶⁷. This is exactly what happened in the case of Lynn Gilderdale.⁶⁸ Lynn took the first step to end her life (by taking almost the whole dose of morphine). It being insufficient to kill her, she had to depend on her mother, Kay Gilderdale, to provide her with more morphine. As a result, Kay Gilderdale’s conduct came within the scope of section 2 (1) of the Act which, as stated above, prohibits any kind of assistance in relation to the suicide of another.

Regarding the law in the jurisdiction of England and Wales, the *only* help one was able to avail of, without implicating another person in their act of self-killing, was the provision of the information on how to commit suicide, which is mostly provided by the campaigners of right to die. Since 1st February 2010, this provision arguably, has taken a different mode. As stated earlier⁶⁹ currently, any person who supplies information on how to commit suicide through any kind of source with intent to encourage or assist suicide of another or attempted suicide of another should attract criminal liability.

Although it may be relatively easy to obtain information on how to attempt to commit suicide, it is more difficult to procure the means to end ones life quickly and painlessly.⁷⁰ As a result, it is often the case that even able-bodied people have to rely on another person, not to perform an act, but to supply means. Terminally ill people normally rely on their doctors for this purpose. Although in most instances doctors would prescribe the drug for the purpose of pain relief, it is arguable that at times, they may in fact do so to assist their patients to put an end

⁶⁷ Tur Richard H.S. (2003) ‘Legislative Technique and Human Rights: The Sad Case of Assisted Suicide’. *Criminal Law Review*, (Jan), p. 5; HC Deb 14 July 1961 vol. 644 cc833-45. ‘Suicide Bill [Lords]’ at <http://hansard.millbanksystems.com/commons/1961/jul/14/suicide-bill-lords>

⁶⁸ Lynn Gilderdale fell ill with ME in 1991 and since then her health kept on deteriorating, but her mind was sharp. She soon was paralysed from the waist to down and became bedridden. In 2007, she attempted unsuccessful suicide. In 2008, she again attempted suicide and this time she did succeed, but only with the help of her mother. See Broadcast on: BBC One, 1st February 2010. ‘I helped my daughter die’, at http://www.bbc.co.uk/iplayer/episode/b00qs930/b00qs8mk/panorama_I_Helped_My_Daughter_Die/

⁶⁹ See pp. 11-13 of the thesis.

⁷⁰ Humphry, Derek. (2002) *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. New York: Dell Publishing.

to their suffering. This type of conduct by doctors is normally shielded by the doctrine of double effect.⁷¹ However, the obligation to comply with record keeping and the duty to prescribe doses of pills that are not more than necessary to relieve pain makes it difficult for doctors to assist in this manner.⁷²

Taking Life ‘Passively’

On the other hand, a person may decide to end his or her life by passive means such as refusing food and water i.e. to starve oneself to death.⁷³ Derek Humphry explains how painful and long this process of ‘silent suicide’ could last for.⁷⁴

In some cases self-starvation can be very painful. In 1987, after a court in Colorado gave Hector Rodas permission to starve himself to death (he was quadriplegic), morphine had to be administered to kill the pain of fatal dehydration. In the fifteen days it took Rodas, who had good medical care, to die he constantly slipped in and out of a coma.⁷⁵

As is evident Mr Rodas’ experience killing oneself in this manner is an independent act for which the dying person takes full responsibility.⁷⁶ However, even in this situation the possibility remains that another person will get involved, not to assist in suicide (a debatable issue), but to make dying comfortable and painless. This is precisely what Kay Gilderdale claimed she had done for her daughter, Lynn (who had actually attempted suicide herself) when she injected Lynn with morphine after Lynn lost consciousness.⁷⁷ Humphry calls this type of

⁷¹ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish.

⁷² More on the role of doctors in the context of double effect is discussed in chapter 2 of the thesis.

⁷³ Humphry Derek. (2002) *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. New York: Dell Publishing. p. 58.

⁷⁴ *Ibid.*, at p. 60.

⁷⁵ *Ibid.*, at p. 59.

⁷⁶ *Ibid.*, at p. 62.

⁷⁷ See Broadcast on: BBC One, 1st February 2010. ‘I helped my daughter die’.

http://www.bbc.co.uk/iplayer/episode/b00qs930/b00qs8mk/panorama_I_Helped_My_Daughter_Die/

conduct ‘assistance in dying’⁷⁸, whereas legally such conduct could potentially be prosecute as ‘attempted murder’ or ‘murder’ depending on the facts and circumstances of the case.

Apart from self-starvation, the issue of whether refusing life-saving treatment or a life-preserving intervention is itself a method of committing suicide has raised concern. If this is categorised as suicide, those who assist by administering drugs that reduce pain can be charged with assisting suicide. Some oppose this view claiming that refusing treatment is merely asserting one’s right to self-determination.⁷⁹ The courts have been reluctant to accept that dying, as a consequence of either withholding treatment or withdrawing treatment is a form of suicide. According to Lord Goff:

“...there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in so doing. It is simply that the patient has, as he is entitled to do so, declined to consent to treatment which might or could have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient’s wishes.”⁸⁰

On the other hand, some commentators argue that “refusing treatment is, or can be a form of suicide....”⁸¹ For example Otlowksi uses the following analogy: “...if a person deliberately chooses not to move from the path of an avalanche, or refuses to leave a burning building, it is arguable that the person is, in effect,

⁷⁸ Humphry Derek. (2002) *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. New York: Dell Publishing. p. 60.

⁷⁹ Freeman Michael. (2002) ‘Denying Death its Dominion: Thoughts on the Diane Pretty Case’. *Medical Law Review*, Vol. 10, p.247.

⁸⁰ *Airedale N.H.S. Trust v Bland* [1993] A.C. 789.

⁸¹ Williams Glenys. (2007) *Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide*. London; New York: Routledge. Cavendis. p.113; Hale Dame Brenda. (2003) ‘A Pretty Pass: When Is There a Right to Die?’ *Comm. L. World Review*, Vol. 1, p. 9; Otlowski M. (1997) *Voluntary Euthanasia and the Common Law*. Oxford: Oxford University Press.

committing suicide”.⁸² However, it is possible that people may in fact have different reasons for so doing, e.g. religious reasons or a dislike of the side effects of the treatment. Nonetheless, it cannot be disputed that one such reason could be a desire to commit suicide.⁸³ The Court of Strasbourg in the case of *Diane Pretty* noted “...that in domestic law, a person may exercise ‘a choice to die’ by refusing life-prolonging treatment”.⁸⁴ This appears to recognise, at least for the purposes of European Human Rights law, that refusing treatment may amount to suicide.

Arguably, another way of ensuring death after attempting suicide is of Kerrie Woollorton. Importantly, this case shows that the negative right to die is not simply immunity from prosecution for those who attempt to take their own life, but a full right to prevent others from interfering to prevent someone from committing suicide.⁸⁵ Woollorton was depressed (about her inability to have children) she had attempted suicide nine times previously. On 15 September 2007, she drew up her directive, which clearly stated that she did not want to be saved. She had also expressed the wish that she wanted medical staff *only* to make her dying comfortable. Three days later she took an overdose at home and called the ambulance. However, she remained conscience in order to hand the letter to the doctors of the Norwich Hospital and to tell them that she did not wish to be saved. The only reason why she called the ambulance is that she did not want to die alone and in pain.⁸⁶ Since the doctors found her mentally competent to make such a decision, and going beyond her wish would mean committing assault, the doctors found themselves in a position where they had to let her die.⁸⁷ In fact Dr

⁸² Otowski M. (1997) *Voluntary Euthanasia and the Common Law*. Oxford: Oxford University Press. p. 63.

⁸³ Keown J. (2003) ‘European Court of Human Rights: Death in Strasbourg – Assisted Suicide, the *Pretty* Case, and the European Convention on Human Rights’. *International Journal of Constitutional Law*, Vol. 1, p. 728.

⁸⁴ *Ibid*; *Pretty v United Kingdom* (2002) 35 E.H.R.R. 1, p. 36.

⁸⁵ Rebecca Smith. (2009) Living wills Case could lead to ‘Assisted Suicide by Backdoor’. Telegraph.co.uk (accessed on 11 March 2010).

⁸⁶ ‘Suicide Woman allowed to die because doctors feared saving her life would be assault’. 30 September 2009, Telegraph.co.uk (accessed on 12th March 2010).

⁸⁷ *Ibid*.

Alexander Heaton⁸⁸ said, “I would’ve been breaking the law and I wasn’t worried about her suing me, but I think she would have asked, ‘What do I have to do to tell you what my wishes’”.⁸⁹ If Dr Heaton had treated Woollorton against her ‘will’, he would risk not only civil liability, but also criminal (battery and assault).

Woollorton was provided with pain relief in order to make her dying comfortable as it was done in the case of Mr Rodas⁹⁰. As much as this could be seen as a duty on the part of the doctor to provide such care at the end of life of the patient,⁹¹ it could also be seen as assisted suicide. However, the Coroner came to the verdict that the hospital should not be blamed because the patient had the capacity to consent to treatment and the doctors acted within the law in following her living will.⁹²

Implications of Limited Scope of Section 1 in the Light of Section 2 (1) of the Act

Section 2 (1) is an obstacle to physically disabled people as well as able-bodied people

As seen above it is not only cases involving disability which can come in the way of the people who wish to end their life peacefully and painlessly without implicating another person in their death. There is also often a difficulty in obtaining resources, which acts as a hurdle for both the ‘able’ person as well as ‘disabled’ person. Section 2 (1) of the Act also prevents those who may be physically able and might even have access to means to end their life, but they are unwilling⁹³ to perform the conduct (attempt to commit suicide) without assistance.⁹⁴ Hence, the person who cannot commit suicide without help cannot

⁸⁸ The hospital’s consultant renal physician.

⁸⁹ ‘Suicide Woman allowed to die because doctors feared saving her life would be assault’. 30 September 2009, Telegraph.co.uk (assessed on 12th March 2010).

⁹⁰ See p. 21 of the thesis.

⁹¹ More on this aspect is said in chapter 2 of the thesis.

⁹² *Ibid.*

⁹³ May be because they lack courage or probably because they do not want to die a lonely death.

⁹⁴ *R (Purdy) v DPP* [2009] 3 W.L.R. 403, p. 426.

exercise the negative right to die except when one is dependant on medical treatment for one's survival. Such a person may choose not to carry on living and refuse treatment either by orally means or through advance directives and opt for the treatment to make one's dying comfortable like Kerrie Woollorton, who got the doctors to assist her by making it more comfortable. Similarly, the distinction between 'assistance in suicide' and 'murder' requires the act to be treated as the cause of death to be an act of the suicide. This prevents a person who is incapable of undertaking the final act for themselves enjoying the negative right to die, not because of section 2 (1) of the Act, but because of the law of murder.

Under the current law on suicide the only people able to die a 'good death'⁹⁵, without incriminating another are those who are physically capable to act alone and who have access to required information and means (e.g. drugs). Other options available (apart from prescribed drugs) to end ones life are easy to acquire but arguably these options do not ensure a 'good death'. This is because it not only has bad side effects such as vomiting, body cramps, etc, but it can be violent and painful, and at times not guarantees death.

As a consequence the negative right to commit suicide, under section 1 in the light of section 2 (1), operates only as a right to choose an uncertain and possibly painful death and also, perhaps, a lonely death. Humphry argues that there are different ways people attempt to commit suicide.⁹⁶ He states that some people attempt suicide by ingestion of cyanide (which comes in different forms such as potassium cyanide, Ferrocyanide, sodium cyanide). He goes on to say that one must take large amount of it in order to ensure immediate death. He does not recommend this option because it does not ensure death in every case, and most of the time the side effects of the poison are extremely unpleasant. Ingesting the

⁹⁵ One that is peaceful, painless and quick.

⁹⁶ Humphry Derek. (2002) *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. New York: Dell Publishing.

poison could lead to bleeding, vomiting and cramps.⁹⁷ Other methods that he notes include a method to inject oneself with air bubbles of 100 to 200ml (a process which must be performed quickly intravenously, and close to the heart i.e. one would have to fill the whole heart with air at once). Humphy does not recommend this method probably because the person does not die immediately and remains conscious during the last 5 minutes before death. This means ending life in this manner would amount to slow and painful process. Other common methods of suicide are hanging and drowning. Some more outlandish methods include hunting for poisonous plants to ingest and some even attempt to freeze themselves to death on a mountain by exposing oneself to the elements.⁹⁸ It is also possible to take huge doses of drugs,⁹⁹ bought without prescription. Generally, this method does not ensure death and if it does cause death, it is slow and painful. For example, taking heavy doses of aspirin will burn the lining of the stomach over several days. As stated above, some people may also attempt to starve themselves to death and while others try to use non-prescribed drugs, in combination with a plastic bag, to commit suicide. Humphry strongly suggests that one should somehow 'shop' for a doctor who is willing to assist in providing pills. When such an option is not available, according to him, one should choose sleeping pills and a plastic bag to ensure death. Hence, for Humphry, this method could prove preferable to the others suggested above.

In the absence of a right in this country to receive drugs that can make death both certain and painless, some of those contemplating suicide choose to travel to countries where such drugs are available.¹⁰⁰ Alternatively, those who are physically able and financially well off, travel to Switzerland to have a good death. This would almost always involve making the choice to die an earlier death

⁹⁷ *Ibid.*

⁹⁸ *Ibid.*

⁹⁹ Which are not lethal unless taken in large doses.

¹⁰⁰ Humphry Derek. (2002) *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. New York: Dell Publishing.

in order to circumvent the restrictions regarding receiving the necessary assistance in the case of a delay.¹⁰¹

c) The Role of the DPP under Section 2 (4) of the Act

i) A Possible Rational for Inclusion of Subsection (4) of the Act

The harshness of the law of assisted suicide, as set out above, has been ameliorated by a prosecution policy that fails to prosecute all cases where those committing suicide have been able to obtain assistance from others. That this could become a policy, rather than the ad hoc decisions of different prosecuting authorities, is a consequence of section 2 (4), which makes all prosecutions subject to the consent of the DPP.

When Parliament passed the legislation in 1961, it made provision in section 2 (4) of the Act for the requirement of the DPP's consent to prosecution. As stated above, no prosecution can be brought under section 2 (1) of the Act without the prior consent of the DPP. This provision was introduced in spite of there being a general practice that the prosecution does not follow automatically.¹⁰² This implies the provision under Suicide Act probably has a special purpose compared to a 'general prosecutorial discretion'¹⁰³ which provided guidance through the Code of the practice issued by the DPP under section 10 of the Prosecution of

¹⁰¹ This is assumed on the basis that people who are well enough to travel unassisted are not about to die.

¹⁰² “In 1951 the question was raised whether it was not a basic principle of the rule of law that the operation of the law is automatic where an offence is known or suspected. The then Attorney General, Sir Hartley Shawcross, said: “it has never been the rule in this country – I hope it never will – be that criminal offences must automatically be the subject of prosecution.” He pointed out that the Attorney General and the Director of Public Prosecutions only intervene to direct a prosecution when they consider it in the public interest to do so and he cited a statement made by Lord Simon in 1925 when he said: “... there is no greater nonsense talked about the Attorney General's duty than the suggestion that in all cases the Attorney General ought to decide to prosecute merely because he thinks there is what the lawyers call a case. It is not true and no one who has held the office of Attorney General supposes it is.” Sir Hartley Shawcross's statement was indorsed, I think, by more than one of his successors’.” See *Regina (Purdy) v Director of Public Prosecutions (Society for the Protection of Unborn Children intervening)* [2009] 3 W.L.R. 403, p. 419.

¹⁰³ Tur Richard H.S. (2003) ‘Legislative Technique and Human Rights: The Sad Case of Assisted Suicide’. *Criminal Law Review*, Jan, pp. 5-6.

Offences Act 1985, in the form of ‘Full Code Test’. It comprises of two stages,¹⁰⁴ an evidential stage¹⁰⁵ and public interest stage¹⁰⁶. In this part of the chapter attempt is made to explore the different views held by academics and practitioners on a possible reason for inclusion of subsection (4) in the Suicide Act. Obtaining a view on the intention underlying this provision will help to understand the spirit of the law on assisted suicide.

To Mark the Gravity of the Crime

Huxtable is of the opinion that the requirement of the consent of the DPP to prosecution was included in the Act to mark the gravity of the crime.¹⁰⁷ Huxtable argues that the reason for this is that the offence “can encompass cases which range ‘from the border of cold blooded murder down to the shadowy area of mercy killing’”.¹⁰⁸ The Joint Under-Secretary of State for the Home Department Mr. Charles Fletcher-Cooke, who read the Suicide Bill for a second time while it was under consideration, also remarked that the cases under this offence may vary.

“The Committee recommended the creation of a completely new offence, aiding, abetting counselling or procuring the suicide of another or an attempt by another to commit suicide, and it recommended that this offence should carry a penalty of a maximum sentence of 14 years imprisonment. This may seem very high, but the offences are not likely to be frequent, and, with very few exceptions, may be expected to attract only a small penalty. But the complicity in the death of another can never be regarded lightly, and it is not difficult to think of circumstances in

¹⁰⁴ *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32, p. 463.

¹⁰⁵ It requires that prosecutors “...be satisfied that there is enough evidence to provide ‘a realistic prospect of conviction’”. See *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32, p. 463.

¹⁰⁶ Only when the requirement of the evidential stage is fulfilled, the prosecutor should then examine the case under second stage and “...decide if a prosecution is needed in the public interest”. See *R (Purdy) v Director of Public Prosecutions* [2009] 1 Cr. App. R. 32, p. 463.

¹⁰⁷ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 78.

¹⁰⁸ *Ibid.*, at pp. 62 – 78.

which the offence would be extremely grave, calling for severe punishment. Indeed, the gravity of these offences will also be marked by the requirement that they should be tried only at Assizes, and only by, or with the consent of, the Director of Public Prosecutions.”¹⁰⁹

The language used in the passage suggests that there were various ways in which someone could be helped or assisted in committing suicide. It also shows an attempt to articulate two sides of the offence, both assisted suicide or complicity in suicide and attempt to murder or murder. Mr. Keir Starmer (DPP) also made reference to the same point in an interview with Guardian. He said the reason why Parliament thought it necessary to include section 2 (4) in the Act providing discretion to the DPP to consent to prosecution is because it recognised that the ways in which one may commit suicide, and the ways in which people may assist, are varied.¹¹⁰ This implies that some ways of encouraging or assisting suicide were not to be prosecuted and some ways were to be prosecuted. In the forthcoming sections attempt is made to explore the possible basis of distinction.

To Spare those who had not offended against the Spirit of the Legislation

In 2000, the Law Commission considered the justification for requiring consent to prosecution.¹¹¹ Andrew Dismore (Hendon) MP, relied on a quote from the report of the then Attorney General, who said in 1959 that

“the purpose of consent was ‘to prevent vexatious proceedings’, which is a more natural way of putting it [than saying that it was to ‘stop busy bodied blundering in and prosecuting people in circumstances which would not be seen as appropriate’¹¹²], and to restrict prosecutions in circumstances

¹⁰⁹ HC Deb 14 July 1961 vol. 644 cc833-45. ‘Suicide Bill [Lords]’.

<http://hansard.millbanksystems.com/commons/1961/jul/14/suicide-bill-lords>

¹¹⁰ ‘Guardian Daily: Assisted suicide and the law’.

<http://www.guardian.co.uk/world/audio/2010/jan/29/guardian-daily-podcast>

¹¹¹ ‘Consent of the Director of Public Prosecutions’, HC Deb 14 April 2000 Vol. 348 cc 603 –66.

¹¹² The BBC’s legal correspondent for news and current affairs, Mr Joshua Rosenberg, provided this reason for provision of consent. See ‘Consent of the Director of Public Prosecutions’, HC Deb 14 April 2000 Vol. 348 cc 603 –66.

where a law has, necessarily, been drafted in broad terms, thereby creating the risk that it would catch those who had not offended against the spirit of the legislation”.¹¹³

Dismore makes two points here. Firstly, he notes that one reason for requiring consent is to avoid proceedings being brought with no legal basis.¹¹⁴ Secondly, he notes that another reason for requiring consent is to protect those persons who perform the action or get involved while fulfilling one’s duty from being prosecuted. In this scenario, the aim is not to assist in suicide or to attempt to kill or kill, but they may potentially fall foul of the existing criminal law. Dismore makes a special reference to doctors, noting that if a doctor becomes involved in a situation of assisted suicide the doctor would potentially fall foul of the existing criminal law under section 2 (1) of the Suicide Act.¹¹⁵ Hence, he argues that the ‘consent provision’ is vital to protect doctors such as Dr David Moor,¹¹⁶ whose intentions are not to breach the law, but to treat the patient. In Dismore’s opinion, these types of cases can be distinguished from other types of cases involving doctors such as Dr Shipman, who clearly offended against the spirit of the law, which is framed to protect vulnerable people¹¹⁷. If the ‘consent provision’ could be understood in the above context, and if it is appropriate to say that the spirit of the law on assisted suicide under section 2 (1) is to protect vulnerable people who are “...sometimes minded to wish themselves dead...” as observed by Lord CJ in Hough¹¹⁸, then it is arguable that subsection (4) is a legislative attempt so to qualify subsection 2(1) so to avoid injustice, without too seriously compromising

¹¹³ ‘Consent of the Director of Public Prosecutions’, HC Deb 14 April 2000 Vol. 348 cc 603 –66.

¹¹⁴ Normally this happens when one intends to harass the defendant or has no sufficient ground to base the case in law.

¹¹⁵ ‘Consent of the Director of Public Prosecutions’, HC Deb 14 April 2000 Vol. 348 cc 603 –66.

¹¹⁶ *Ibid.* Dr David Moor was charged with murder of one of his patients to whom Dr David Moor had administered lethal dose of painkilling drug. He was prosecuted of the alleged offence. However, the jury found him not guilty. This case is examined in detail in chapter 2 of the thesis.

¹¹⁷ ‘Consent of the Director of Public Prosecutions’, HC Deb 14 April 2000 Vol. 348 cc 603 –66. More on this is said in the following chapter of the thesis.

¹¹⁸ *R v Hough* (1984) 6 Cr App R (S) 406. In this case, Hough performed the last act on her friend who had attempted suicide, but did not die for several hours. Hough acted on the prior consent of her friend who had asked her to intervene if her attempt failed.

the sanctity of life.¹¹⁹ In other words, subsection (4) acts as a kind of ‘referee’, with the DPP performing the function in order to draw a line between assistance, to those who are not vulnerable (which does not require prosecution), and matters of complicity in death (which does require prosecution). The reason for this is that in the former scenario, the party involved does not offend the spirit of the law i.e. ‘protection of the vulnerable’, but in the latter scenario, the party involved falls within the criminal element of the legislation and therefore, the party should be prosecuted.¹²⁰ This means not only doctors who fall foul of the existing criminal law should benefit by section 2 (4) of the Act, but also lay people whose conduct is similar to that of a doctor for example. On this basis, it is possible to suggest that the justification for the inclusion of subsection (4) is to enable the DPP to discern between those whose conduct defeats the purpose of the Act, i.e. ‘protection of the vulnerable’ and those who do not and to act accordingly.¹²¹

To Limit the Scope of Section 2(1) of the Act

Richard Tur argues that the purpose of section 2 (4) was intended to restrict prosecutions in some kinds of cases. These cases, according to him, are morally justified assisted suicide “...in which conviction would be seriously absurd or grossly unjust”.¹²² He cites *Diane Pretty’s* case as an example in this context and suggests that if Mr Pretty had to assist Diane Pretty in suicide, he would be not guilty of any offence for so doing.¹²³ Perhaps what he means is since the negative right to die already exist it would be insubstantial to count such an act as an act of

¹¹⁹ Tur Richard H.S. (2003) ‘Legislative Technique and Human Rights: The Sad Case of Assisted Suicide’. *Criminal Law Review*, Issue Jan, p. 6.

¹²⁰ Lord Hope in the case of *Debbie Purdy* did raise this point, but those who oppose assisted suicide are concerned about it. They think this reason coupled with ‘compassionate interest’ could integrate with ‘interested interest’ i.e. interest to gain as a result. See *R (Purdy) v DPP* [2009] 3 W.L.R. 403, pp. 423-424.

¹²¹ Lady Baroness Hale while referring to the content of the policy the DPP required to promulgate observed that the DPP should focus on the characteristics which should distinguish between the cases in which the fear of prosecution will be “disproportionate” from those in which it will not. See *R (Purdy) v DPP* [2009] 3 W.L.R. 426.

¹²² Tur Richard H.S. (2003) ‘Legislative Technique and Human Rights: The Sad Case of Assisted Suicide’. *Criminal Law Review*, Issue Jan, pp. 3-4.

¹²³ *Ibid.*, at p. 3.

assistance in suicide in the given circumstances. As a result, Mr Pretty's conduct would be morally excusable.

It is obvious that for Tur, the case of *Diane Pretty* presented a set of facts that could allow the DPP to withhold his consent to prosecution. Tur makes a distinction between morally justified cases of assisted suicide and morally unjustified cases of assisted suicide and he opines that only the latter cases should be prosecuted.¹²⁴ In stating this, Tur also accepts the idea that the ways by which one may attempt to commit suicide and the ways by which one may be assisted to commit suicide are varied. Hence, for Tur the role of the DPP under subsection (4) should be to make distinction between cases on the basis of moral culpability. Therefore, the DPP should not ask merely 'who assists in suicide of another' but rather 'under what circumstances one assists in the suicide of another'.

However, it is not easy to divide assisted suicide into what is morally justifiable and what is morally not justifiable. While Tur argues it is possible to make a morally justifiable argument in favour of assistance in suicide in *Diane Pretty's* case¹²⁵, he thinks the *McShane's* case¹²⁶ was not morally justifiable. In this case, McShane attempted to assist in the suicide of her mother¹²⁷ by supplying her with pills to end her life. However, McShane did this so that she could eventually benefit financially from her mother's death.¹²⁸ Although Tur's perspective, based on these two cases, seems appealing, it only deals with the problem on a case to case basis. To come to a definite solution to the problem it is necessary to address the issue at a deeper level i.e. by taking into account the moral values surrounding the concept of assisted suicide. Arguably, the three most important and competing

¹²⁴ *Ibid.*

¹²⁵ That is Diane Pretty was competent and non-vulnerable. Her choice to end her life in preference to slow, distressing and undignified death was clear and stable, and that what prevented her from taking her life was her physical disability. See, Tur Richard H.S. (2003) 'Legislative Technique and Human Rights: The Sad Case of Assisted Suicide'. *Criminal Law Review*, Issue Jan, p. 4.

¹²⁶ Tur Richard H.S. (2003) 'Legislative Technique and Human Rights: The Sad Case of Assisted Suicide'. *Criminal Law Review*, Issue Jan, p. 6.

¹²⁷ Who was old and in a social care.

¹²⁸ *McShane* (1997) 66 Cr. App. Rep. 97.

values pertaining to this concept are ‘self-determination’ (each individual is free to do what he or she wants with his or her life), ‘sanctity of life’ (the state has a duty to protect life and the interests of vulnerable persons) and ‘humanity’ (the duty to eradicate suffering). These principles play a vital role in the debate concerning assisted suicide. In order to resolve the current debate in England and Wales concerning ‘end of life’ issues, these three core values need to be addressed. This is necessary in order to ensure justice and fairness in meeting the needs of those who desire to die a ‘good death’.

To Prosecute only when there is Realistic Prospect of Securing a Conviction and when it will be in the Public Interest

Lord Pannick, counsel for Debbie Purdy at the Court of Appeal, focused his arguments in the same direction as Lord Steyn who thought section 2 (4) had a limited purpose. In using discretion, under his general guidelines¹²⁹ the DPP should consider “...whether there is a realistic prospect of securing a conviction and whether a prosecution would be in the public interest”.¹³⁰ Lord Pannick cited the reasoning provided by Lord Philips in the case of *Dunbar v Plant*¹³¹ in favour of his argument in relation to subsection (4).¹³²

“When the Act is considered ... it gives a clear indication that the circumstances in which the offence is committed may be such that the public interest does not require the imposition of any penal sanction. This, in my judgment, is the logical conclusion to be drawn from the ‘consent’ provision.”¹³³

In other words, the point Lord Pannick makes is that even in cases where there is sufficient evidence to prove that an offence has been committed, if the person to be prosecuted does not deserve to be punished taking into account the type of

¹²⁹ Section 10 of the Prosecution Offences Act 1985.

¹³⁰ *R. (on the application of Pretty) v DPP* [2002] 1 All E.R. 1, para. 65.

¹³¹ [1998] Ch. 412 p. 437.

¹³² *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32, p. 485.

¹³³ *Ibid.*

intervention, then the DPP should withhold consent to prosecution. It is arguable that Lord Pannick's submission is comparable with Tur's claim that only some kinds of assisted suicide should be prosecuted particularly those which lacks moral justification i.e. a good reason to do so. Once again, it is arguable that the requirement of section 2 (4) in the statute is not purely based on dispensing a person involved in assisted suicide, but that it also refers to the fact that assisted suicide is justified morally i.e. where there is good reason to do so.

Similarly, Judge Hedley in the case of *Ms Z* observed: "Although not unique, it [the requirement for consent] is rare and is usually found where parliament recognises that although an act may be criminal, it is not always in the public interest to prosecute in respect of it."¹³⁴ For example, the DPP may decide not to prosecute 'in the public interest' in cases where the anticipated sentence could be perceived as being light,¹³⁵ or when it is clear that the prosecution could cause grave injustice or harm to the person prosecuted or when the case involves "...a doctor of repute 'acting in good faith' in a situation of great difficulty..."¹³⁶. That is probably performing an act which is actually illegal but medically justified in the circumstances in which it is performed.

To Prevent the Risk of Prosecutions being brought in Inappropriate Circumstances

While addressing the provision in section 2 (4) in the case of *Debbie Purdy*,¹³⁷ Lord Hope stated that "it has long been followed that prosecution does not follow automatically"¹³⁸ and the purpose of the subsection must be understood in the light of this background.¹³⁹ He examined the submission made by Lord Pannick

¹³⁴ In re Z (Local Authority: Duty) [2005] 1 W.L.R. 959, p. 964

¹³⁵ In fact, this (that court is unlikely to impose custodial sentence) was *one* of the reasons why the DPP in the case of Daniel James decided not to prosecute his parents and his friend for assisting Daniel James to attain his desire of ending life with the help of Dignitas. See, Mullock Alexandra. (2009) 'Prosecutors making (bad) law?' *Medical law Review*, Vol. 17, No.2, p. 294.

¹³⁶ Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p.292.

¹³⁷ *R (Purdy) v DPP* [2009] 3 W.L.R. 403, p. 419.

¹³⁸ See footnote 102.

¹³⁹ *R (Purdy) v DPP* [2009] 3 W.L.R. 403, p. 419.

in the case of *Debbie Purdy* at the Court of Appeal that the purpose of section 2 (4) is only to prosecute when there is realistic prospect of securing a conviction and when it will be in the public interest. He also considered Lord Chief Justice submission that “the basic reason for including in a statute a restriction on the bringing of prosecutions was that otherwise there would be a risk of prosecutions being brought in inappropriate circumstances.”¹⁴⁰ Lord Hope found the approach adopted by the Lord Chief Justice more persuasive.¹⁴¹ The reasons provided in support of this perspective are as follows: to ensure consistency in bringing prosecution, to avoid vexatious proceedings, to take into account mitigating factors and to provide control over the criminal law in dealing with sensitive and controversial cases.¹⁴² It is suggested that these reasons reflect the general concept of public interest and hence this resembles the guidelines provided by the DPP under section 10 of the Prosecution of Offences Act 1985.

Implications: From Spirit to Policy

It is apparent from the reasons outlined above that the inclusion of section 2 (4) had a special purpose, in contrast to how it is viewed today.¹⁴³ It is arguable that this special purpose included an intention both to mark the gravity of the offence¹⁴⁴ as well as to spare those who did not offend against the spirit of section 2 (1), which is to protect the interests of persons who could be described as ‘weak’ and ‘vulnerable’.¹⁴⁵ In other words, it is suggested that parliament incorporated section 2 (4) to ensure the freedom to commit suicide, provided to all under section 1 of the Act, and at the same time to protect vulnerable persons, who may be made to believe that their life is not worth living.¹⁴⁶ Hence the

¹⁴⁰ *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32, p. 485.

¹⁴¹ *Ibid.*

¹⁴² *Ibid.*

¹⁴³ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA; Canada: Routledge.Cavendish. p.78.

¹⁴⁴ That the offence committed under section 2 (1) could be grave such as murder and at the same time, it could be trivial assistance such as opening the bottle of pills for the victim.

¹⁴⁵ The Court of Strasbourg in the case of *Diane Pretty* held this. See *Pretty v United Kingdom* (2002) 35 E.H.R.R. 1.

¹⁴⁶ *R v Hough* (1984) 6 Cr App R (S) 406. However, it is relevant to note that they are not allowed to harm another person in doing so.

suspect, who provides assistance to an adult who is mentally competent and non-vulnerable with settled desire to die, should be spared from prosecution and those who intervene in the life of weak and vulnerable should be prosecuted.

The modern approach, in the context of subsection (4) on the other hand, focuses on the “generalised concept of public interest”¹⁴⁷. However, it is important to mention that the ‘offence specific policy’¹⁴⁸ promulgated by the DPP, reflects (to some extent) the intention of parliament for incorporating section 2 (4) of the Act.¹⁴⁹ Hence, the ‘offence specific policy’ and the decisions taken based on this policy appear to recognise the intention of parliament for incorporating subsection (4) and in this way, the spirit of the law (the need to protect the vulnerable) is captured in the ‘offence specific policy’.

Having outlined the possible reasons for the inclusion of subsection (4), the following section discusses how the DPP performs his function in practice.

ii) The Practice of the DPP

Although it is appropriate to say that the person who assists in suicide runs the risk of exposure to criminal liability, it is also true that there is every possibility that that particular person may not reach the stage of prosecution.¹⁵⁰ As stated above section 2(4) provides for flexibility in the application of section 2(1) by giving the DPP a discretionary power to consent to the prosecution. The DPP applies discretion by taking into account the facts and circumstances of each case, to which he applies the guidelines provided for Crown prosecutors under section 10 (1) of the Prosecution of Offences Act 1985.¹⁵¹ However, recently the DPP has

¹⁴⁷ *R (Purdy) v DPP* [2009] 3 W.L.R. 426.

¹⁴⁸ The ‘offence specific policy’ is discussed in detail under subheading ‘Encouraging or Assisting in Suicide: The Offence Specific Policy’ for Prosecutors.

¹⁴⁹ Most important point is that the DPP has shown willingness not to prosecute those whose conduct in encouraging or assisting suicide would not amount to more than trivial and also that the person acts with compassionate motive.

¹⁵⁰ This is evident from the situation of Daniel James whose parents did not reach at the stage of prosecution. This case is discussed little later in this chapter.

¹⁵¹ See ‘Prosecution of Offences Act 1985’. <http://www.statutelaw.gov.uk>

published additional offence-specific factors i.e. the facts and circumstances to be taken into account when deciding whether or not to prosecute in cases of assisted suicide.¹⁵² Nevertheless, the procedure adopted to determine whether proceedings should be instituted remains the same. The decision process involves two stages:

“ (i) the evidential stage; and (ii) the public interest stage. The evidential stage must be considered before the public interest stage. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be. Where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.”¹⁵³

Evidential Stage

After the police have investigated the alleged complicity in suicide, the case will be forwarded to the Crown Prosecution Services.¹⁵⁴ At this stage, the DPP exercises discretionary power by taking into consideration the facts and circumstances of each case. The evidentiary test that is then applied requires the conduct element (*actus reus*) and the mental element¹⁵⁵ to prove *prima facie* the conduct of the suspect was sufficient to be found guilty. If the case passes this stage successfully, then the prosecutors must apply the factors in the public interest by looking at all the facts and circumstances of the case.¹⁵⁶

Public Interest Stage

At the public interest stage, the “...prosecutors must apply the public interest factors set out in the Code for Crown Prosecutors and the factors set out in [the

¹⁵² See Appendix A.

¹⁵³ See, point 13 of the ‘Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide’. www.cps.gov.uk

¹⁵⁴ Decision on Prosecution – ‘The Death by Suicide of Daniel James’, 9 December 2008. www.cps.gov.uk/news/nationalnews/death_by_suicide_of_daniel_james.html.

¹⁵⁵ That is intention to assist and the knowledge that that conduct was capable of assisting the victim in committing suicide.

¹⁵⁶ *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32.

‘offence specific policy’] in making their decisions”.¹⁵⁷ As stated in point 14 of the ‘offence specific policy’, “[t]he DPP will only consent to a prosecution for an offence of encouraging or assisting suicide in a case where the Full Code Test is met”.¹⁵⁸

Having considered the function of the DPP, it is necessary to consider recent developments in relation to the role of the DPP under subsection (4) of the Act. It is arguable that these developments brought about an increased degree of clarity and transparency. How this is achieved and to what extent, will be seen by examining the following: the case of *Diane Pretty*¹⁵⁹, Daniel James’ situation¹⁶⁰ and the case of *Debbie Purdy*¹⁶¹.

iii) Immunity

In the year 2002, the Court of Strasbourg on the European Convention of Human Rights pronounced a landmark judgment in the case of *Diane Pretty* on the issue of assisted suicide.¹⁶² She approached the Court on the ground that the refusal of the DPP to grant immunity to her husband from prosecution under section 2 (4) and proscription of assisted suicide under section 2 (1) infringed her rights under Articles 2, 3, 8 and 9 of the European Convention on Human Rights. In addition, she also argued that her right under Article 14 of the European Convention on Human Rights was also violated on the ground of her disability. She contended that those who did not suffer from any disability i.e. an “able-bodied person, might exercise the right to suicide”¹⁶³.

¹⁵⁷ See, point 38 of the ‘Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide’. www.cps.gov.uk

¹⁵⁸ See point 14 of Appendix A.

¹⁵⁹ *Pretty v United Kingdom* [2002] 35 E.H.R.R. 1.

¹⁶⁰ Decision on Prosecution – The Death by Suicide of Daniel James, 9 December 2008. www.cps.gov.uk/news/nationalnews/death_by_suicide_of_daniel_james.html.

¹⁶¹ *R (Purdy) v DPP* [2009] 3 W.L.R. 403.

¹⁶² *Pretty v United Kingdom* [2002] 35 E.H.R.R. 1.

¹⁶³ *R (Pretty) v DPP* [2002] 1 A.C. 800.

Diane Pretty was in the last stage of motor neurone disease when she decided to end her life, maintaining that she did not want to live in an undignified and unbearable situation during the last moments of her life and she was afraid of dying in that condition if she were to let nature take its course.¹⁶⁴ In these circumstances, she was able to choose death over life, but could not end her life unaided.¹⁶⁵ Although she was of sound mental capacity, she was paralysed up to her neck and had to be fed through a tube.¹⁶⁶ Her husband was willing to help her provided he would not be prosecuted for the offence of complicity in suicide of another.¹⁶⁷ Diane Pretty filed an application asking the DPP to declare that her husband would not be prosecuted if he assisted her in committing suicide.¹⁶⁸ The DPP rejected her application on the ground that he had no such power to grant her husband immunity from prosecution before the crime was committed.¹⁶⁹ Diane Pretty then filed a judicial review to the Division Court. On its refusal, she filed an appeal to the Court of Appeal and then to the House of Lords which held that there was no violation of her rights. It further held if any rights were engaged, interference was justified under Article 8 (2) of the Convention and the law on assisted suicide was needed to “protect the vulnerable and prevent abuse....”¹⁷⁰ Upholding the decision of the DPP it held:

“That, since the executive had no power to dispense with or suspend law or their execution without parliament consent, the Director had no power to undertake that a crime yet to be committed should be immune from prosecution....”¹⁷¹

¹⁶⁴ Hale Dame Brenda. (2003) ‘A Pretty Pass: When Is There a Right to Die?’ *Comm. L. World Review*, Vol. 1, p. 2.

¹⁶⁵ *Ibid.*

¹⁶⁶ *Ibid.*

¹⁶⁷ *Ibid.*

¹⁶⁸ *Ibid.*

¹⁶⁹ *Ibid.*

¹⁷⁰ *R (Pretty) v DPP* [2002] 1 A.C. 800.

¹⁷¹ *Ibid.*, at pp. 800–801.

Following this decision, Diane Pretty approached the European Court of Human Rights.¹⁷² This Court also decided that none of Diane Pretty's Convention rights were violated under the domestic law on assisted suicide.¹⁷³ However, the court acknowledged that:

"The applicant [Diane Pretty] in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guarantee under Article 8 (1) of the Convention."¹⁷⁴

"Nevertheless, the Court finds... that States are entitled to regulate through the operation of the general criminal law activities which are detrimental to the life and safety of other individuals. The more serious the harm involved the more heavily will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy. The law in issue in this case, section 2 of the 1961 Act, was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life. Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of the class which provides the rationale for the law in question. It is primarily for States to assess the risk and the likely incidence of abuse if the general prohibition on assisted suicides were relaxed or if exceptions were to be created. Clear risks of abuse do exist, notwithstanding arguments as to the possibility of safeguards and protective procedures."¹⁷⁵

¹⁷² *Pretty v United Kingdom* [2002] 35 E.H.R.R. 1. p.40.

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid.*, at p. 37.

¹⁷⁵ *Ibid.* at pp. 38-39.

On this basis and on the basis that the law on assisted suicide was flexible¹⁷⁶ the Court stated the absolute prohibition on assisted suicide was not “disproportionate” and by keeping in mind the gravity of the “act for which the immunity was claimed, the court concluded that in this situation the decision of the DPP cannot be said to be arbitrary or unreasonable”.¹⁷⁷

Even though Diane Pretty lost her battle at the Court of Strasbourg, her case drew attention to the power of the DPP and also to the fact that the law on assisted suicide interferes with the right to respect for private and family life guaranteed under article 8(1) of the Convention rights. The Strasbourg Court observed that:

“Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.”¹⁷⁸

Nevertheless, it was found that such interference was justified under article 8 (2) which provides:

“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

¹⁷⁶ That it required the consent of the DPP for prosecution and allowed the courts to impose even the least sentence. See Keown John. (2003) ‘European Court of Human Rights: Death in Strasbourg - assisted suicide, the *Pretty* case, and the European Convention on Human Rights’. *International Journal of Constitutional Law*, Vol. 1, No.4, p.725.

¹⁷⁷ *Ibid.*, at p. 39.

¹⁷⁸ *Pretty v United Kingdom* (2002) 35 E.H.R.R. 1.

crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”¹⁷⁹

Huxtable states, regarding the case of *Diane Pretty*, that the case:

“...provided a battleground for three competing ethical injunctions: there is a right to be assisted in suicide, premised on an appeal to patient autonomy, and may be a corresponding duty to help; there is a need, perhaps a duty to, to uphold the sanctity of life; [i.e. to protect life] and there is a need, again perhaps a duty, to eradicate suffering.”¹⁸⁰

It is clear from the decision of the Strasbourg Court, that the State’s interest to protect life, including the lives of weak and vulnerable people, ‘stood its ground’¹⁸¹ as it did throughout her case.¹⁸² However, this led to criticism on the grounds that the decision of the Strasbourg Court “attached insufficient importance to individual autonomy and to the alleviation of human suffering and [it] exaggerated the difficulties of framing and enforcing adequate safeguards against abuse”.¹⁸³ Huxtable on the other hand, adopts a neutral view in this regard. He argues that the law in this area i.e. assisted suicide “discloses a compromise of values”.¹⁸⁴

There is little doubt that the case of *Diane Pretty* proved to be one of the most important cases on the law on assisted suicide, and as noted above, it went all the way to the Human Rights Court at Strasbourg. Diane Pretty did not succeed in earning immunity for her husband (in case he had to assist her suicide).

¹⁷⁹ *R (Pretty) v DPP* [2002] 1 A.C. 810.

¹⁸⁰ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA; Canada: Routledge.Cavendish. p. 82.

¹⁸¹ *Ibid.*, at p. 137.

¹⁸² From the Division Court to the House of Lords and then in the Court of Human Rights.

¹⁸³ Keown John. (2003) ‘European Court of Human Rights: Death in Strasbourg - assisted suicide, the *Pretty* case, and the European Convention on Human Rights’. *International Journal of Constitutional Law*, Vol. 1, No.4, p. 726.

¹⁸⁴ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA; Canada: Routledge.Cavendish. p. 82.

Nonetheless, it was suggested that the power of the DPP is flexible and furthermore, that there was scope for non-prosecution of the suspect but only *after* the offence was committed.

iv) The Moves towards Greater Clarity through Guidance

Decision in the situation of Daniel James

In 2008, the DPP considered the offence under section 2 (1) of the Suicide Act in relation to the Daniel James' case.¹⁸⁵ Daniel James, at the age of 21, suffered a major accident during rugby training, which left him totally paralysed. Medical authorities agreed that he would never be able to overcome his disability.¹⁸⁶ This had such a detrimental impact on Daniel James' life that he decided to end it. He unsuccessfully attempted suicide a few times and finally chose to die with the help of Dignitas against the will of his parents. His parents and a family friend reluctantly decided to help Daniel James to carry out his wish.¹⁸⁷ His parents helped him to make arrangements with Dignitas and they decided to travel with him. A family friend arranged tickets for Daniel James and his parents to fly to Switzerland and back.¹⁸⁸ Daniel James travelled with his parents to Switzerland where in the presence of his parents and with the help of the doctor (who prescribed him with the lethal drug) at Dignitas, he successfully ended his life.¹⁸⁹ The conduct of his parents and their family friend in providing assistance to Daniel James to end his life, proved risky. Their role in suicide was investigated and the file was subsequently perused by the DPP according to the correct procedures of the law.¹⁹⁰ Despite finding sufficient evidence against Daniel

¹⁸⁵ Decision on Prosecution – The Death by Suicide of Daniel James, 9 December 2008. www.cps.gov.uk/news/nationalnews/death_by_suicide_of_daniel_james.html.

¹⁸⁶ Mullock A. (2009) 'Prosecutors making (bad) Law?' *Medical Law Review*, Vol. 17, No. 2, p. 290.

¹⁸⁷ Chrispin E., English V., Harrison C., Sheather J. and Sommerville A. (2009) 'Ethics briefings'. *J. Med. Ethics*. Vol. 35, p.80.

¹⁸⁸ Decision on Prosecution – The Death by Suicide of Daniel James, 9 December 2008. www.cps.gov.uk/news/nationalnews/death_by_suicide_of_daniel_james.html.

¹⁸⁹ Chrispin E. and others. (2009) 'Ethics Briefings'. *J. Med. Ethics*. Vol. 35, p.80.

¹⁹⁰ Mullock Alexandra. (2009) 'Prosecutors making (bad) Law?' *Medical Law Review*, Vol. 17, p. 290.

James' parents and their family friend, the DPP decided not to prosecute them in the public interest, having taken into consideration the particular facts and circumstances of the case.¹⁹¹ Although the DPP thought that the nature of the offence committed by the suspects in this case was serious and that the assistance provided could warrant conviction, the factors against prosecution prevailed.¹⁹² Those factors included: the strong will and full mental capacity of the victim to commit suicide; the reluctance of the suspects to concur with the victim's desire; the remoteness of the acts committed in comparison to other cases such as *Wallis*¹⁹³ and *Hough*¹⁹⁴ and, finally, the fact that the acts were undertaken purely out of a selfless motive without any materialistic gain.¹⁹⁵ The DPP concluded that:

“Taking those factors [above stated] into account and bearing in mind the observation of Lord Lane CJ in *Hough* that in enacting section 2(1) Suicide Act 1961, “Parliament had in mind the potential scope for disaster and malpractice in circumstances where elderly, infirm and easily suggestible people are sometimes minded to wish themselves dead”, I have decided that the factors against prosecution clearly outweigh those in favour. In the circumstances I have concluded that a prosecution is not needed in the public interest.”¹⁹⁶

The DPP's view that even “arranging and paying for the flights” is sufficient to bring the conduct within the scope of section 2 (1) is arguably a strict interpretation of the Act in relation to the evidential test.¹⁹⁷ This can be compared

¹⁹¹ *Ibid.*

¹⁹² Decision on Prosecution – The Death by Suicide of Daniel James, 9 December 2008.

www.cps.gov.uk/news/nationalnews/death_by_suicide_of_daniel_james.html.

¹⁹³ *R v Wallis* (1983) 5 Cr App R (S) 342. In this case, Wallis helped his flatmate to commit suicide by providing her means to end life as well as encouragement in spite of knowing the unstable position of her mind.

¹⁹⁴ See footnote 118.

¹⁹⁵ Decision on Prosecution – The Death by Suicide of Daniel James, 9 December 2008.

www.cps.gov.uk/news/nationalnews/death_by_suicide_of_daniel_james.html.

¹⁹⁶ *Ibid.*

¹⁹⁷ Mullock Alexandra. (2009) ‘Prosecutors making (bad) Law?’ *Medical Law Review*, Vol. 17, p. 298.

to what happened in the case of *Chard* where the supply of pills to a person was interpreted by the court as simply providing an option.¹⁹⁸ The DPP's decision means that even those who escort the victim when he or she travels to Switzerland for the purpose of assisted death may actually violate the law on assisted suicide. Hence, there is every possibility that they will be prosecuted unless their conduct falls within the public interest factors against prosecution.¹⁹⁹ At the same time, the decision of the DPP has in fact "through his analysis of the public interest factors, effectively promulgated a code of sorts for those who assist in a suicide tourism case",²⁰⁰. Central to this concept of public interest are the ideals of competence, commitment, altruistic motive and compassion.²⁰¹ It is arguably a good approach to take in relation to assessing the involvement of potential suspects in the cases of suicide tourism, but as it was rightly observed by the House of Lords, the reasons provided in the Daniel James case are not sufficient or transparent enough to guide the public in their behaviour.²⁰² For example, the supply of pills as stated above in the case of *Chard* was held to be not incriminated enough to find the defendant guilty of assisted suicide.²⁰³ As seen above, the DPP in Daniel James' situation reached the decision that arranging and paying for flight tickets amounts to aiding and abetting a suicide.²⁰⁴ However, he also concluded that even if Daniel James' friend was successfully prosecuted, it would be "very unlikely" that a court would impose a custodial sentence on him.²⁰⁵ This reason provided by the DPP makes it difficult to predict the legality and illegality of the action performed in connection with a suicide case.

Furthermore, the discretionary power of the DPP allows him to take considerations of morality and intuition into account as part of the decision

¹⁹⁸ The Guardian 23 September 1993.

¹⁹⁹ Mullock A. (2009) 'Prosecutors making (bad) Law?' *Medical Law Review*, Vol. 17, p. 298.

²⁰⁰ *Ibid.*

²⁰¹ This is visible from the 'offence specific policy'.

²⁰² In spite of this further clarity aimed by the House of Lords, there will still remain ambiguity in the process because of the filtering role of the DPP.

²⁰³ The Guardian 23 September 1993.

²⁰⁴ Mullock Alexandra. (2009) 'Prosecutors making (bad) law?' *Medical Law Review*, Vol. 17, p. 298.

²⁰⁵ *Ibid.*, at p. 298.

making process.²⁰⁶ Although the conduct of Daniel James' parents and family friend would arguably warrant conviction, it was stated by the DPP that their moral culpability was not found to be as severe as that of Wallis. It appears that the DPP in this matter has taken into account the facts and circumstances in which Daniel James was helped by his parents and a friend. It is possible to suggest that compared to the case of *Wallis*, Daniel James situation was such that he was not vulnerable and competent to make decision about his life and death. He was also very clear that his disability is unacceptable for him. Furthermore, his parents had made every attempt to dissuade him from taking that recourse. That they wished he could change his mind indicated that they did value life, but in the light of Daniel James personal autonomy and his subjective view on his disability, they had to compromise. As a result, decisions in individual matters attract an element of subjectivity on the part of the DPP that arguably creates scope for uncertainty.

The DPP published his decision along with the factors that he had taken into account in deciding the Daniel James case. This case has provided a precedent for those who may contemplate travelling to Switzerland for the purposes of assisted suicide. However, there still remain some doubts with regard to the exact terms of the guidance set out in the general Code (most of which the DPP found irrelevant in the Daniel James case).²⁰⁷ At the same time, the decision provided in the case was made subject to changes in future cases.²⁰⁸ Arguably, this does not meet the goal that the law on assisted suicide should be clear and transparent. Therefore, the House of Lords recognised the need to provide further clarity and transparency in the law in the later case of *Debbie Purdy*. This case is discussed next.

²⁰⁶ *Ibid.*, at p. 295.

²⁰⁷ Mullock A. (2009) 'Prosecutors making (bad) law?' *Medical Law Review*, Vol. 17, p. 294.

²⁰⁸ Other than assisted suicide abroad.

Decision in the case of *Debbie Purdy*

The case of *Debbie Purdy* has a close resemblance to that of *Dianne Pretty*.²⁰⁹ Debbie Purdy also suffers from physical disability owing to her incurable illness (MS), she also wishes to end her life (before natural death comes to her), to avoid pain and suffering which would effect the quality of her life and thereby her dignity²¹⁰. Furthermore, Debbie Purdy wanted to rely on her husband for assistance, but feared his prosecution. She wanted to know under what circumstances her husband could face prosecution and hence she asked for clarification on this matter. This is where her case differed from that of *Dianne Pretty*.²¹¹ Debbie Purdy decided to challenge the law on assisted suicide by seeking an order requiring the DPP to set out the policy he had adopted when deciding whether to give consent to prosecution under section 2 (4) of the Suicide Act. She claimed that the information provided under section 10 of the Crown Prosecution of Offenders Act 1985, was not sufficiently clear in relation to assessment of the behaviour of the assisting person under section 2 (1). The concerned authority (the DPP) declined her request to publish details of policy. As a consequence Debbie Purdy sought judicial review on the basis that

“...his refusal to publish details of his policy as to the circumstances in which a prosecution would be brought for complicity in a suicide contrary to section 2 (1) and/or of his failure to promulgate such a policy [was unlawful], relying on her right to respect for her private life under article 8 (1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms, as scheduled to the Human Rights Act 1998.”²¹²

Debbie Purdy's claim did not succeed either at the Divisional Court of the Queen's Bench Division, nor at the Court of Appeal. The Court of Appeal

²⁰⁹ Stephens G. C. (2008) 'From Pretty to Purdy: Suicide and Assistance from across the border – R (on the application of Purdy) v Director of Public Prosecutions'. *Scots Law Times*, Vol. 39, p. 267.

²¹⁰ *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32, p. 459.

²¹¹ The case discussed earlier in this chapter.

²¹² *R (Purdy) v DPP* [2009] 3 W.L.R. 403.

provided the following reasons for its dismissal: The court held that it was bound by the decision of the House of Lords taken in the case of *Diane Pretty* and that *Debbie Purdy's* case did not fall in the category of 'exceptional circumstances' which would allow for overriding the binding precedent.²¹³ The Court of Appeal decided to follow the law of precedent (i.e. the decision of the House of Lords in the case of *Diane Pretty*) and decide the matter on the basis that Article rights were not engaged. The Court of Appeal felt unable to adopt the decision of the Court of Strasbourg in the case of *Diane Pretty* and explored Debbie Purdy's claim on the basis that Article 8 rights were engaged (at the same time the Court urged the House of Lords to provide clarity).²¹⁴ In addition, and on the substantive point of whether the DPP could be required to issue offence specific guidance, the Court held that "the DPP could not dispense with or suspend the operation of s.2 (1)," nor could he set out "a case-specific policy in the kind of certain terms sought which would, in effect, recognise exceptional defences to the offence which Parliament had not chosen to enact...."²¹⁵ This is because in the Court's "...judgement the DPP is not in dereliction of his statutory duty".²¹⁶ Nor "[t]he absence of a crime-specific policy relating to assisted suicide ...make the operation and effect of s.2 (1) of the 1961 Act unlawful...".²¹⁷

Debbie Purdy next appealed to the House of Lords. The House of Lords decided the matter in favour of Debbie Purdy in the light of the decision of the European Court of Human Rights in the case of *Dianne Pretty*.²¹⁸ The House of Lords held that Debbie Purdy's right under Article 8(1) was engaged and the law on section 2 (4) was not accessible and foreseeable so that a person would know exactly how to act accordingly and control one's behaviour without breaching section 2 (1) of the Act.²¹⁹ The Court further acknowledged the prime importance of section 2 (4).

²¹³ *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32, p. 459.

²¹⁴ *Ibid.*

²¹⁵ *Ibid.*, at p. 489.

²¹⁶ *Ibid.*

²¹⁷ *Ibid.*

²¹⁸ *Pretty v United Kingdom* [2002] 35 E.H.R.R. 1.

²¹⁹ Cartwright N. (2009) '48 Years On: Is the Suicide Act fit for purpose?' *Medical Law Review*, Vol. 17, p. 473.

The court recognised that a blanket ban on assisted suicide, which provides for no exceptions, could in fact breach Article 8, according to the Strasbourg court.²²⁰ As a consequence, the only way a person can avoid breaching the law under section 2 (1) is by knowing the exact factors under which they could be prosecuted for such an offence.²²¹ In other words, it is necessary for people to know in what circumstances a breach of the law would result in prosecution. The House of Lords also remarked, in relation to the factors provided by the Code, that most of the terms of the Code (as outlined by the DPP's decision in respect of Daniel James) were irrelevant in cases of assisted suicide.²²² Overall, the decision handed down in the case of Daniel James was insufficiently clear and furthermore, it was potentially subject to change at any time.²²³ In addition, the House of Lords recognised the problem faced by Debbie Purdy and many others like in a similar position. The court accepted that this problem will not go away.²²⁴ As a consequence the House of Lords saw the need for an offence specific policy and found that the DPP

“...was under a duty to clarify his position as to the factors which he regarded as relevant for and against prosecution in such a case and he would be required to promulgate an offence-specific policy identifying the facts and circumstances which he would take into account in deciding whether a prosecution under section 2 (1) of the 1961 Act should be brought.”²²⁵

From this decision of the House of Lords, it follows that section 2 (4) forms an integral part of section 2 (1) of the Act.²²⁶ The role of section 2 (4) is to help

²²⁰ *Ibid.*

²²¹ *Ibid.*

²²² Factors regarded as not relevant to the case on assisted suicide (while dealing with Daniel James situation) were identified as 5.9 (b), (c), (d), (e), (j), (k), (m), (n), (p) and 5.10 (b), (c) (d), (e), (f), (g), (h), and (i) of the Code.

²²³ Cartwright N. (2009) '48 Years On: Is the Suicide Act fit for purpose?' *Medical Law Review*, Vol. 17, p. 473.

²²⁴ *R (Purdy) v DPP* [2009] 3 W.L.R. 403, pp. 414–415.

²²⁵ *Ibid.* at pp. 403-404

²²⁶ *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32, p. 485.

people to comprehend what conduct would put them at risk of prosecution under section 2 (1). In its decision, the House of Lords stated that the law on assisted suicide under section 2 (4) lacked clarity.²²⁷ Hence, their Lordships required the DPP to set an offence specific policy. Lady Baroness Hale, observed that in clarifying the law under section 2 (4) the DPP should direct his attention onto the “features which will distinguish those cases in which deterrence will be disproportionate from those cases in which it will not”²²⁸ in order to overcome the existing confusion. She argued that he should do this rather than to focus “...upon a generalised concept of the public interest...”²²⁹ It is arguable that the reasoning of Lady Baroness Hale reflects the intention of parliament for the inclusion of subsection (4) of the Act.²³⁰ The provision which is observed as an exception to the absolute ban on assisted suicide, provides the DPP with the option of withholding consent to prosecution of an individual under section 2 (1) of the Act.²³¹

It is submitted that the purpose of the House of Lords judgement in requiring the DPP to set offence specific guidelines was to respect the right to family and private life. The court also stressed the need to provide maximum certainty under the law in relation to the justification for its interference with the right. However, it is important to consider whether the policy has achieved this task. It is certainly arguable that the policy does “guarantee legal certainty”²³².

²²⁷ Cartwright N. (2009) '48 Years On: Is the Suicide Act fit for purpose?' *Medical Law Review*, Vol. 17, pp. 467-476.

²²⁸ *R (Purdy) v DPP* [2009] 3 W.L.R. 426.

²²⁹ *Ibid.*

²³⁰ This claim is based on the Committees Report. See p. 28 of the thesis.

²³¹ *R (Purdy) v DPP* [2009] 3 W.L.R. 425.

²³² Cartwright N. (2009) '48 Years On: Is the Suicide Act Fit for Purpose? R (on the application of Purdy) v DPP'. *Medical Law Review*, Vol. 17, p. 473.

Encouraging or Assisting Suicide: The ‘Offence Specific Policy’ for Prosecutors

The main points of the additional offence specific factors promulgated by the DPP in the public interest (for and against prosecution) are as follows²³³:

1) Public interest factors in favour of prosecution

- The victim was under 18 years of age; lacked mental capacity²³⁴ to reach an informed decision and did not have a settled, long-standing wish to commit suicide.
- The victim did not ask the suspect for help on his own initiative and did not indicate his wish explicitly.
- The victim was capable of undertaking the act that constituted assistance; the victim was coerced into making a decision and the case lacked altruistic motive and compassion.
- That the suspect failed to ensure the seriousness of the decision; that the relationship of the suspect with the victim was not good; that the suspect was unknown to the victim and provided specific information via internet or publication; that the suspect provided assistance to more than one victim; the suspect was under duty of care towards the victim; the suspect was aware that the victim intended to commit suicide in a public place where the members of general public may be present; the suspect was attached to the organisation which provides environment in which to allow the victim to commit suicide.

2) Public interest factors against prosecution

- The victim had reached informed decision which was voluntary, clear and settled.
- The suspect was wholly motivated by compassion.
- The suspect only provided “minor encouragement or assistance”²³⁵.

²³³See Appendix A for the full content; Here “Victim” is referring to the person who commits suicide; “suspect” is referring to the assistant.

²³⁴As required in accordance with the law on Mental Health Act 2005.

- The suspect had tried to dissuade the victim from taking ones life and the assistance provided by the suspect was of reluctant nature.
- The suspect informed the police of his involvement in assisted suicide and provided cooperation in investigation of the case.

The key features of these factors are: competence, commitment, communication, act and motive. Hence, it can be said that the guidance list focuses on the mental capacity of the victim, the action undertaken by the suspect and also, the motive of the suspect. Arguably, the guidelines place a heavy burden on the suspect. The suspect is expected to ensure the victim's competence and commitment. The suspect is also expected to try and dissuade the victim from taking that particular course (suicide) if possible. Under these conditions, the DPP may decide to withhold his consent to prosecution. However, this does not mean the conduct of the suspect is not criminal. The fact remains that his or her conduct is still criminal. This creates room for morality and subjective judgement but also scope for uncertainty.

In the following section, an attempt is made to analyse this policy in order to see whether it serves the purpose of bringing clarity and a sense of legal security to people. This was what Debbie Purdy requested, and the promulgation of the policy is the outcome of the decision of her case.²³⁶

Comments on the 'Offence Specific Policy'

It is important firstly to look into some statements which are clear from the 'offence specific policy'. Arguably, the 'offence specific policy' serves two main purposes. Firstly, it provides guidance to prosecutors, police and general public. Secondly, it explicitly states that the policy does not in any sense 'decriminalise'

²³⁵ See point 45 (3) of Appendix A.

²³⁶ See point 4 of Appendix A

the offence of encouraging or assisting in suicide nor does it assure ‘immunity’ to persons giving encouragement or assistance to suicide.²³⁷

Regarding the concrete content of the ‘offence specific policy’, it is clear that it is also very careful to exclude ‘generality’. In fact, the policy is firm in stating that each case has to be examined individually. Therefore it is useful with regard to the evaluation of the clarity of the guidelines, to go through the exact wording of point 39 (while keeping in mind that the prosecutors *have* to follow this point):

“Assessing the public interest is not simply a matter of adding up the number of factors on each side and seeing which side has the greater number. Each case must be considered on its own facts and on its own merits. Prosecutors must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment. It is quite possible that one factor alone may outweigh a number of other factors which tend in the opposite direction.”²³⁸

It is useful to also compare point 47:

“These lists of public interest factors are not exhaustive and each case must be considered on its own facts and on its own merits.”²³⁹

Point 45 (2) is equally relevant:

“[T]he actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance.”²⁴⁰

²³⁷ See point 6 of Appendix A.

²³⁸ See point 39 of Appendix A.

²³⁹ See point 47 of Appendix A.

²⁴⁰ See point 45 (2) of Appendix A.

Considering the first two points, an important question must be asked. Is there any use at all in the publication of the factors? The policy at first glance gives the impression that these newly published factors strongly reflect the practice of prosecution. However, it is also possible to suggest that the ‘offence specific policy’ somehow parallels the intention of Parliament regarding the Act. The ‘offence specific policy’ clearly takes note of section 1 of the Act by imposing *the* important requirement of mental capacity, as otherwise required by the law, and it imposes a heavy burden on the suspect to justify his or her conduct of assistance.²⁴¹ But oddly enough, one of the main reasons why a victim needs assistance is not given prime importance i.e. whether or not the victim was physically able to attempt to commit suicide, with only minor assistance. Arguably, this means that the ‘offence specific policy’ is not doing justice to the arguments put forward by Diane Pretty and Debbie Purdy, because people in their position would not be able to attempt suicide with ‘minor’ assistance (if this term is interpreted literally). Their claim was based on the fact of their own physical disability. They argued that owing to their physical disabilities they are in fact unable to attempt to commit suicide without significant assistance. Diane Pretty’s physical condition was such that she could not have done anything more to help herself, except to bite on a switch²⁴² or give consent to lethal injection. This is because her physical condition was such that she was paralysed up to her neck.²⁴³ In this regard she needed much more assistance than what appears to be allowed through the ‘offence specific policy’ guidelines. Similarly, Debbie Purdy’s condition is such that she is dependent on her husband for most things although she is able to move around with the help of a wheelchair. For instance, her condition at present is such that she is even unable to open a bottle of pills.²⁴⁴

²⁴¹ See, factors for and against prosecution.

²⁴² The extreme step one may have to take owing to one’s physical disability. This means the assistant will have to carry out all the necessary steps from procuring a lethal dose, preparing the mixture to be fed through tube and placing the switch between the teeth of the victim. This is how the worse conditions in the cases of assisted suicide are treated in the Dignitas.

²⁴³ Hale Dame Brenda. (2003) ‘A Pretty Pass: When Is There a Right to Die?’ *Comm. L. World Review*, Vol. 1, p. 2.

²⁴⁴ ‘Guardian Daily: Assisted suicide and the law’.

<http://www.guardian.co.uk/world/audio/2010/jan/29/guardian-daily-podcast>

Hence, if she decides not to travel to Switzerland and decides instead to end her life in this country, the assistance her husband will have to provide her could be more than ‘trivial’.²⁴⁵

Issues arising from the ‘Offence Specific Policy’

In some respect, the ‘offence specific policy’ guidelines attempt to shed some light on the most problematic aspects of the law on assisted suicide. One such example is of providing minor assistance above stated. This factor gives rise to two concerns. Firstly, it fails to specify what kind of assistance amounts to ‘trivial’. Hence, the difficulty in this area lies in the evaluation of when an act can be considered as “minor” or “trivial”. What matters is assistance not form.²⁴⁶ Providing assistance, in travelling for example, is arguably like providing assistance in any other form.²⁴⁷ Secondly, its vagueness could lead to further litigations.²⁴⁸ The decision regarding what counts as trivial will always involve subjective judgements. As a result, it is obvious that the application of such approach may lead to a potential discrepancy in decision-making process.

At the same time, it is possible to suggest that the ‘offence specific Policy’ should express the intention of Parliament under section 2 (4). In a sense, the ‘offence specific policy’ should specify the circumstances under which one may be prosecuted. It should be possible to infer that those people who do not get prosecuted could be said to have not offended against the intention of parliament and hence persons should not be regarded as criminals. Those who are prosecuted and found guilty are all criminals²⁴⁹ and that the degree of their culpability is reflected in their sentences, ranging from conditional discharge to imprisonment.

²⁴⁵ Keeping in mind the deteriorating condition of her body.

²⁴⁶ Keown, J. (2009). ‘In Need of Assistance?’ *New Law Journal*. Oct. Issue, 1340-1341.

²⁴⁷ *Ibid.*

²⁴⁸ Richard Nobles and David Schiff. (2010) ‘Disobedience of Law – Debbie Purdy’s Case’. *Modern Law Review*, 73 (2) p. 299.

²⁴⁹ At least in the eyes of law.

In addition, the factors being non- exhaustive,²⁵⁰ the policy still leaves scope for ambiguity. Finally, as argued earlier, those who need assistance most, such as those who are not able to carry any act are potentially still at the mercy of the law.²⁵¹ This gives cause for concern and it also leaves open the possibility that the law in this area requires further development.

v) Likely Future Developments arising from the Case of Debbie Purdy

The House of Lords has explicitly recognised in the case of Debbie Purdy that Article 8 (1) of the European Convention on Human Rights (ECHR) is engaged regarding ‘end of life decision-making’.²⁵² It is further arguable that this decision could be used as a stepping-stone to develop the law further in this area. Three possible future developments could arise: Firstly, the ‘offence specific policy’ which is an outcome of Purdy’s case could act as an exception to section 2 (1). This means those who assist in suicide of another, and whose conduct comes within the specific factors ‘against prosecution’ would be immune from prosecution. This means the limited scope of a negative right to die²⁵³ which provides immunity to suicidal from prosecution would further extend to those who would encourage or assist in suicide of another provided this other person is wholly motivated by compassion and his or her conduct does not progress assisted suicide and the person whom he or she assist is competent with a settled desire to end his or her life.²⁵⁴ Secondly, the existing negative right to die may give way to the right to die with dignity (under Article 3 of the ECHR).²⁵⁵ Thirdly, the idea of ‘assistance in suicide’ could lead to an idea of ‘assistance in attaining a good death’.

²⁵⁰ See point 47 of Appendix A.

²⁵¹ Like Lynn Gilderdale, who feared her mother’s prosecution.

²⁵² *R (Purdy) v DPP* [2009] 3 W.L.R. 403.

²⁵³ See p. 18 of the thesis.

²⁵⁴ In other words, the conduct of the one who assist should come within the factors against prosecution.

²⁵⁵ Coggon John. (2006) ‘Could the Right to Die with Dignity Represent a New Right to Die in English Law?’ *Medical Law Review*, Vol. 14, p. 237.

Immunity from Prosecution for those who may encourage or assist Suicide of another

The decision in the case of *Debbie Purdy* to some extent²⁵⁶ “...reflects society’s increasing acceptance that individuals are entitled to make choices to end life with the help of another”²⁵⁷. As noted above, an examination of the contents of the ‘offence specific policy’ also helps support this idea.²⁵⁸ The policy allows any person to assist in the suicide of another as long as his assistance is at a minor level. However, what amounts to minor or trivial, other than escorting the person, arranging flight tickets,²⁵⁹ booking hotel room,²⁶⁰ putting bag over victim’s head and helping to arrange to put together the gas apparatus,²⁶¹ is unclear. The principal reason why it is assumed that escorting and arranging for flight tickets is permitted is because there is some evidence that no one has been prosecuted since 2002, the approximate date that this practice, of dying abroad with assistance started.²⁶² Similarly, Daniel James’s friend, who paid for flight tickets and made travel arrangements for Daniel James and his parents, did not face prosecution. This legality of this practice is further strengthened by the ‘offence specific policy’ promulgated by the DPP. The ‘offence specific policy’ allows this practice to be carried forward without any fear of prosecution and therefore sanctions,²⁶³ unless the motive of the suspect is ‘selfish’, the conduct was more than trivial and the victim lacked competence and commitment.²⁶⁴ The ‘offence specific policy’ also appears to appreciate the idea that “...autonomous

²⁵⁶ Probably as long as it does not impose obligation on the other person to assist.

²⁵⁷ Heywood R. (2009) ‘Article 8 and end of life decisions’. *Law Quarterly Review*, Vol. 125, p. 396.

²⁵⁸ ‘Interim Policy for Prosecutors in Respect of Cases of Assisted Suicide’. www.cps.gov.uk

²⁵⁹ Mullock A.. (2009) ‘Prosecutors making (bad) law?’ *Medical Law Review*, Vol. 17, pp. 290-299.

²⁶⁰ See footnote 30.

²⁶¹ On 24 May 2010, the DPP decided not to charge Mr Bateman with the offence of assisted suicide who helped his wife (who suffered from chronic pain) to commit suicide in the year 2009. Mr Bateman helped Mrs Bateman to put together the helium gas apparatus and to put a plastic bag over her head. See ‘Assisted Suicide Charge not in the Public Interest’.

http://www.cps.gov.uk/news/press_releases/120_10/

²⁶² *R (Purdy) v DPP* [2009] 3 W.L.R. 426.

²⁶³ It is to be noted that the DPP does not guarantee non-prosecution in any case.

²⁶⁴ ‘Interim Policy for Prosecutors in Respect of Cases of Assisted Suicide’. www.cps.gov.uk

individuals have different views about what makes their lives worth living”²⁶⁵ by not imposing any impediment on who can be assisted in suicide. There is one exception to this, the ‘offence specific policy’ incorporating one point in favour of prosecution i.e. where “the victim was physically able to undertake the act that constituted the assistance him or herself;”²⁶⁶ It is submitted that this point should not be used literally against the able bodied people, because as stated by the DPP in point 40 “[t]he absence of a factor does not necessarily mean that it should be taken as a factor tending in the opposite direction. For example, just because the victim is not ‘under 18 years of age’ does not transform the ‘factor tending in favour of prosecution’ into ‘factor tending against prosecution’.”²⁶⁷ This statement of the DPP concurs with his own decision in the recent case of Caractacus Downes.²⁶⁸ Caractacus Downes who apart from escorting his parents to Switzerland to Dignitas also booked room for their use in Switzerland which (booking room) they were capable of doing themselves. The DPP in his decision on this point said, although it is true that Caractacus Downes’ parents were in a position to perform the act of booking room, their competent, clear and settled decision to end their life with the assistance of Dignitas overrules the factor that they were physically able to undertake the action, their son, undertook for them.²⁶⁹ All of this arguably suggests that the ‘negative’ right to die with its limited scope is inching towards an extended negative right to die: “...that those who choose to provide ...assistance [in suicide would] not be punished or threatened with the prospect of punishment...”²⁷⁰ Furthermore, the established practice of ‘immunity from prosecution’ would prove that what Debbie Purdy sought for (demand to know when the DPP will not prosecute) was no different from that what Diane Pretty sought for (demand that the DPP not prosecute)

²⁶⁵ More of this aspect will be said in the next chapter of the thesis. *R (Purdy) v DPP* [2009] 3 W.L.R. 426.

²⁶⁶ See point 43 (10) of Appendix A.

²⁶⁷ See point (40) of Appendix A.

²⁶⁸ See footnote 30.

²⁶⁹ See ‘No Charges following deaths of Sir Edward and Lady Downes’.

http://www.cps.gov.uk/news/press_releases/113_10/index.html

²⁷⁰ Richard Nobles and David Schiff. (2010) ‘Disobedience to Law – Debbie Purdy’s Case’. *Modern Law Review*, 73 (2), p. 296.

except that Debbie Purdy adopted a different strategy to that of Diane Pretty. In other words, as stated above, the ‘offence specific policy’ used in decision-making process, to consent prosecution, could become a policy through the legislative act of Parliament.²⁷¹

Right to Die with Dignity

It is also feasible that one may use *Debbie Purdy*’s case to claim the ‘right to die with Dignity’ by invoking Article 3 of the Convention.²⁷² The article provides:

“‘No one shall be subjected to torture or to inhuman or degrading treatment or punishment’.”²⁷³

There is strong evidence to suggest that the main reasons why people like Debbie Purdy and Diane Pretty wish to end their life are to avoid suffering and to have dignified death.²⁷⁴ Persons in this situation fear suffering and they consistently argue that they want to have control over their death; they also want to preserve their self-respect and privacy at the time of their death.²⁷⁵ Owing to their physical disabilities, the absolute ban imposed by the law on assisted suicide²⁷⁶ forces them either to die an early death, or to die a degrading and undignified death. Although it is important to note, as held in the case of *Diane Pretty*, that it is not the state that subjects individuals to degrading treatment, but their own illness.²⁷⁷ However, since the state is under a positive obligation to prevent degrading treatment, it is arguable that the failure of the law in this area should amount to

²⁷¹ Cartwright N. (2009) ‘48 Years On: Is the Suicide Act Fit for Purpose? R (on the application of Purdy) v DPP’. *Medical Law Review*, Vol. 17, p. 475.

²⁷² Coggon John. (2006) ‘Could the Right to Die with Dignity Represent a New Right to Die in English Law?’ *Medical Law Review*, Vol. 14, pp. 219-237.

²⁷³ This article imposes negative as well as positive obligation on the state to protect its subjects from the “ill-treatment proscribed”. See Morris Dan. (2003) ‘Assisted suicide under the European Convention on Human Rights: a critique’. *European Human Rights Law Review*, Vol. 1, p. 70.

²⁷⁴ *R (Purdy) v DPP* [2009] 1 Cr. App. R. 32, p. 485.

²⁷⁵ Cohen Almagor R. (2001) *The Right to Die with Dignity: An Argument in Ethics, Medicine and Law*. New Brunswick, N.J.: Rutgers University Press. p. 76.

²⁷⁶ Coggon John. (2006) ‘Could the Right to Die with Dignity Represent a New Right to Die in English Law?’ *Medical Law Review*, Vol. 14, pp. 219-237.

²⁷⁷ *Ibid.*

breach of Article 3. This right being absolute, the state would then have to either allow assistance in suicide or assistance in attaining a ‘good death’. This would necessarily lead to a change in the law in this area. This is because unlike Article 8 which has qualifying conditions, Article 3 has no such conditions. It is an absolute right. As a result, a claim brought under Article 3 should follow different outcome to that of a claim brought under Article 8 of the ECHR. For example, in the case of a person who is physically handicapped to an extent that he or she could not end his or her life, it is possible that he or she is suffering a huge amount of pain and mental distress. In other words, “...it could be said that that person is enduring inhuman and degrading conditions”²⁷⁸ and these conditions are sustained because other persons who might wish to help are at risk of prosecution of attempt to murder.²⁷⁹ This problem would take the law a step further from encouraging or assisting suicide to assistance in attaining a ‘good death’.

Stretching the Boundaries: From Assisted Suicide to Assistance in Attaining a ‘Good Death’

To some extent, the decision in the case of *Debbie Purdy* has moved the law on assisted suicide from a position of confusion to a systemic ambiguity through guidelines. At present, the involvement of a person in suicide still falls within the boundaries of the existing criminal law. However, there is a likelihood that that person would not be prosecuted once it is established that his or her conduct was wholly motivated by compassion and it did not progress ‘assisted suicide’.²⁸⁰

The introduction of ‘excusable’ circumstances in the ‘offence specific policy’²⁸¹ renders the law inconsistent. The ‘offence specific policy’ protects some people from being prosecuted despite the absolute ban on assisted suicide declared under

²⁷⁸ Mr Pushpinder Saini. (1999) ‘The Doctrine of Double Effect and the Law of Murder’, *Medico-Legal Journal*, Vol. 67, p.111.

²⁷⁹ Like for example in the case of *Kay Gilderdale*.

²⁸⁰ Although the assistance provided must be of trivial nature, since what amounts to ‘trivial’ is not defined, here it is assumed that as long as the assistance provided does not progress to another act liable of criminal liability, the suspect could rely on the immunity, provided his or her conduct fulfils other required factors.

²⁸¹ Keown, J. (2009). ‘In Need of Assistance?’ *New Law Journal*. Oct., pp.1340-1341.

section 2 (1) of the Act. The ‘offence specific policy’ through this liberal attitude has ‘effectively’ partially decriminalised assisted suicide by eroding section 2 (1) of the Act.²⁸² Nonetheless, the DPP has disputed this claim by stating that he has not done so, nor he has the right to do so.²⁸³ Even if one agrees with him, it is clear the ‘offence specific policy’ has created exception to section 2 (1) by promulgating the policy setting out offence specific factors in cases of encouraging or assisting suicide cannot be disputed. As a result, although “the legal duty to obey the law [on encouraging or assisting suicide] remains in place”²⁸⁴, disobedience, under special circumstances, will provide suspect ‘immunity from prosecution’.

Keeping in mind the limited scope of the negative right to die, in particular the difficulty faced by people to acquire lethal drugs such as barbiturates to ensure a good death, it is desirable that the scope of the law should not be restricted to assistance in suicide, but extended to assistance in attaining a ‘good death’. This is because those who attempt to commit suicide may need further assistance in dying such as to ease the passing either by accelerating it or to make it painless or both. As a result, a dying person may still have to rely on another to act as happened in the case of *Hough*.²⁸⁵ Or the attendant may willingly choose to aid in dying knowing the intention of the dying person as it happened in the Gilderdale case.²⁸⁶

Kay Gilderdale was charged with attempted murder of her daughter Lynn Gilderdale.²⁸⁷ Keir Starmer, the head of the Crown Prosecution Service (CPS)

²⁸² *Ibid.*

²⁸³ ‘Guardian Daily: Assisted suicide and the law’.

<http://www.guardian.co.uk/world/audio/2010/jan/29/guardian-daily-podcast>

²⁸⁴ Richard Nobles and David Schiff. (2010) ‘Disobedience of Law – Debbie Purdy’s Case’. *Modern Law Review*, 73 (2) pp. 297-8.

²⁸⁵ See footnote 118.

²⁸⁶ See Broadcast on: BBC One, 1st February 2010. ‘I helped my daughter die’.

http://www.bbc.co.uk/iplayer/episode/b00qs930/b00qs8mk/panorama_I_Helped_My_Daughter_Die/

²⁸⁷ The Daily Mail, 26 January 2010, ‘Decision to charge loving mother Kay Gilderdale with attempted murder of ME daughter was right, says DPP’. <http://www.dailymail.ac.uk/news/article->

said, Kay Gilderdale's "...conduct, began as assisted suicide progressed to attempted murder when Mrs Gilderdale herself went on to administer morphine...to her daughter after her daughter had lost consciousness."²⁸⁸ He further stated that the offence of assisted suicide involves assisting the victim to take his or her own life. However, the offence of attempted murder, which is much more serious offence, involves a direct attempt to take the victim's life.²⁸⁹ In the light of the facts presented by Kay Gilderdale, her conduct, in administering morphine to Lynn after she lost her consciousness, could have been treated as assistance in attaining a 'good death',²⁹⁰ instead of attempt to murder, by treating such conduct as a continuum.²⁹¹ Another possible reason why her conduct could have been treated as part and parcel of assisted suicide is because

“[w]hen you know [as argued by Glanville Williams] that your conduct will have two consequences, one in itself good and one in itself evil, you are compelled as a moral agent to choose between acting and not acting by making a judgment of value, that is to say by deciding whether the good is more to be desired than the evil is to be avoided.”²⁹²

The choice one has to make in the above case is either to sit and watch someone die a slow and painful death or to aid the dying person by doing what is necessary to complete the action already taken by dying person. This, no doubt will bring the conduct of that person under the criminal liability for attempted murder or murder, but without undermining the law on murder or attempted murder, such

[1246222/Keir-Starmer-says-decision-charge-Kay-Gilderdale-attempted-murder-daughter-Lynn-public-interest.html#ixzz0zrNK](https://www.bbc.com/news/health-41246222/Keir-Starmer-says-decision-charge-Kay-Gilderdale-attempted-murder-daughter-Lynn-public-interest.html#ixzz0zrNK)

²⁸⁸ *Ibid.*

²⁸⁹ *Ibid.*

²⁹⁰ Here 'assistance in attaining a 'good death' refers to that conduct of the assistant which is performed with intent not to kill, but to make ones dying comfortable and painless. A genuine case of palliative care at the end of life which doctors claim to do and so did Kay Gilderdale. More is said on this topic in chapter 2 of the thesis.

²⁹¹ That is, as the part of the process of assisted suicide by taking into account the suicidal intent of Lynn Gilderdale and the fact that the conduct of Kay Gilderdale was an attempt to fulfil that intent rather than attempt to murder.

²⁹² Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 286.

conduct of the assistant could be judged in the same way as that of a doctor who provides lethal drugs (painkilling doses) to a terminally ill patient at the end of his or her life. For example, Kay Gilderdale actions could be determined to be similar to that of Dr David Moor, who assisted his dying patient Mr George Liddell yet was found not guilty.²⁹³ Whether such conduct and omissions in cases of duty of care amounts to active euthanasia or not is the subject matter of the following chapter.

²⁹³ More on this topic is discussed in the following chapter of the thesis.

Chapter 2

The Law of England and Wales on Euthanasia

2.1 The Law on Euthanasia

Euthanasia is officially regarded as a form of murder.²⁹⁴ Hence one who performs euthanasia commits murder punishable with life imprisonment. By contrast, the ancient Greeks called it a ‘good death’.²⁹⁵ Somerville defines euthanasia as “...intentionally killing another person to relieve their suffering”.²⁹⁶ According to Foot it is an act “...of inducing or otherwise opting for death for the sake of the one who is to die”.²⁹⁷ Draper on the other hand, defines it as “death that results from the intention of one person to kill another person, using the most gentle and easy means possible, that is solely motivated by the best interests of the person who dies”.²⁹⁸

There are three categories of euthanasia: voluntary euthanasia, nonvoluntary euthanasia and involuntary euthanasia.²⁹⁹ Voluntary euthanasia is said to occur

²⁹⁴ That is causing death of another person without a lawful excuse with intent to kill. See, *Airedale Hospital Trustees v Bland* [1992] UKHL 5 p. 27; Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 283; ‘Attempted Murder of Terminally Ill Patient’. *Medical Law Review*, Vol. 1, 1993, p. 232.

²⁹⁵ See Shaw D.M. (2009) ‘Euthanasia and Eudaimonia’. *J Med Ethics*, Vol. 35, p. 530. Here it is relevant to note that in the recent years the reason why people desire to die is heavily premised on the fact that people want to live and die in dignity. Most of the cases of ‘death tourism’ such as of Daniel James support this view. Diane Pretty also desired to die a dignified death. Debbie Purdy One such personality who is currently a focus of attention of public and media is Debbie Purdy who wishes to end her life before natural death comes to her (see chapter 1 of the thesis). Those who help or willing to help in these circumstances, their conduct is normally seen as an act of mercy. See Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 279.

²⁹⁶ Somerville Margaret. (2006) ‘Against Euthanasia’. *Arts and Opinion Magazine*, Vol. 5, No. 4.

²⁹⁷ Foot Phillipa. (1977) ‘Euthanasia’. *Philosophy and Public Affairs*, Vol. 6, p. 87.

²⁹⁸ Draper H. (1998) ‘Euthanasia’, in Chadwick R. (ed.) *Encyclopaedia of Applied Ethics*, Vol. I. San Diego, Academic Press.

²⁹⁹ Simillis C. (2008) ‘Euthanasia: A Summary of the Law in England and Wales’. *Medicine Science and the Law*, Vol. 48, p.191.

when “a person’s life is ended following his own wish to die”.³⁰⁰ Nonvoluntary euthanasia involves the “ending of a person’s life when the person is not able to express his wish to die or to prolong his life, or is not competent to make that decision, e.g. an unconscious patient”.³⁰¹ Involuntary euthanasia involves the “killing of a person against their will”. Each of these categories is further subdivided into two groups, active and passive euthanasia. The former involves “a deliberate act designed to kill” and the latter involves “withdrawing or withholding treatment while the disease process takes its course to cause death.”³⁰² However, in a legal sense no such distinction is drawn. All categories of euthanasia are treated under one concept i.e. murder.

Euthanasia is unlawful in England and Wales. However, acting to relieve the pain, suffering and distress of a terminally ill patient, by administering lethal doses of painkilling drugs in the knowledge that such action will or may accelerate death or cause death of the patient, is lawful.³⁰³ Similarly, withholding or withdrawing treatment from a patient, who refuses to consent to it, is lawful. Furthermore, it is permissible for a doctor to withhold or withdraw treatment in the best interest of the patient.³⁰⁴ The justification for this kind of behaviour is found not only in the patient’s right to autonomy and doctor’s duty of care, but also in the idea that “...causing a result by an action is serious from a moral point of view, than causing the same result by an omission”³⁰⁵. Similarly, the doctrine of double

³⁰⁰ *Ibid.* According to Glanville, such conduct would be “regarded as suicide in the patient who consents [or desires] and murder in the doctor who administers”. See Williams G. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 283.

³⁰¹ Simillis C. (2008) ‘Euthanasia: A Summary of the Law in England and Wales’. *Medicine Science and the Law*, Vol. 48, p.191.

³⁰² *Ibid.*

³⁰³ Palmer Henry. (1975) ‘Dr. Adams’ Trial for Murder’. Burke J., and Allsop P. (eds). *Criminal Law Review*. London: Sweet and Maxwell Limited. p. 365; *Airedale Hospital Trustees v Bland* [1992] UKHL 5 at 12; Mr Saini Pushpinder. (1999) ‘The Doctrine of Double Effect and the Law of Murder’. *Medico-Legal Journal*, Vol. 67, pp.106-120; Jackson Emily (2010) *Medical Law: Text, Cases, and Materials*. Oxford: Oxford University Press. p. 856.

³⁰⁴ Goff Robert. (1995) ‘A Matter of Life and Death’. *Medical Law Review*, Vol. 3, pp. 1-21; Keown J. (2000) ‘Beyond *Bland*: A critique of the BMA guidance on withholding and withdrawing medical treatment’. *Legal Studies*, Vol. 20, pp. 66-84.

³⁰⁵ Kugler I. (2003) ‘Two concepts of omission’. *Criminal Law Forum*, Vol. 14, p. 447.

effect³⁰⁶ and the doctrine of omission in the absence of duty to act provide justification in above circumstances.³⁰⁷

This chapter sets out the legal position and the scope of the doctrine of double effect and the ability to withhold and withdraw treatment on the basis of a notion of duty. The doctrine of double effect justifies the shortening of life, or the causing of death, as long as it is merely a foreseen (and not intended) side-effect of promoting a good end such as relieving someone from pain and suffering. In discussing these two doctrines, this chapter will show the disparity in the application of the criminal law in relation to medical professionals³⁰⁸ in comparison with laypeople. The chapter also aims to discuss whether there is a real (legal) difference between what doctors are permitted to do (i.e. acting with the aim in order to relieve pain while foreseeing death and letting die by withholding or withdrawing treatment) and that what is prohibited as murder.³⁰⁹

a) Acts that Kill

i) Double Effect Doctrine

The doctrine of double effect (DDE) is rooted in Roman Catholic theology.³¹⁰ It has received attention from moral philosophers and legal theorists.³¹¹ It was first imported into the criminal law of England and Wales through the law of self-defence.³¹² Since then, the doctrine has found utility in cases dealing with health

³⁰⁶ *Airedale Hospital Trustees v Bland* [1992] UKHL 5; *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam. 147; Kugler I. (2002) *Direct and Oblique Intention in the Criminal Law: And Inquiry into Degrees of Blameworthiness*. England: Ashgate. p. 54.

³⁰⁷ *Airedale Hospital Trustees v Bland* [1992] UKHL 5; Kugler I. (2002) *Direct and Oblique Intention in the Criminal Law: And Inquiry into Degrees of Blameworthiness*. England: Ashgate.

³⁰⁸ Medical Professionals here refers to doctors and physicians. The two terms are used interchangeably in the thesis.

³⁰⁹ That is euthanasia.

³¹⁰ Kugler Itzhak. (2002) *Direct and Oblique Intention in the Criminal Law: And Inquiry into Degrees of Blameworthiness*. England: Ashgate; Price David. (1997) 'Euthanasia, Pain Relief and Double Effect'. *Legal Studies*. Vol. 17, p. 325.

³¹¹ Price D. (1997) 'Euthanasia, Pain Relief and Double Effect'. *Legal Studies*. Vol. 17, p. 325.

³¹² Suzanne Uniacke. (1994) *Permissible Killing: The Self-Defence Justification of Homicide*. Cambridge: Cambridge University Press. pp. 92-155; Price David. (1997) 'Euthanasia, Pain Relief and Double Effect'. *Legal Studies*, Vol.17, p. 331; Price D. (2009) 'What Shape to Euthanasia

care issues. Apart from using the doctrine to justify cases of abortion,³¹³ it is employed to justify the use of potentially fatal opioids and diamorphine in the cases of terminally ill people and cases of those who suffer from severe pain and distress.³¹⁴ In addition, it is also thought to have utility “...in relation to sedation and the withdrawal of life-sustaining treatment”.³¹⁵

The Meaning of the DDE

The doctrine is commonly understood to draw a distinction between “...impermissible intended consequences and permissible (merely) foreseen consequences”³¹⁶. As stated above, the most common example in this regard is “the administration of drugs in order to suppress the pain of the dying with the knowledge that they will hasten death.”³¹⁷ Glanville Williams sees no difference between an outcome that is foreseen as certain and that what is desired or intended. He claims that if the DDE “...means that the necessity of making a choice of values can be avoided merely by keeping your mind off one of the consequences, it can only encourage a hypocritical attitude towards moral problems”.³¹⁸ However, John Finnis thinks that Glanville Williams has misunderstood the doctrine. He states that it is not about keeping one’s “...mind steadily off the consequence...”³¹⁹ i.e. the way it is understood by Glanville Williams. For John Finnis, it is about “...what figures in the rational proposal

after Bland? Historical, Contemporary and Futuristic Paradigms’. *Law Quarterly Review*, Vol. 125, pp. 142-174.

³¹³ Shaw A.B. (2002) ‘Two Challenges to the Double Effect Doctrine: Euthanasia and Abortion’. *J Med Ethics*, Vol. 28, pp. 102-104.

³¹⁴ As it was agreed in the case of Annie Lindsell who made an application to the court to ensure that her doctor would not be prosecuted if he administers pain killing drugs to her at the end of her life stage which could accelerate her death.

http://news.bbc.co.uk/1/hi/health/background_briefings/euthanasia/332464.stm

³¹⁵ Huxtable Richard. (2004) ‘Get out of Jail Free? The Doctrine of Double Effect in English Law’. *Palliative Medicine*, Vol. 18, p. 62; Glenys Williams (2001) ‘The Principle of Double Effect and Terminal Sedation’. *Medical Law Review*, Vol. 9, pp. 42-43; Boyle J. (1991) ‘Who is Entitled to Double Effect?’ *The Journal of Medicine and Philosophy*, Vol. 16, pp. 475-494.

³¹⁶ Huxtable Richard. (2004) ‘Get out of Jail Free? The Doctrine of Double Effect in English Law’. *Palliative Medicine*, Vol. 18, p. 62.

³¹⁷ Finnis John. (1991) ‘Intention and Side-Effects’ in (eds) Frey R.G. and Morris C. W. *Liability and Responsibility: Essays in Law and Morals*. Cambridge: Cambridge University Press. p. 51.

³¹⁸ Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 286.

³¹⁹ *Ibid.*

(moral or immoral) which one adopts by choice and which thus constitutes one's immediate reason for acting as one does"³²⁰. Finnis explains this in the following words:

"On Williams' own account, it is clear that the second doctor is acting 'in order to relieve pain' by giving a dose which is 'the minimum necessary to deaden pain', all that figures in this doctor's proposal is his responsibility to relieve pain, and the fulfilling of that responsibility by administering a dose calculated not so as to bring relief *by* bringing death but so as to relieve pain. Such a doctor can realistically and resolutely resolve never to intend to kill, or intentionally bring about death, and yet welcome the patient's death just insofar as it is a relief from suffering. This is not a 'direction of intention', artificial, hypocritical, or at all."³²¹

Kugler, on the other hand, states that the doctrine that makes a distinction in the following way is known as the DDE.

"It is forbidden to kill the person with direct intention (i.e. to act in order to kill him as a means to achieve the good result) but it is allowed to act in order to achieve the good result, with the knowledge that the act will certainly cause the death of an innocent person as a side effect."³²²

Kugler comprehends the meaning of the doctrine from the contextual point of view.³²³ According to him, "...there are circumstances in which it is morally permissible to knowingly bring about as a side effect something which it would be forbidden to bring about purposely as a means, even if the balance of benefit

³²⁰ Finnis John. (1991) 'Intention and Side-Effects' in Frey R.G. and Morris C. W. (eds) *Liability and Responsibility: Essays in Law and Morals*. Cambridge: Cambridge University Press. p. 52.

³²¹ *Ibid.*

³²² Kugler Itzhak. (2002) *Direct and Oblique Intention in the Criminal Law: And Inquiry into Degrees of Blameworthiness*. England: Ashgate. p. 35.

³²³ *Ibid.*, at p. 53.

and harm in the consequences remains the same”.³²⁴ Although utilitarian does not envisage a difference between the two scenarios³²⁵, Kugler argues that the doctrine makes a distinction on the basis that in the former case there is a desire to kill, whereas in the latter case death is only “...known to follow as a by-product...” of the action performed.³²⁶

Both, Finnis and Kugler seek to provide an explanation as to why and how this type of conduct which knowingly causes death which is justified under the DDE, is treated morally different to the conduct that intentionally causes the same result.

The Rational basis for the DDE

One line of argument put forward by Kugler³²⁷ is that the DDE provides a “...reasonable explanation for our moral intuitions concerning certain cases”³²⁸ i.e. cases where the motive and the outcome remains the same, but the intention is different.³²⁹ This notion is analysed by Kugler from two perspectives. Firstly, the doctrine could be explained with a direct appeal to intuition “...so that the doctrine is viewed as one of our basic moral beliefs, without further explanation”.³³⁰ Secondly, it could be understood within the context of the actor, victim or value itself. In other words, one who intends the consequence disregards moral norms such as the moral integrity of the actor, the right of a person to life and the respect for value of human life.

The distinction drawn by the DDE also reflects the fact that morality is not *only* about attaining overall good with good motives. It is also about the actions of the

³²⁴ *Ibid.*, at p. 36.

³²⁵ *Ibid.*

³²⁶ *Ibid.*

³²⁷ Which according to him is accepted by many writers.

³²⁸ Kugler Itzhak. (2002) *Direct and Oblique Intention in the Criminal Law: And Inquiry into Degrees of Blameworthiness*. England: Ashgate. p. 37.

³²⁹ *Ibid.*, at p. 53.

³³⁰ *Ibid.*, at p. 56.

actor.³³¹ Hence, morality “...sometimes instructs him that he is not allowed to perform a certain act even if it would produce the best overall outcome”.³³² At this stage, the deontological constraints that impose personal responsibilities upon each individual become active. For example, the reason why one should not kill another person is to preserve one’s own “moral integrity”.³³³ Similarly, another reason why one should not kill could be to respect the other person’s right to life and to not treat that other person as a means to an end.³³⁴ Furthermore, one should not do harm to abstract values such as value of human life.³³⁵

Finally, as put forward by John Finnis the doctrine “...in no way suggests that one can chose ‘regardless’ of the certain side-effects. One’s acceptance of the double-effects must satisfy all moral requirements...”³³⁶ The side effect of the act must be proportionate.³³⁷ The result of the act must be morally acceptable and the reason for the action must be ‘good’ and the good effect must be immediate.³³⁸ According to Finnis one of the most important moral requirements is that one should “never *choose*” or intend to destroy or damage “any instantiation of a basic human good”.³³⁹ He further states that the distinction between intended impermissible consequences and side effect is “*morally*” significant because “...one who *intends* to destroy, damage or impede some instantiation of a basic human good necessarily acts contrary to reason, i.e., immorally”.³⁴⁰ In addition he states that “[a]ccepting – knowingly causing – harms caused to basic human

³³¹ *Ibid.*, at p. 40.

³³² *Ibid.*

³³³ *Ibid.*, at p. 49.

³³⁴ *Ibid.*, at p. 51.

³³⁵ *Ibid.*, at p. 52.

³³⁶ Finnis John. (1991) ‘Intention and Side-Effects’ in Frey R.G. and Morris C. W. (eds) *Liability and Responsibility: Essays in law and Morals*. Cambridge: Cambridge University Press. p. 56.

³³⁷ *Ibid.*; Quill T. E., Dresser R. and Brock D.W. (1997) ‘The Rule of Double Effect – A critique of its role in end-of-life decision making’. *The New England Journal of Medicine*, Vol. 337, p. 1768.

³³⁸ Boyle J.M. (1980) ‘Toward Understanding the Principle of Double Effect’. *Ethics*, Vol. 90, p. 528; Price D. (1997) ‘Euthanasia, pain relief and double effect’. *Legal Studies*. Vol. 17, p. 323; Mr. Saini Puspinder. (1999) ‘The Doctrine of Double Effect and the Law of Murder’. *Medico-Legal Journal*, Vol.67, p. 114; Glenys Williams. (2001) ‘The Principle of Double Effect and Terminal Sedation’. *Medical Law Review*, 9, p. 45.

³³⁹ Finnis John. (1991) ‘Intention and Side-Effects’ in Frey R.G. and Morris C. W. (eds) *Liability and Responsibility: Essays in law and Morals*. Cambridge: Cambridge University Press. p. 56.

³⁴⁰ *Ibid.*, at p. 63.

goods as side-effects will be contrary to reason (immoral) only if doing so is contrary to a reason of another sort..." i.e. by reason of "impartiality and fairness" or by reason arising from "role-responsibility and prior commitments".³⁴¹ These moral norms "...do recognize that we have some discretion about *which* bad side-effects to accept".³⁴²

In some cases, the options should be rejected, according to Finnis. This is "...because bringing about the side-effects would be unfair or unfaithful".³⁴³

"The only situation in which one can be, so to speak, a *priori* certain that harmful side-effects are *not* such as to give reason to reject an option is (i) the situation in which the feasible alternative option(s) involves *intending* destroy, damage or impede some instantiation of a basic human good, or (ii) the situation (if any) in which any feasible alternative option, while not involving such an intention, is necessarily accompanied by harmful side-effects which it could not be reasonable to accept".³⁴⁴

Having briefly discussed the DDE, the following meaning of the doctrine is adopted for the purpose of the thesis. "[I]t is sometimes permissible to bring about as a side effect of one's intentional action what it would be wrong to bring about intentionally."³⁴⁵ For instance, suppose a patient is terminally ill and in severe pain, attempting to control the patient's pain would mean risking the life of the patient. If, under these circumstances, the doctor administers the minimum pain-killing drug required to relieve pain, and as a result, the patient dies, then the doctor's conduct would fall within the scope of the DDE. In this way, the doctor's conduct i.e. acting to prevent pain, is justified *ethically* (being morally

³⁴¹ *Ibid.*, at pp. 63-64.

³⁴² *Ibid.*, at p. 63.

³⁴³ *Ibid.*, at pp. 63 -64.

³⁴⁴ *Ibid.*

³⁴⁵ Boyle J. (1991) 'Who is entitled to Double Effect?' *The Journal of Medicine and Philosophy*, Vol. 16, p. 475.

good) and *medically* (it being a proper medical treatment in the given circumstances).³⁴⁶

Adoption of the Doctrine in the Criminal Law

As stated earlier the doctrine plays a vital role in the health care issues. In 1957, it emerged in the context of ‘life or death treatment decisions’,³⁴⁷ through the case of *Dr Bodkin Adams*.³⁴⁸ In this case, Judge Devlin made a distinction “between those outcomes that are directly sought and those that are incidental to the doctor’s purpose”.³⁴⁹ The doctrine has been invoked by doctors who find themselves in a similar position to that of Dr. Bodkin Adams.³⁵⁰ Generally, doctors in these situations have claimed that their intention, for example, in administering lethal drugs was not to kill, but to relieve pain.³⁵¹ Notwithstanding the scope of the mental element for murder, which extends not only to direct intention, but also to indirect intention,³⁵² doctors in these types of cases have generally managed to avoid criminal liability.³⁵³ In the following part of the chapter, the case of *Dr Bodkin Adams* and the case of *Dr David Moor* will be analysed in the light of the DDE.

³⁴⁶ Price D. (1997) ‘Euthanasia, Pain Relief and Double Effect’. *Legal Studies*, Vol. 17, p. 331.

³⁴⁷ Mr. Saini Puspinder. (1999) ‘The Doctrine of Double Effect and the Law of Murder’. *Medico-Legal Journal*, Vol.67, p. 106.

³⁴⁸ Palmer Henry. (1975) ‘Dr. Adams’ Trial for Murder’ in Burke J. and Allsop P. (ed) *Criminal Law Review*. London: Sweet and Maxwell Limited. p. 365. This case is discussed in detail in the following part of this chapter.

³⁴⁹ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 92.

³⁵⁰ Williams Glenys. (2007) *Intention and Causation in Medical Non-Killing: The Impact of Criminal Concepts on Euthanasia and Assisted Suicide*. London and New York: Routledge.Cavendish.p.33; Arlidge Anthony. (2000) ‘The Trial of Dr David Moor’. *Criminal Law Review*, Jan, pp. 31-40; BBC News, Tuesday, 28 November, 2000. ‘Dr. Moor: Landmark verdict’. http://news.bbc.co.uk/1/hi/health/background_briefings/euthanasia/331263.stm

³⁵¹ It is to be noted that the doctrine of double effect prohibits intentional killing. See Suzanne Uniacke. (1994) *Permissible Killing: The Self-Defence Justification of Homicide*. Cambridge: Cambridge University Press. pp. 92-155.

³⁵² *R v Woollin* [1998] 3 WLR 382.

³⁵³ Mr. Saini Puspinder. (1999) ‘The Doctrine of Double Effect and the Law of Murder’. *Medico-Legal Journal*, Vol.67, pp. 106-120.

ii) The Doctrine of Double Effect and the case of *Dr Bodkin Adams* and the case of *Dr David Moor*

The Case of *Dr Bodkin Adams*

As stated above, the case of *Dr Bodkin Adams* is important because in this case, the principle of double effect was recognised in the medical context.³⁵⁴ Dr. Bodkin Adams was charged with the murder of his terminally ill patient to whom he had administered increasing doses of morphine, barbiturate and diamorphine resulting in the immediate death of the patient.³⁵⁵ The autopsy report showed a high level of these drugs in the patient's body and that consequently, the patient had suffered a stroke and a cerebral arteriosclerosis.³⁵⁶ The counsel for Dr. Bodkin Adams argued that the treatment provided "was designed to promote comfort"³⁵⁷. Further to this, evidence was shown that under certain circumstances doctors are *medically* justified in giving drugs to their patients which would 'incidentally' lead to death.³⁵⁸ Hence, in these cases there exists a risk of shortening the life of a patient, which doctors are allowed to take, provided their conduct is *medically* justified in doing so.³⁵⁹ Thus, Judge Devlin directed the jury with the following words:

"If the first purpose of medicine, the restoration of health can no longer be achieved there is still much for a doctor to do and he is entitled to do all that is proper and necessary [to relieve pain and suffering, even if the measures he takes may³⁶⁰]... incidentally shorten life."³⁶¹

³⁵⁴ Palmer Henry. (1975) 'Dr. Adams' Trial for Murder'. Burke J. and Allsop P. (eds) *Criminal Law Review*. London: Sweet and Maxwell Limited. p. 365.

³⁵⁵ *Ibid.*

³⁵⁶ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 87.

³⁵⁷ Arlidge Anthony. (2000) 'The Trial of Dr David Moor'. *Criminal Law Review*, Jan, p. 34; Palmer Henry. (1975) 'Dr. Adams' Trial for Murder'. Burke J. and Allsop P. (eds) *Criminal Law Review*. London: Sweet and Maxwell Limited. p. 365.

³⁵⁸ Arlidge Anthony. (2000) 'The Trial of Dr David Moor'. *Criminal Law Review*, Jan, pp. 31-40.

³⁵⁹ *Ibid.*

³⁶⁰ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 87.

³⁶¹ Arlidge Anthony. (2000) 'The Trial of Dr David Moor'. *Criminal Law Review*, Jan, p. 34.

Judge Devlin further observed:

“This is not because there is a special defence for medical men but because no act is murder which does not cause death. We are not dealing here with the philosophical or technical cause, but with the commonsense cause. The cause of death is the illness or the injury, ‘and the proper medical treatment that is administered and that has an incidental effect on determining the exact moment of death is not the cause of death in any sensible use of the term. But ...no doctor, nor any man, no more in the case of the dying than of the healthy, has the right deliberately to cut the thread of life.’ It is not contended by the defence that Dr Adams had any right to make that determination.”³⁶²

The jury found Dr Bodkin Adams not guilty. It is arguable that the jury were influenced by the words of Judge Devlin on the application of the ‘standard tests’ on intention and causation principles.³⁶³ Firstly, Judge Devlin made it clear to the Jury that Dr Bodkin Adams was *not* the cause of death of his patient. Secondly, Judge Devlin adopted a narrow definition of intention which “...does not fit into the conventional criminal law” as it excludes foreseeable consequences.³⁶⁴ Hence, although Judge Devlin placed heavy emphasis on the cause of death, it is arguable that “...the case is nonetheless authority for the proposition that a doctor, whose primary intention is to relieve pain, even if life is incidentally shortened, has an exceptional defence to murder”.³⁶⁵ In other words, the verdict supported the

³⁶² Devlin Patrick. (1985) *Easing the Passing: The Trial of Dr John Bodkin Adams*. London: The Bodley Head. pp. 171-172.

³⁶³ Williams Glenys. (2007) *Intention and Causation in Medical Non-Killing: The Impact of Criminal Concepts on Euthanasia and Assisted Suicide*. London and New York: Routledge.Cavendish.pp.34-39.

³⁶⁴ *Ibid.*, p. 42; Price D. (1997) ‘Euthanasia, pain relief and double effect’. *Legal Studies*, Vol. 17, p. 334.

³⁶⁵ Williams Glenys. (2007) *Intention and Causation in Medical Non-Killing: The Impact of Criminal Concepts on Euthanasia and Assisted Suicide*. London and New York: Routledge.Cavendish.pp pp.36-37.

observation made by Judge Devlin regarding the context of double effect, thereby providing it with a “...clear legal recognition”³⁶⁶ in medical cases.

The Case of *Dr David Moor*

The case of *Dr David Moor* is another prominent example of the double effect doctrine. Dr David Moor was charged with the murder of his terminally ill patient, but like Dr Bodkin Adams, Dr David Moor was found not guilty.³⁶⁷ The verdict in this case once again established that “...doctors who administer drugs to relieve pain are acting within the law whether or not the patient dies as a result”.³⁶⁸ What appears to be paramount in these types of cases is the action taken in order to relieve pain rather than the result i.e. death that follows as a side effect. Since doctors are *medically* justified to administer lethal doses of pain killing drugs, which may incidentally cause death, their intention in so doing *must* be to relieve pain. Hence, as far as the law is concerned, it is necessary for the court to know *only* the *prime* purpose of the doctor behind such an act. As far as the cause of death is concerned, as seen above in the comments of Judge Devlin, ‘illness or injury’ remains the operational and substantial cause of death of the patient. Alternatively, as suggested by Huxtable, medication cannot be said to be a cause of death because it is provided for the relief of ‘pain, suffering or distress’.³⁶⁹ In other words, it is provided for the benefit of the patient.

In this case, Dr David Moor injected his patient with 60 mg of diamorphine while the patient was unconscious.³⁷⁰ The patient died soon thereafter. Although Dr David Moor had identified correctly that his patient was in pain and close to

³⁶⁶ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 88.

³⁶⁷ Arlidge Anthony. (2000) ‘The Trial of Dr. Moor’. *Criminal Law Review*, pp. 38-39. It is to be noted that Dr David Moor admitted in the media of helping many of his patients to die by administering lethal dose of drugs. See BBC News, Tuesday, 28 November, 2000. ‘Dr. Moor: Landmark verdict’.

http://news.bbc.co.uk/1/hi/health/background_briefings/euthanasia/331263.stm

³⁶⁸ *Ibid.*

³⁶⁹ Huxtable R. (2004) ‘Get out of Jail Free? The Doctrine of Double Effect in English Law’. *Palliative Medicine*, Vol. 18, p.63.

³⁷⁰ Goss James. (2000) ‘A Postscript to the Trial of Dr David Moor’. *Criminal Law Review*, Jul, 568.

death, he wrongly presumed that the pain was caused by cancer. It later transpired that the patient was dying from heart failure.³⁷¹ Owing to this complication, Judge Hooper decided to direct the jury to find intention on the basis of the subjective test.³⁷² The issues raised to help the jury come to the decision were as follows:

- Whether the dose administered exceeded 60mg?
- Whether Dr David Moor caused the death of his patient?
- What was the purpose of Dr David Moor for administering such a dose? Was it to treat or was it to kill?³⁷³

The verdict was pronounced in the favour of Dr David Moor who had taken the same stance as Dr Bodkin Adams i.e. he argued that his intention was not to kill, but to treat the patient.³⁷⁴ In this case, Judge Hooper placed more emphasis on the intention of the doctor rather than the cause of death, as Judge Devlin did in the case of *Dr Bodkin Adams*.³⁷⁵ Once again the ‘standard tests’ on intention and causation principles were suspended and the doctrine of double effect was applied which as seen above justifies doctors conduct that causes death as a side effect of prescribed treatment. Under these circumstances, doctors are not treated as murderers because they are under a professional duty³⁷⁶ to treat the patient and this behaviour of a doctor fits within the DDE which has earned position in the criminal law.

³⁷¹ Mr. Saini Puspinder. (1999) ‘The Doctrine of Double Effect and the Law of Murder’. *Medico-Legal Journal*, Vol.67, p. 116.

³⁷² Arlidge Anthony. (2000) ‘The Trial of Dr. Moor’. *Criminal Law Review*, pp. 38-39.

³⁷³ Goss James. (2000) ‘A Postscript to the Trial of Dr David Moor’. *Criminal Law Review*, Jul, 568.

³⁷⁴ ‘Dr. Moor: Landmark verdict’. BBC News, 28 November 2000.

http://news.bbc.co.uk/1/hi/health/background_briefings/euthanasia/331263.stm

³⁷⁵ Williams Glenys. (2007) *Intention and Causation in Medical Non-Killing: The Impact of Criminal Concepts on Euthanasia and Assisted Suicide*. London and New York: Routledge.Cavendish.pp.34-39.

³⁷⁶ That is reason arising from the “role-responsibility”, one of the reasons cited by Finnis that permits the actor to act contrary to basic reason in the case of oblique intention.

Inferences drawn from the case of *Dr Bodkin Adams* and the case of *Dr David Moor*

The consideration that "...the jury is not entitled to convict... [the doctor] of murder if his purpose is to give treatment which he believes, in the circumstances as he understands them, to be proper treatment to relieve pain"³⁷⁷, has almost become a rule³⁷⁸. Nonetheless, "...it remains the law, that no doctor, nor any man no more in the case of the dying than the healthy, has the right to deliberately cut the thread of life"³⁷⁹. In other words, the directions of the Judges in these types of cases show that doctors *may* take the risk of providing medication, whether of analgesics or sedatives³⁸⁰, to their patients in the last moments of life. The law accepts that such conduct is justified *medically*. However, what the law does not accept is the providing of such treatment with the intent to kill.³⁸¹ Dr Carr, who was charged with attempted murder for allegedly overdosing his terminally ill patient with phenobarbitone was, however, found not guilty. However, Dr Carr was told by the judge that: "A doctor is not entitled to play God and cut short life because he believes the time has come to end the pain and suffering and to enable his patient to 'die with dignity'."³⁸²

Furthermore, it is possible that administering even a palliative drug could prove dangerous legally, in the circumstances where the dose administered is more than is required to relieve pain. Such conduct by a doctor could be observed as being of 'single effect' rather than 'double effect'. This interpretation could also be applied in the cases where the drug used to treat the patient had no therapeutic effect. Under these circumstances doctors cannot claim defence of double effect because their sole aim is to end life. This is despite the fact that the reason for so

³⁷⁷ Smith J.C. (2000) 'A Comment on Moor's Case'. *Criminal Law Review*, p.44.

³⁷⁸ Lord Goff also observed this consideration in the case of Bland. See p. 85 of the thesis.

³⁷⁹ Arlidge Anthony. (2000) 'The Trial of Dr. Moor'. *Criminal Law Review*, p. 34.

³⁸⁰ Except when further step to withdraw nutrition and hydration is taken with intend to cause death. More on this is said in the following part of this chapter.

³⁸¹ Palmer Henry. (1975) 'Dr. Adams' Trial for Murder'. Ed. Burke J., and Allsop P. *The Criminal Law Review*. London: Sweet and Maxwell Limited. p. 365.

³⁸² Cole Lloyd. (1992) 'Let me die: A study of voluntary euthanasia containing many case studies'. Maidenhead: Lloyd Cole. Cited in Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p.107.

doing may be morally right and good i.e. to relieve the patient from pain and suffering and to enable him or her to die with dignity as correctly referred to by the Judge in the case of *Dr Carr*.³⁸³

iii) The Position of Doctors who cannot claim Double Effect

A doctor who intends to cause death, or shorten the life of a terminally ill or severely ill patient, by injecting a substantial dose of morphine in order to relieve or avoid further pain and suffering, would be acting beyond the boundaries of the doctrine of double effect.³⁸⁴ The first reason for this is that the intention of the doctor in this scenario is not consistent with one of the requirements of the double effect doctrine i.e. that the intention must be "...to produce good effect".³⁸⁵ Secondly, since deliberately causing death or shortening life is inherently morally wrong, it contravenes another proviso of the doctrine which requires that "...the action itself (as distinct from its consequences or effects) must not be inherently morally wrong".³⁸⁶ Lastly, by bringing good effect through the medium of the bad effect, the doctor in this scenario breaches the third provision of the doctrine which specifies, that the "...good effect must not be brought about via the bad effect".³⁸⁷

Similarly, the DDE is of limited assistance in cases of terminal sedation.³⁸⁸ Even though the purpose, in a case of terminal sedation, is to relieve pain and suffering

³⁸³ *Ibid*. Huxtable claims that in reality doctors do exactly the same but still claim double effect. See Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 107.

³⁸⁴ *R v Cox* [1992] 12 BMLR 38; Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 106-7; Finnis J. (1991) 'Intention and Side-Effect' in Frey R.G. and Morris C.W. (eds) *Liability and Responsibility: Essays in Law and Morals*. Cambridge: Cambridge University Press.

³⁸⁵ Huxtable R. (2004) 'Get out of jail free? The doctrine of double effect in English law'. *Palliative Medicine*, Vol. 18, p.62.

³⁸⁶ *Ibid*.

³⁸⁷ *Ibid*; Finnis J. (1991) 'Intention and Side-Effect' in Frey R.G. and Morris C.W. (eds) *Liability and Responsibility: Essays in Law and Morals*. Cambridge: Cambridge University Press; Kugler I. (2002) *Direct and Oblique Intention in the Criminal Law: And Inquiry into Degrees of Blameworthiness*. England: Ashgate.

³⁸⁸ Quill E.T., Dresser R. and Brock W.D. (1997) 'The Rule of Double Effect – A Critique of its Rule in End-of-Life Decision Making'. *The New England Journal of Medicine*, Vol. 337, pp. 1768-1771.

by diminishing consciousness, life prolonging therapies such as food and water are withdrawn with the intent to hasten death.³⁸⁹ Arguably, this could raise allegations of active voluntary euthanasia (when it is done with consent) and active involuntary euthanasia (when it is performed without consent).³⁹⁰ In other words, a doctor could be accused of murder. “Terminal sedation would thus not be permitted under the rule of double effect, even though it is usually considered acceptable according to current legal and medical ethical standards.”³⁹¹

Similarly, even if the intention is to relieve pain, if the doctor administers more than the required painkilling dose to the patient and the patient dies as a result, the conduct of the doctor would arguably not fall within the scope of the DDE. This is because such conduct would fall short of the standard of proportionality required to be fulfilled in order for the conduct to be in accordance with the principle of double effect.³⁹² The doctrine requires that the reason for so doing must be grave. However, it is evident from some of the cases³⁹³ that the legal officials, including the jury, have a tendency to find doctors under these conditions ‘not guilty’ of murder unless the doctor has been grossly negligent. Under these circumstances, the doctor would in all likelihood be found guilty of unlawful killing (generally manslaughter)³⁹⁴ in spite of the act done for the lawful purpose.³⁹⁵ It is also possible that there could be a case of premeditated murder as with the case of Harold Shipman, who was found guilty of murdering 15 of his patients by

³⁸⁹ Glenys Williams. (2001) ‘The Principle of Double Effect and Terminal Sedation’. *Medical Law Review*, Vol. 9, p.45.

³⁹⁰ *Ibid.*, at p.45.

³⁹¹ Quill E.T., Dresser R. and Brock W.D. (1997) ‘The Rule of Double Effect – A Critique of its Rule in End-of-Life Decision Making’. *The New England Journal of Medicine*, Vol. 337, p. 1769.

³⁹² Huxtable R. (2004) ‘Get out of jail free? The doctrine of double effect in English law’. *Palliative Medicine*, Vol. 18, p.62.

³⁹³ Such as the case of Dr Carr. See, Huxtable Richard. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 107.

³⁹⁴ Goff Robert. (1995) ‘A Matter of Life and Death’. *Medical Law Review*, Vol. 3, p. 2.

³⁹⁵ Finnis J. (1991) ‘Intention and Side-Effect’ in Frey R.G. and Morris C.W. (eds) *Liability and Responsibility: Essays in Law and Morals*. Cambridge: Cambridge University Press. p. 52.

injecting them with a lethal overdose of painkilling drugs (diamorphine Hydrochloride).³⁹⁶

The Case of *Dr Cox*

In the situation where a doctor uses a drug, which has no therapeutic effect, but which eases the pain of the imminently dying patient, this conduct could fall short of the doctrine, as happened in the case of *Dr Cox*³⁹⁷. Dr Cox injected his patient, Lillian Boyes, with potassium chloride. This was a drug which would certainly kill the patient, but which would, at the same time, provide relief from pain in the last moments of the life of the patient.³⁹⁸ It was decided by the jury that Dr Cox intentionally caused the death of his patient, albeit, with her consent.³⁹⁹ The fact was that Lillian Boyes was in severe bodily pain in the last stages of her life. It was so severe that even if her son touched her, it would cause her pain. She repeatedly requested Dr Cox to put an end to her unbearable suffering. Consequently, Dr Cox finally decided to accord with her wish by injecting a substance that was intended to kill her. Following the act, Dr Cox was arrested, charged and found guilty of attempt to murder.⁴⁰⁰

Dr Cox denied that he had an intention to kill. He attempted to make the same argument as Dr Bodkin Adams and Dr David Moor i.e. that his intention was to

³⁹⁶ However, it was alleged that he must have murdered at least as many as 215 of his patients. See 'Harold Shipman: Timeline'. See <http://news.bbc.co.uk/1/hi/uk/2136444.stm>

³⁹⁷ 'Attempted Murder of Terminally Ill Patient'. (1993) *Medical Law Review*, Vol.1, pp. 232-234.

³⁹⁸ This was proved from the expert evidence based on the facts of the case. See Arlidge Anthony. (2000) 'The Trial of Dr Moor'. *Criminal Law Review*, Jan, p.36.

³⁹⁹ 'Attempted Murder of Terminally Ill Patient'. (1993) *Medical Law Review*, Vol.1, pp. 232-234.

⁴⁰⁰ The reason why he was charged with attempt to murder and not with murder is that it could not be proved whether it was the drug that caused the death of Lillian Boyes or whether she died from her underlying illness, as her body had already been cremated when the authorities received the information about her death. "One also suspects the prosecution took the view that there was more chance of persuading the jury to convict the defendant of a crime where the judge had a discretion as to sentence rather than, as is the case for murder, one where the penalty is fixed at life imprisonment." See, 'Attempted Murder of Terminally Ill Patient'. (1993) *Medical Law Review*, Vol.1, p. 233.

treat the patient's pain and suffering.⁴⁰¹ Judge Ognall directed the jury in the following terms to decide whether Dr Cox intended to kill Lillian Boyes:

“There can be no doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death. What can never be lawful is the use of drugs with the primary purpose of hastening the moment of death.

And so, in deciding Dr Cox's intention, the distinction the law requires you to draw is this. Is it proved that in giving the injection, in that form and in those amounts, Dr Cox's primary purpose was to bring the life of Lillian Boyes to an end? If it was then he is guilty. If on the other hand, it was, or may have been, his primary purpose in acting as he did to alleviate her pain and suffering, then he is not guilty.”⁴⁰²

In light of the evidence, the jury decided that Dr Cox's main purpose was to end Lillian Boyes' life. What appears to be markedly different in this case is the particular drug used to kill Lillian Boyes.⁴⁰³ It is possible to suggest that the jury could have inferred Dr Cox's intention from the substance used, rather than the consequence that followed from his action. If Dr Cox had used an analgesic drug even in high doses, the outcome of his case would probably have been different, despite the fact that he acted with intent to kill.⁴⁰⁴ Furthermore, it is arguable that the sentence pronounced in this case also supports this view; Dr Cox was awarded a suspended sentence.⁴⁰⁵

⁴⁰¹ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 106.

⁴⁰² Arlidge Anthony. (2000) 'The Trial of Dr Moor'. *Criminal Law Review*, Jan, p.37.

⁴⁰³ Glenys Williams. (2001) 'The Principle of Double Effect and Terminal Sedation'. *Medical Law Review*, Vol.9, p.47.

⁴⁰⁴ Boyle J.M. (1980) 'Toward Understanding the Principle of Double Effect'. *Ethics*, Vol. 90, p. 535.

⁴⁰⁵ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 106.

Implications drawn from the case of *Dr Cox*

It is arguable that the decision in the case of *Dr Cox* once again throws light on the double effect doctrine, which prohibits intended impermissible consequences.⁴⁰⁶ As stated by Huxtable, "...the legal officials want only to afford an explicit justification to those doctors taking positive steps that might shorten life whose conduct can be reconciled, however, shakily, with the DDE."⁴⁰⁷ As stated above, the doctrine disapproves of any and all intended evil ends and evil means, which result from the actions of the doctor, as morally wrong. In addition, the doctrine approves of some consequences which are brought about knowingly and which occur as a side effect of the main act, as long as the good effect outweighs the bad consequence and the drug used was proportionate to the pain relief.⁴⁰⁸ However, in spite of the strict application of the rule of double effect to cases involving 'life or death treatment decisions', at times, when the conduct of the doctor does not fall within the scope of this doctrine and the doctor is found guilty, the courts appear to be reluctant to punish such doctors with imprisonment⁴⁰⁹ as happened in the case of *Dr Cox*.⁴¹⁰ In other situations, as noted by Glanville Williams, "... a jury will be reluctant to convict a doctor in these circumstances, and may only seize upon any defect in evidence as a reason for acquitting, but may even acquit when the evidence and the judge's direction leave them with no legal reason for doing so".⁴¹¹ However, when it comes to laypeople, the law treats them differently from doctors, even when the action taken is the same as the action of the medical professionals.

⁴⁰⁶ 'Attempted Murder of Terminally Ill Patient'. (1993) *Medical Law Review*, Vol.1, pp. 232-234.

⁴⁰⁷ *Ibid.*

⁴⁰⁸ Price D. (1997) 'Euthanasia, pain relief and double effect'. *Legal Studies*, Vol. 17, No. 2, p. 323; Finnis J. (1991) 'Intention and Side-Effect' in Frey R.G. and Morris C.W. (eds) *Liability and Responsibility: Essays in Law and Morals*. Cambridge: Cambridge University Press.; Kugler I. (2002) *Direct and Oblique Intention in the Criminal Law: And Inquiry into Degrees of Blameworthiness*. England: Ashgate.

⁴⁰⁹ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p.106.

⁴¹⁰ 'Attempted Murder of Terminally Ill Patient'. (1993) *Medical Law Review*, Vol.1, pp. 232-234. It is plausible to suggest that if Dr Cox were to be convicted of murder, "...executive clemency will in all probability intervene to...reduce a period of imprisonment otherwise fixed by the law....". See Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 292.

⁴¹¹ Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 292.

iv) Exploring the difficulties faced by laypersons in relying on the Double Effect Doctrine

The DDE, as noted above, is understood as a principle of justification.⁴¹² It justifies unintended, merely foreseen consequences that follow from intended action.⁴¹³ As stated above, the relevant intended action must always be good and morally permissible. The unintended merely foreseen consequence which is otherwise evil and morally impermissible *may* be justified when “...there is a serious reason for undertaking the action”⁴¹⁴. For example, the serious reason could be to save a person’s life or to avoid being killed.⁴¹⁵ Similarly, acting to relieve the serious pain, suffering and distress of another person is considered to be a ‘good’ reason to justify one’s actions.⁴¹⁶ As stated above, Doctors employ this reasoning when it comes to ‘life or death treatment decision-making.’⁴¹⁷ In these situations doctors use analgesic or sedative drugs to treat the pain of terminally ill or severely ill patients, in the knowledge that this could mean accelerating or causing the immediate death of the patient. This type of conduct by the doctor is potentially justifiable, not only morally, but also medically and legally, as noted above.⁴¹⁸ In fact, one commentator has stated:

“...namely, that a doctor is not in breach of his duty to his patient when he administers pain relieving drugs which incidentally shorten the patient’s life. By contrast, the law does not consider it to be any part of a doctor’s duty to act for the sole purpose of killing his patient. This argument

⁴¹² Boyle Joseph M. (1980) ‘Towards Understanding the Principle of Double Effect’. *Ethics*, Vol. 90, p. 532.

⁴¹³ *Ibid.*

⁴¹⁴ *Ibid*; Finnis J. (1991) ‘Intention and Side-Effect’ in Frey R.G. and Morris C.W. (eds) *Liability and Responsibility: Essays in Law and Morals*. Cambridge: Cambridge University Press.; Kugler I. (2002) *Direct and Oblique Intention in the Criminal Law: And Inquiry into Degrees of Blameworthiness*. England: Ashgate.

⁴¹⁵ As in the case of self-defence.

⁴¹⁶ As it was agreed in the case of Annie Lindsell who made an application to the court to ensure that her doctor would not be prosecuted if he administers pain killing drugs to her at the end of her life stage which could accelerate her death.

http://news.bbc.co.uk/1/hi/health/background_briefings/euthanasia/332464.stm

⁴¹⁷ Mr. Saini Puspinder. (1999) ‘The Doctrine of Double Effect and the Law of Murder’. *Medico-Legal Journal*, Vol.67, pp. 106-120.

⁴¹⁸ Price D. (1997) ‘Euthanasia, Pain Relief and Double Effect’. *Legal Studies*, Vol. 17, p. 324.

requires us to accept that a consideration of a doctor's duty is relevant not only when death follows from the *omission* to treat a patient but also when it results from his *acts*.”⁴¹⁹

However, when it comes to laypersons the same exception does not apply.⁴²⁰ The position of laypersons does not reconcile with the position of doctors, even when the action, the circumstances and the consequence are one and the same. The first reason for this results from the fact that laypeople cannot argue, as doctors can, “...they understood their actions to be in line with the actions of other responsible doctors....”⁴²¹ i.e. laypersons cannot argue that their conduct is medically justified. That, like a doctor, he or she has responsibility to the patient to relieve his or her suffering. Their (i.e. laypersons) intention was ‘to treat’ the patient and not to kill.⁴²² Similarly, as argued by Glanville Williams, an overdose administered by a doctor is difficult to establish because of the nature of evidence required.⁴²³ As a result, it will often be difficult to establish the crucial amount of the final dose that killed the patient in the case where the amount of the dose is said to be the cause of death.⁴²⁴ All this goes against the layperson whose involvement in the given circumstances would be seen as interference in the absence of the authority (status of a doctor) that imposes responsibility on the doctor to act to relieve pain. Under these circumstances, even if the conduct of a layperson is justified under the doctrine of double effect by arguing that every human being has some kind of moral responsibility towards the other, not to let that other person suffer,⁴²⁵ when it comes to legal justification, the layperson will lack the authority (licence) to perform such a task that permits the licence holder

⁴¹⁹ ‘Attempted Murder of Terminally Ill Patient’. (1993) *Medical Law Review*, Vol.1, p. 234

⁴²⁰ Except when one acts in self-defence. See, Price D. (1997) ‘Euthanasia, Pain Relief and Double Effect’. *Legal Studies*, Vol. 17, p. 325.

⁴²¹ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 104.

⁴²² Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. pp. 291-292.

⁴²³ *Ibid.*

⁴²⁴ *Ibid.*

⁴²⁵ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 130.

to do all that is necessary for the wellbeing of the patient. This assertion is made on the basis that Lord Goff also acknowledged the idea that

“...a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient’s life. Such a decision may properly be made as part of the care of the living patient, in his best interest; and, on this basis, the treatment will be lawful”,⁴²⁶.

As a result, although the jury are legally free to convict the accuse of murder in the circumstances in which the death is virtually certain and the defendant foresaw it to be virtually certain, the jury are unlikely to find a doctor guilty. This is because the doctor acts in accordance to medical requirements and thus does no wrong. However, in the case of layperson such verdict is unlikely to follow.⁴²⁷ This is because as argued earlier since layperson stands in a different position to that of a doctor it would prove difficult for the jury not to find the defendant guilty of a crime that explicitly supports the verdict of guilt. Under these circumstances, there is high possibility that the jury would find the defendant guilty. From this, it follows that different rules are applied between laypeople and doctors.⁴²⁸

As a result, it is arguable that in comparison to laypersons, doctors enjoy a unique position in their profession. It allows them to act during the critical moment in the life of the patient in a manner which may lead to the death of the patient. Furthermore, as stated by Glanville Williams, a doctor under these circumstances will “...be able to preserve a measure of ambiguity about his acts, which helped

⁴²⁶ *Airedale Hospital Trustees v Bland* [1992] UKHL 5, p. 12.

⁴²⁷ For example, if at all the layperson is found not guilty of murder he or she will not get away with manslaughter conviction or attempt to murder. See ‘Manslaughter –ingredients of offence where death caused by gross negligence’. *Criminal Law Review*, 1998, Nov., pp. 830-833.

⁴²⁸ The case of *Dr Bodkin Adams*, *Dr David Moor* and the case of *Woollin* are good examples of this.

to still both his conscience and any fear he might have of the law”.⁴²⁹ In this way, it is not just the act that is justified but it is also the person i.e. the doctor who is excused.⁴³⁰ Therefore, as argued by Price, only a person in the capacity of a doctor, who is under a duty of care towards the patient, can perform the action of administering a drug which inevitably leads to death.⁴³¹ It is knowledge, skill and authority (licence to practice medicine) of a doctor that prevails over the subjective view of laypeople⁴³² who fall short of this position.⁴³³ This is clear from the two most recent cases: the case of *Kay Gilderdale* and the case of *Frances Inglis*.

The Case of *Kay Gilderdale*

Kay Gilderdale administered morphine to her dying daughter Lynn Gilderdale, who had attempted suicide.⁴³⁴ Consequently, Kay Gilderdale was charged with attempted murder of her daughter.⁴³⁵ She contended that her purpose in doing so was not to attempt to kill her daughter but to comfort her as she was dying. The DPP had found sufficient evidence against Kay Gilderdale to charge her with attempted murder.⁴³⁶ The court and the jury on the other hand, took a different view from the course taken by the DPP. Justice Bean opined that Kay Gilderdale should not have been brought before the court. When the jury acquitted Kay Gilderdale, Justice Bean commented on the Jury’s verdict by stating that the jury used common sense, decency and humanity in acquitting Kay Gilderdale.⁴³⁷

⁴²⁹ Williams Glanville. (1973) ‘Euthanasia’. *The Medico-Legal Society*, Vol. 41, p. 15.

⁴³⁰ Price D. (1997) ‘Euthanasia, Pain Relief and Double Effect’. *Legal Studies*, Vol. 17, p. 327.

⁴³¹ *Ibid.*

⁴³² *Ibid.*

⁴³³ Smith J.C. (2000) ‘A Comment on Moor’s Case’. *Criminal Law Review*, p.42.

⁴³⁴ For further details on this case, refer chapter 1.

⁴³⁵ It is relevant to note as discussed in chapter 2, she was also charged with separate offence of assisted suicide to which she pleaded guilty and was awarded a suspended sentence.

⁴³⁶ The Daily Mail, 26 January 2010, ‘Decision to charge loving mother Kay Gilderdale with attempted murder of ME daughter was right, says DPP’. <http://www.dailymail.ac.uk/news/article-1246222/Keir-Starmer-says-decision-charge-Kay-Gilderdale-attempted-murder-daughter-Lynn-public-interest.html#ixzz0zrNK>

⁴³⁷ BBC News Online, 26 Jan 2010. ‘Should law be changed on ‘Mercy Killing’?

Since the jury provide no reason on their decision, the acquittal of Kay Gilderdale from the charge of attempted murder leaves one to speculate whether the jury released Kay Gilderdale in the light of the double effect doctrine (i.e. her intention was good), or, because they considered her conduct to be part and parcel of assisted suicide (a continuing act that began as a process of assisted suicide), a charge to which she pleaded guilty to and for which she was awarded a suspended sentence.⁴³⁸ It is unlikely that they found Kay Gilderdale not guilty on the basis of double effect because as argued above Kay lacked the authority to act in the capacity of a doctor⁴³⁹, even though she probably had the required knowledge and skill to act in that manner taking into account that she acted as a carer for her daughter.⁴⁴⁰ Hence, it is more likely that they acquitted her on the basis that she had already pleaded guilty of assisted suicide (for which she was awarded sentence).

The Case of *Francis Inglis*

Francis Inglis injected her brain-damaged son, Thomas, with an analgesic drug (heroin, also know as diamorphine⁴⁴¹). Thomas died and Francis Inglis was charged with his murder.⁴⁴² The toxicology report showed that Thomas was given “a very large dose of heroin” – a dose which fell within the fatal levels.⁴⁴³ Francis Inglis admitted injecting her son with the lethal painkilling drug. However, she contended that her act was an act of ‘mercy killing’, rather than murder. She said that she felt her son was in severe pain and that he was suffering. Her desire was to end his suffering by allowing him to have a painless death. She further argued

⁴³⁸ See chapter 1 of the thesis.

⁴³⁹ That is to administer pain relieving drug in order to comfort dying as for example, doctors did in the circumstances of Wooltorton.

⁴⁴⁰ Although the doctrine does not specify the requirement of the professional in these circumstances, one of the reasons that could justify the actor’s conduct is “role-responsibility”. This means the actor ought to be responsible to perform such an act in the given circumstances. If Kay Gilderdale is observed as a responsible agent for the best interest of her daughter in the given circumstances then it is possible to suggest that probably the jury found her conduct justifying under the doctrine of double effect and in this way, excused her from conviction.

⁴⁴¹ Huxtable Richard. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish.

⁴⁴² Mother ‘injected brain-damaged son with fatal dose of heroin to end misery’. Telegraph News, 5th January 2010. <http://www.telegraph.co.uk/news/uknews/crime>

⁴⁴³ *Ibid.*

that her intentions in so doing were ‘good’ and she had acted merely out of love for her son.⁴⁴⁴

Judge Brian Barker directed the jury that there was no such thing as ‘mercy killing’ under the law. Hence, he stated that the jury should not look at the motive, but at the intention of the accused to find out whether she murdered her son or not. Frances Inglis was found guilty of murder.⁴⁴⁵ The Judge awarded her a sentence of life imprisonment for a minimum of 9 years.

Francis Inglis’ conduct clearly went beyond the scope of the DDE because her intention was to relieve pain by causing death. However, if she had not admitted the fact that she desired to end Thomas’ suffering by ending his life and if it had not been evident that she had attempted to end his life on previous occasion then the double effect doctrine would have been relevant⁴⁴⁶. However, under these circumstances the question arises as to whether her conduct would have been treated in the same manner as that of medical professionals. That is, she acted out of responsibility to relieve pain of her son. As argued by Huxtable, taking into account the proximity of her relationship with Thomas, she owes some duty towards him. Under these circumstances, morally her conduct should be treated analogous to a doctor. However, the question remains whether it will be justified legally. The answer to this question is that it is doubtful because of lack of authority to act. Hence, it is possible to suggest that the basis of the legally justification for the actions of doctors in these types of cases does not entirely lie within the DDE, their role as a doctor plays vital part.

⁴⁴⁴ By Ninemsn staff, on 15th January 2010. <http://news.ninemsn.com.au/world/1000181/mother-explains-why-she-killed-son-with-heroin>

⁴⁴⁵ This is because the law “decrees all mercy-killing to be murder”. See Williams Glanville. (1973) ‘Euthanasia’. *The Medico Legal Society*, Vol.41, p. 16.

⁴⁴⁶ Mother ‘injected brain-damaged son with fatal dose of heroin to end misery’. Telegraph News, 5th January 2010. <http://www.telegraph.co.uk/news/uknews/crime>

This inference could also be drawn from Lord Goff's observation:

"It is this principle [that the doctor must act in the best interests of the patient]... which, in my opinion, underlies the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life. Such a decision may properly be made as part of the care of the living patient, in his best interests; and, on this basis, the treatment will be lawful."⁴⁴⁷

By contrast, Lord Goff asserted that "it forms no part of a [doctor's] duty to give his patient a lethal injection to put him out of his agony."⁴⁴⁸

v) Exploring the DDE and the Criminal Law

There are a number of important cases⁴⁴⁹ which support the principle that medical professionals who act in order to relieve the pain, suffering or distress of the terminally ill or severely ill patient, do not act unlawfully when that conduct kills the patient or incidentally leads to the death of that patient.

However, it is relevant to note what Dr Oliver, a hospice director, has to say on the use of painkilling drugs. According to him diamorphine is likely to cause death only if used inappropriately⁴⁵⁰. This means not all actions done for the lawful purpose i.e. in order to relieve pain would be justifiable medically or legally. Glanville Williams on the other hand, claims that sometimes there can be an incident in which the minimum necessary dose required to relieve pain may kill the person.⁴⁵¹ This implies that although there may be a possibility that death

⁴⁴⁷ *Airedale Hospital Trustees v Bland* [1992] UKHL 5, at 12.

⁴⁴⁸ *Ibid.* at p.12.

⁴⁴⁹ Such as the case of *Dr Bodkin Adams* and the case of *Dr David Moor*.

⁴⁵⁰ Oliver D. (1997) 'Easing pain for the terminally ill', *The Times*, 11 November.

⁴⁵¹ Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 285.

may follow as a result of the administration of the dose to relieve pain, there is also a chance that death may not follow as a result of the administration of the dose unless used inappropriately. Hence, as argued by Huxtable, it is necessary that the legal officials take a hard look at these types of cases⁴⁵² so to maintain a distinction between death that follows as a side effect of pain killing drug and death that is brought about deliberately. This is necessary to ensure that doctors such as Dr Bodkin Adams do not get away with criminal acts by trying to fit their conduct within the DDE.⁴⁵³

However, as and when the legal officials encounter the cases of double effect in the context of palliative care, as argued above, it is rare that these cases reach the stage of prosecution. However, when these cases arise, the judges generally adopt a narrow construction of intention adopted by the DDE.⁴⁵⁴ At the same time the decision in the case of *Woollin*⁴⁵⁵ provides jury flexibility in finding the accused guilty or not guilty. As far as the rule of causation is concerned, the court tends to use a 'common sense' approach in order to show that the cause of death was not the drug administered, but the underlying disease of the patient.⁴⁵⁶ This kind of practice illustrates a level of inconsistency within the common law system, and it also shows disparity in the application of the law. It is arguable that there is unfairness in the way that the law is applied to doctors and the way that it is applied to laypeople.⁴⁵⁷ For example, in the case of *Dr Bodkin Adams*, where the

⁴⁵² Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish.

⁴⁵³ It is alleged that Dr Bodkin Adams acted with malicious intentions. See 'Crime File-Famous Criminal: Dr John Bodkin Adams'. <http://www.crimeandinvestigation.co.uk/crime-files/dr-john-bodkin-adams/biography.html>

⁴⁵⁴ Price D. (2009) 'What shape to euthanasia after Bland? Historical, cotemporary and futuristic paradigms'. *Law Quarterly Review*, Vol. 125, p.146.

⁴⁵⁵ That is the jury may find one guilty of murder if they "...feel sure that death or serious harm was a virtual certainty (barring some unforeseen intervention) as a result of the defendant's actions and that the defendant appreciated that such was the case.... The decision is one for the jury to be reached upon a consideration of all the evidence". See *R v Woollin* [1998] 4 All ER 103.

⁴⁵⁶ 'Attempted Murder of Terminally Ill Patient'. (1993) *Medical Law Review*, Vol. 1, pp. 232-234.

⁴⁵⁷ Wilson W. (1995) 'Is Life Sacred?' *Journal of Society, Welfare and Family*, Vol.17, p. 137.

causation was very much present⁴⁵⁸, Judge Devlin deemed it absent.⁴⁵⁹ William Wilson suggests that the possible rational behind the reasoning of Judge Devlin “...may be that the doctor’s contribution was too negligible to be causal”.⁴⁶⁰ The autopsy report suggests otherwise.⁴⁶¹ The patient died from a stroke and a cerebral arteriosclerosis caused by high level of drug administered. In other words, medically speaking the cause of death could be ‘drug administered’ rather than the underlying disease of the patient as it happened in the case of Thomas.⁴⁶² Therefore, even under the principle of causation the conduct of a doctor and layperson cannot be distinguished except on the basis of the status of a doctor as argued by Smith. “We cannot distinguish between a doctor and a layman doing the same act on grounds of causation, but only on the ground that what is permissible for the one is not permissible for the other”.⁴⁶³

The criminal law makes a distinction between the actions of a medical professional and the actions of a layperson when it comes to the rule of double effect.⁴⁶⁴ As a result, as argued by Saini the law is “...intellectually incoherent and intellectually dishonest ...” in its application which illustrates a certain level of dishonesty within the law.

In addition, even if death is not an immediate effect of the act, such an act could shorten life which according to Ashworth is sufficient to find the causal link between doctors’ conduct and the death of the patient.⁴⁶⁵ On the other hand, as argued by Glenys Williams, an act undertaken by a doctor may be the factual

⁴⁵⁸ William Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 290.

⁴⁵⁹ In spite the fact that in some cases it was clear that another effect i.e. respiratory failure arose from the administration of painkilling drugs. See William Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 290.

⁴⁶⁰ Wilson W. (2008) *Criminal Law: Doctrine and Theory*. Third Ed. Harlow; England; New York: Pearson Longman. p. 101.

⁴⁶¹ See p. 73 of the thesis.

⁴⁶² See p. 87 of the thesis.

⁴⁶³ Smith J.C. (2000) ‘A Comment on Moor’s Case’. *Criminal Law Review*, p. 42.

⁴⁶⁴ Huxtable R. (2004) ‘Get out of jail free? The doctrine of double effect in English law’. *Palliative Medicine*, Vol. 18, p. 65.

⁴⁶⁵ Ashworth Andrew. (2009) *Principles of Criminal Law*. Oxford: Oxford University Press. p. 104.

cause of death of the patient, but it cannot be the legal cause probably because the doctor's conduct under such circumstances would be justified medically and morally.⁴⁶⁶ That is, although but for the action of the doctor the patient would not have died, the action carried out was necessary in the best interest of the patient and the doctor had a duty to do so. As a result, death that follows from the action of the doctor is a side effect.

In this way, the DDE not only assist legal officials to overcome the hurdle of dealing with the principle of causation but also helps to overcome the hurdle of principle of *mens rea*. It springs from the DDE that doctors do not intend to kill their patients in the cases of palliative care. In other words, the doctrine provides them with an opportunity to say that they did not cause nor did they intend the death of the patient.⁴⁶⁷ The aim of the doctor is to treat the pain or to relieve the pain of the patient. The potential criminal issues arising from the intention in such cases are overcome with the help of the DDE⁴⁶⁸ and with the help of the ruling led down in the case of *Woollin*. This reflects the arbitrary application of the general principles of the criminal law which differs in its role towards the cases involving doctors and cases involving laypeople. If the law was applied equally as argued by Huxtable, then doctors who administer a dose inappropriately (for example, those who administer more of a drug than what is actually required to relieve pain), should not be able to avoid criminal liability.⁴⁶⁹ Hence, this possible scenario should provide reason for legal officials to pause and reflect on the state of the law at present.⁴⁷⁰

⁴⁶⁶ Glenys Williams. (2001) 'The Principle of Double Effect and Terminal Sedation'. *Medical Law Review*, Vol. 9, p. 45.

⁴⁶⁷ *Ibid.*

⁴⁶⁸ That relies on the narrow definition of the intention. Price D. (2009) 'What shape to euthanasia after Bland? Historical, cotemporary and futuristic paradigms'. *Law Quarterly Review*, Vol. 125, p.146.

⁴⁶⁹ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish.

⁴⁷⁰ *Ibid.*, at p.101.

Hence, it is possible to agree with Huxtable's view:

“It certainly looks like a legal fiction, designed to aid the doctor and notably, if perhaps understandingly, unavailable to the layperson. Yet, even if this is a viable reading of Judge Devlin's direction [...better understood as signalling that morphine will not be recognised as a cause *in law*], the absence of causation does not equal innocence: the doctor could still be charged with *attempted* murder. However, this is highly unlikely, given the legal officials' apparent willingness to find the innocent intention.”⁴⁷¹

On the other hand, in contrast to the position of doctors, the position of laypersons differs with respect to not only causation but also intention. If laypeople manage to get away with murder, on the basis that it cannot be shown whether it was the drugs or the underlying disease that killed the patient, they still cannot avoid the charge of attempted murder. This is because “...in ‘criminal’ type cases intention has been extended to include foresight, in ‘medical’ type cases involving doctors who foresee a patient's death, the courts contrarily accept a narrower definition of intention which does not fit into the conventional criminal law”.⁴⁷²

From the above analysis, it is more than clear that the DDE plays a vital role in the criminal law. Huxtable suggests that the doctrine is valuable and ought to survive in the law, but it needs to be ‘tidied’ up. He argues that it should apply to all cases of murder in like circumstances and not *only* when doctors are involved. If not, according to Huxtable, it is logical to envisage some trials and consequent sanctioning of those practitioners who foresee death as a virtually certain outcome of their actions.⁴⁷³ As stated above, if Dr Oliver is right in what he has to say,

⁴⁷¹ *Ibid.* at, p.102.

⁴⁷² Williams Glenys. (2007) *Intention and Causation in Medical Non-Killing: The Impact of Criminal Concepts on Euthanasia and Assisted Suicide*. London and New York: Routledge.Cavendish. p.42.

⁴⁷³ Huxtable R. (2004) ‘Get out of Jail Free? The Doctrine of Double Effect in English law’. *Palliative Medicine*, Vol. 18, p. 64.

then one should expect doctors to know for example how painkillers are to be administered safely, and the cases in which the patient dies there should be close examination.⁴⁷⁴ Furthermore, such practitioners should be asked the same question that Judge Ognall put to the jury in the case of *Dr Cox* when considering intention:⁴⁷⁵ “What did he know of the properties and potential of potassium chloride used in this way?”⁴⁷⁶

Arguably, it is not only the DDE that comes to the aid of doctors. When for example death is hastened deliberately by doctors who withdraw treatment or care, the law is constructed and interpreted in such a way that doctors are able to ‘dodge the dock’, as stated by Huxtable.⁴⁷⁷ This occurs in circumstances where doctors withhold or withdraw treatment, either with consent or in the best interest of the patient.

b) Omissions that Kill

i) Understanding the Duties which make Omissions into Acts

The criminal law in England and Wales does not impose a general duty on people to salvage another person from harm or peril.⁴⁷⁸ However, there are circumstances that arise through statutory law and the common law, where the criminal law does recognise a ‘duty of care’.⁴⁷⁹ Hence, the breach of that duty will result in criminal liability.⁴⁸⁰ William Wilson has remarked that the “basis upon which the duty of care is imposed is the foreseeability of injury to those who might be imperilled by

⁴⁷⁴ *Ibid.*

⁴⁷⁵ *Ibid.*

⁴⁷⁶ *Ibid.*

⁴⁷⁷ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p.107.

⁴⁷⁸ Wilson W. (2008) *Criminal Law: Doctrine and Theory*. Harlow; England; etc: Pearson Longman. pp. 81-82.

⁴⁷⁹ Kugler I. (2003) ‘Two Concepts of Omission’. *Criminal Law Forum*, Vol. 14, pp. 421-447.

⁴⁸⁰ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p.73; Keown J. (1997) ‘Restoring moral and intellectual shape to the law after Bland’. *Law Quarterly Review*, Vol. 113, pp. 482-503.

careless [or deliberate] acts or omissions”⁴⁸¹ of another person. This person could be for example, one who voluntarily agrees to care for that person who is dependent on him or her. The reason for this dependency could be age, illness or severe physical disability. This normally is the case in the parent-child relationship, or relationships involving legal guardians or spouses.⁴⁸² Similarly, this person could be a doctor who has a duty to provide appropriate care⁴⁸³ to his or her patient.⁴⁸⁴ For example, if a doctor withholds or withdraws treatment of a patient when under a duty to do so, such conduct of a doctor could amount to breach of his duty, unless he or she has a good reason to do so. One such good reason could be that the patient has refused to consent to treatment.⁴⁸⁵ The subject matter of this part of the chapter is based on such duties in the context of the doctor-patient relationship and the relationship between a patient and a layperson.

Duty of care

A duty of care in a medical and legal sense refers to a duty “that exists where there is a doctor-patient relationship in existence”.⁴⁸⁶ A doctor’s duty of care, under the common law, is to take “reasonable steps (as other reasonable doctors would) to save or prolong life”, or to act in the patient’s best interests. This duty is “applicable in the setting of end of life care”.⁴⁸⁷ Hence, for example, when a doctor accepts a patient, he acquires a duty of care towards that patient. The failure of a doctor to act in accordance with the duty of care would amount to a

⁴⁸¹ Wilson W. (2008) *Criminal Law: Doctrine and Theory*. Harlow; England; etc: Pearson Longman. p.376.

⁴⁸² *Ibid.*, at pp. 82-93.

⁴⁸³ The term ‘care’ in this context is applied in broad sense, which does not include only ordinary care, but also treatment.

⁴⁸⁴ Wilson W. (2008) *Criminal Law: Doctrine and Theory*. Harlow; England; etc: Pearson Longman. pp. 82-93.

⁴⁸⁵ See, *Re T (Adult: Refusal of Treatment)* [1992] 3 Cr App. WLR, at 782) In this case it was held that: “If a patient decides, with full knowledge of the potential situation, to refuse life-sustaining medical treatment and the patient communicates this decision via clear and convincing oral directives, actions or writings, the patient’s desires should be carried out.”

⁴⁸⁶ Torda A. (2005) ‘How far does a doctor’s “duty of care” go?’ *Internal Medicine Journal*, Vol.35, p. 295.

⁴⁸⁷ ‘Respecting Patient Choices- What is a Doctors duty of care regarding end-of-life care?’

<http://www.respectingpatientchoices.org.au/medico-legal-general-faqs/what-is-a-doctors-duty-of-care-re>

breach of his duty.⁴⁸⁸ However, it is relevant to note that doctors have no absolute duty to save life.⁴⁸⁹ For example, as stated by Glanville Williams, “[t]he Roman Catholic Church has for over twenty years accepted that whereas the physician may never kill his patient by positive act, here is a limit to the extent to which he is required to fight for the life of a dying patient”⁴⁹⁰. Similarly, Wilson states that a doctor’s “duty to sustain life lasts only so long as the patient’s interests are being furthered”.⁴⁹¹ In the following part of this chapter, an attempt is made to set out the circumstances and conditions under which a doctor is able to cancel his or her duty or duties towards the patient.

ii) The Ability of Doctors to cancel those Duties

Although a physician would normally be “under a duty to use reasonable care to conserve [or prolong] his patient’s life, he is probably exempted from that duty if life has become a burden to the patient”.⁴⁹² The circumstances of the case may be such that the patient is unable to communicate his or her wishes and the only possible way to act in the best interest of the patient is to let the patient die a dignified death.⁴⁹³ In the same way, if the person has positively forbidden particular treatment⁴⁹⁴ or refuses to consent to treatment⁴⁹⁵ or withholds consent to it, the doctor is absolved from his duty.⁴⁹⁶ The same effect would transpire in the case when a patient consents to the withdrawal of continuing treatment.⁴⁹⁷ The reason that justifies a doctor’s conduct in the first case is the ‘decision taken in the

⁴⁸⁸ Wellman Carl. (1999) *The Proliferation of Rights: Moral Progress or Empty Rhetoric*. US: Westview Press. p. 139.

⁴⁸⁹ William Glanville. (1973) ‘Euthanasia’. *The Medico Legal Journal*, Vol. 41, p.19

⁴⁹⁰ *Ibid.* at, p.18.

⁴⁹¹ Wilson W. (2008) *Criminal Law: Doctrine and Theory*. Harlow; England; etc: Pearson Longman. p.337.

⁴⁹² Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd. p. 291.

⁴⁹³ *Airedale N.H.S. Trust v Bland* [1992] UKHL 5.

⁴⁹⁴ Williams Glanville. (1973) ‘Euthanasia’. *The Medico Legal Journal*, Vol. 41, p. 24.

⁴⁹⁵ *Re C (Adult: Refusal of Treatment)* (1994) 1 WLR 290.

⁴⁹⁶ Huxtable Richard (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p.73.

⁴⁹⁷ *B v An NHS Trust* [2002] 2 All ER 449.

best interest of the patient'. The justification in the second case relies on the patient's right to self-determination.⁴⁹⁸

Refusal to Consent to Treatment or Refusal of Continuing Treatment

It has been stated that "[i]f the competent patient refuses consent to treatment or continued treatment, the legal effect is that the doctor is absolved from his or her duty by the patient."⁴⁹⁹ This means that doctors in these circumstances are neither lawfully permitted to intervene, nor liable for failing to prevent the death of the patient. This is because the doctrine of omission or withdrawal of treatment in this context is "duty-driven than rights- or interest-led"⁵⁰⁰. That is the patient has the right to refuse to consent to treatment and the doctor (who otherwise has right and duty to act in the best interest of the patient) has a concurrent duty to respect the patient's right to self-determination. Another line of argument in this context (i.e. the reason why doctor ought to respect patient's decision) is found in the criminal law itself. That is since a duty to treat the patient also means providing for a duty to care for that patient "intervening against the patient's wishes [as argued by Wilson could mean] is not an act of caring but an assault on his or her autonomy".⁵⁰¹ Hence, for example, if a person has positively forbidden particular treatment, a doctor will be acting illegally if he or she administers the treatment without the consent of that patient.⁵⁰² In the light of this scenario, an example of Kerrie Woollorton and the case of *Re C* and *Ms B* are briefly explained below, and discussed thereafter in the context of omissions which kill.

The instance of Kerrie Woollorton

Woollorton, who attempted suicide prevented doctors from saving her life but permitted them to treat her pain in order to make the dying process painless. She drew up advance directives that clearly indicated her wish not to be treated to save

⁴⁹⁸ Wilson W and Smith K.J.M (1995) 'The Doctors' Dilemma: Necessity and the Legality of Medical Intervention'. *Medical Law International*, Vol. 1, pp. 387-410.

⁴⁹⁹ Kennedy I. (1997) 'Commentary 3: A Response to Lowe'. *Journal of Medical Ethics*, Vol. 23, p. 162.

⁵⁰⁰ Wilson W. (1995) 'Is life sacred?' *Journal of Social Welfare and Family Law*, Vol. 17, No.2, p.135.

⁵⁰¹ *Ibid.*

⁵⁰² Williams Glanville. (1973) 'Euthanasia'. *The Medico Legal Journal*, Vol. 41, p. 24.

her life, but to make her dying process painless.⁵⁰³ The doctors cooperated with her desire by letting her die a painless death. The Coroner in this case held that the doctors acted in accordance with the law.⁵⁰⁴ The possible reasons why the doctors under these circumstances cannot be said to have abetted suicide, in spite of possessing the required knowledge, are as follows. Firstly, the doctor cannot act without the consent of the person as he has no such right. Secondly, if the doctor refrains from acting on the request of the patient, the intention of the doctor is merely an omission to act in the absence of a duty to act, such conduct of a doctor arguably could not amount to abetment to suicide. The exception to this is when a doctor has a legal right to control the patient in the circumstances and when a patient is mentally disordered and the protection is required in the interests of the patient's safety.⁵⁰⁵

The case of *Re C*

The patient in the case of *Re C* was told by his doctors that he required serious treatment in order to save his life. The patient who had gangrene in his left leg, refused to consent to the treatment of amputating his leg which was considered necessary to save his life. He was detained in a mental hospital on the basis that he was a paranoid schizophrenic and his illness rendered him incapable to make decision about his health.⁵⁰⁶ He approached the court to bring an injunction against the hospital to prevent the hospital treating him without his consent. The hospital, which refused to respect his decision, was directed by the court in the following way. It was stated that every person of full age and mental capacity has the right to refuse treatment, even if that refusal would cause death, or permanent injury, to the patient. Furthermore, it was held that although the patient was a paranoid schizophrenic, his mental illness did not render him automatically incapable of making decisions about his health.⁵⁰⁷

⁵⁰³ See at p. 23 of chapter 1 for further details on this case.

⁵⁰⁴ 'Suicide Woman allowed to die because doctors feared saving her life would be assault'. 30 September 2009, Telegraph.co.uk (assessed on 12th March 2010)

⁵⁰⁵ Williams Glanville. (1973) 'Euthanasia'. *The Medico Legal Journal*, Vol. 41, pp. 30-1.

⁵⁰⁶ *Re C (Adult: Refusal of Treatment)* (1994) 1 WLR 290,

⁵⁰⁷ *Ibid.*

The case of *Ms B*

In another case, a patient known as Ms B desired that her treatment be withdrawn. Ms B was granted relief by the court against the doctors, who had declined to accord with her decision.⁵⁰⁸ Ms B suffered from a serious physical disability and she was kept alive with the support of artificial respiration. Ms B asked the doctors in charge of her to remove her life support when she could not see any scope for improvement in her condition. The doctors refused to do so, on the ground that she did not possess the mental capacity to refuse her treatment. The court allowed Ms B to decide the issue for herself. The court further held that forcing treatment on her against her wish would amount to an unlawful trespass which could accrue civil as well as criminal liability⁵⁰⁹ As a result, it is established law that doctors are bound to act in accordance with the wishes of the patient.

The Consequences of Withholding or Withdrawing Treatment on Refusal to Consent

Under the right to refuse treatment, a person is able to protect oneself from unwanted intrusion to his or her body.⁵¹⁰ However, it also enables a person to ensure the manner and time of his death.⁵¹¹ Furthermore, it arguably helps people to die a painless death. This is possible not only in the cases like that of *Ms B* whose pain was controlled at the time of her death, but also people like Kerrie Woollorton, who managed to die a painless death, after first attempting to deliberately inflict death upon her self.

This gives rise to a relevant concern. The concern is that although the doctors in such cases were capable of being tried for the offence of assisted suicide or attempted murder if not murder, avoided liability apparently because of their

⁵⁰⁸ *B v An NHS Trust* [2002] 2 All ER 449.

⁵⁰⁹ *Ibid.*

⁵¹⁰ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge.Cavendish. p. 72.

⁵¹¹ Lady Hale Dame Brenda. (2003) 'A Pretty Pass: When is there a Right to Die?' *Comm. L. World Review*, Vol.1, p.4.

status as doctors which allows them to act or omit to act in certain circumstances in which a layperson would attract criminal liability. This claim is made on the basis that the conduct of a doctor who acts to make dying comfortable of a patient who has attempted suicide for example, in fact, not only intends to assist in suicide (by administering pain relieving drug), but also know that his or her act will help the dying person attain a painless and probably quick and peaceful death. Such doctors could also be held responsible for attempted murder because their act most probably would accelerate the death. Similarly, in cases like that of Ms B, who received pain killing drug to die a painless death after refusing life saving treatment, doctors could be said to assist in her dying by making it painless and probably peaceful and quick. However, as argued earlier, since doctor is under a duty to act in the best interest of the patient, so if patient desires painkilling drug after attempting to kill one self, doctors seem to have an obligation to act in the best interest of the patient which include not letting patient suffer in pain.

Lord Goff in the case of *Anthony Bland* refuted the possibility that this could be classed as assisted suicide by stating that

“...there is no question of the patient having committed suicide, nor therefore of the doctor having aided or abetted him in so doing. It is simply that the patient has, as he is entitled to do so, declined to consent to treatment which might or could have the effect of prolonging his life, and the doctor has, in accordance with his duty, complied with his patient’s wishes.”⁵¹²

Arguably, this interpretation prevents Lord Goff from having to consider whether the statute overrides the common law developments on consent to medical treatment. Under the current legal position (particularly focusing on the circumstances of Wooltorton), the observation made by Lord Goff seems to raise

⁵¹² *Airedale N.H.S. Trust v Bland* [1992] 5 UKHL at 10.

a certain amount of doubt. This is because it is a fact that Woollorton ended her life by way of suicide, and furthermore, that the doctors did facilitate her in her dying process by making it painless. It is true that the doctors did not have her consent to act in order to save her life and therefore, they had to let her die. However, the fact arguably remains that they facilitated suicide.⁵¹³

Similarly, the right to refuse treatment, which Lord Goff stated effectively, absolves the doctor from his or her duty to provide treatment, and to let the patient die. Doctors also do not have unlimited obligation to fight a hopeless battle⁵¹⁴ and as a result this should justify their conduct in 'hopeful cases'. Furthermore, doctors are also absolved from their duty of care in cases of the premature death of the patient on patient's own terms.⁵¹⁵

In the Best Interest of the Patient

The basis on which the act or omission distinction is drawn in cases of withdrawal of treatment of a patient who is in a persistent vegetative state (PVS) is founded upon the ground of quality of treatment. In other words, the treatment must be either futile or burdensome to the patient, rather than helping to improve the quality of life of the patient.⁵¹⁶ One of the important cases in this scenario is that of Anthony Bland.⁵¹⁷

The case of *Anthony Bland*

In this case, Anthony Bland, who had suffered injuries in the Hillsborough football ground disaster, was in a PVS. His doctors, in consensus with his parents, applied to the court seeking a declaration stating that if they withdraw Anthony

⁵¹³ This could mean two things. It could either mean the conduct of the doctors amounted to abetment in suicide or doctors merely performed their duty of care towards Kerrie Woollorton who desired painless death notwithstanding the fact that it is a deliberate act of self killing.

⁵¹⁴ Williams Glanville. (1973) 'Euthanasia'. *The Medico Legal Journal*, Vol. 41, p. 19.

⁵¹⁵ One can make his or her wishes known either by oral or implied or through advance directives.

⁵¹⁶ Huxtable Richard. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge. Cavendish. pp.12-13.

⁵¹⁷ *Airedale Hospital Trustees v Bland* [1992] UKHL 5.

Bland's nutrition and hydration, their conduct would not fall foul of the existing criminal law of murder. The House of Lords decided that the doctors could lawfully withdraw Anthony Bland's nutrition and hydration, and withhold other treatment, despite the fact that to do this would inevitably cause Anthony Bland's death.⁵¹⁸ This is because firstly, such conduct by the doctors would not amount to a positive act. It would amount to a negative act (omission). Secondly, the doctors would be acting in the best interest of the patient.⁵¹⁹ Lord Mustill stated that:

“(iv) All hope of recovery has now been abandoned. Thus, although the termination of his life is not in the best interests of Anthony Bland, his best interests in being kept alive have also disappeared, taking with them the justification for the non-consensual regime and the co-relative duty to keep it in being.

(v) Since there is no longer a duty to provide nourishment and hydration to failure to do so cannot be a criminal offence.”⁵²⁰

In other words, the finding of the House of Lords was that despite the fact that the doctors intentionally let Anthony Bland die, the doctors did not breach the law. As stated by Constantinos Simillis “[t]he House of Lords attempted to classify the *Anthony Bland's* case as one relating to ‘medical futility’ rather than euthanasia”.⁵²¹ As per the courts decision, it was clear that the presence of a ‘reasonable medical opinion provided the ultimate key to the withdrawal of treatment’⁵²². In this case, a responsible body of doctors agreed that continuing treatment was no longer in the best interest of Anthony Bland. Therefore, it was agreed that the treatment served no purpose, since it neither cured nor improved

⁵¹⁸ *Ibid.*

⁵¹⁹ Wilson W and Smith K.J.M (1995) ‘The Doctors’ Dilemma: Necessity and the Legality of Medical Intervention’. *Medical Law International*, Vol. 1, p. 391.

⁵²⁰ *Airedale Hospital Trustees v Bland* [1992] UKHL 5, at 45.

⁵²¹ However, he argues that since Bland would have not died otherwise, the court in this case allowed nonvoluntary euthanasia. See, Simillis Constantinos. (2008) ‘Euthanasia: A Summary of the Law in England and Wales.’. *Medicine Science and Law*, Vol. 48, No. p.193.

⁵²² Glanville Williams (1977) ‘Letters to the Editor: Switching off life support machines’. *Criminal Law Review*, p.635.

the condition of the patient.⁵²³ Hence, the doctors were not under an obligation to continue with the treatment provided to Anthony Bland. Therefore, the court held that the withdrawal of the treatment (an omission to act) which otherwise would take a form of a criminal act or omission, would not in this case amount to murder.⁵²⁴

Exploring the Implications of *Anthony Bland's* case

As argued by Simillis, *Anthony Bland's* case was complex because “it was difficult to define what was in his best interests”.⁵²⁵ Taking into account the condition of Anthony Bland, Lord Mustill observed that Anthony Bland effectively had no interests. He was neither in distress, nor in pain, and he had no potential to feel pleasure either. Similarly, his condition was such that it would never improve. Furthermore, there was not chance that Anthony Bland would ever regain his consciousness.⁵²⁶ Under these circumstances, withdrawing treatment on the basis that it was burden on Anthony Bland would not justify the doctor's conduct. Hence, the other solution to the problem was to justify withdrawal by holding that the continuation of such treatment would amount to unnecessary invasion on Anthony Bland's body.⁵²⁷

Price is of the view that “[t]he issue ...is rightly determined in the context of the duties of the doctor founded upon the interests and rights of the patient”⁵²⁸. Similarly, commentators such as Wilson and Smith argue that the doctors in fact acted in accordance with their duties to Anthony Bland by withdrawing his treatment.⁵²⁹ They further argue that the doctors may have ‘desired’ the death of

⁵²³ Huxtable R. (2004) ‘Get out of Jail Free? The Doctrine of Double Effect in English law’. *Palliative Medicine*, Vol. 18, p.63; Simillis Constantinos. (2008) ‘Euthanasia: A Summary of the Law in England and Wales.’ *Medicine Science and Law*, Vol. 48, No. p.191.

⁵²⁴ *Airedale Hospital Trustees v Bland* [1992] UKHL 5, at 45.

⁵²⁵ Simillis Constantinos. (2008) ‘Euthanasia: A Summary of the Law in England and Wales’. *Medicine Science and Law*, Vol. 48, p.192.

⁵²⁶ *Airedale Hospital Trustees v Bland* [1992] UKHL 5.

⁵²⁷ *Ibid.*

⁵²⁸ Price. (1997) ‘Euthanasia, Pain Relief and Double Effect’. *Legal Studies*, Vol. 17, pp. 339-340.

⁵²⁹ Wilson W and Smith K.J.M (1995) ‘The Doctors’ Dilemma: Necessity and the Legality of Medical Intervention’. *Medical Law International*, Vol. 1, p. 389.

Anthony Bland, However, the doctors had no intention to kill Bland. The commentators claim that the two elements were mixed up by the House of Lords, when the court stated that the doctors intended to cause the death of Bland.⁵³⁰ Arguably, had this actually been the case then this would have probably been incompatible with the standards of ethics of medical practice, as well as an offence under the criminal law.⁵³¹ In other words, it is the argument of these commentators that in *Anthony Bland's* case, the doctors had no ethical or legal basis to continue his treatment.⁵³²

Keown on the other hand argues that the decision in *Anthony Bland's* case is properly assessed by judging the value of life itself from the 'quality of life' of the patient rather than the sanctity of life in general.⁵³³ He further argues that the decision in the case of *Anthony Bland* has left the law in a "morally and intellectually misshapen state, prohibiting active, intentional killing but permitting (if not requiring) intentional killing by omission, even by those under a duty to care for the patient".⁵³⁴

iii) Examining the difficulties faced by laypersons in cancelling their Duties to provide care

There is little doubt that the law treats laypersons differently when compared with the treatment of medical professionals, in relation to cancellation of duties of care. For example, in the case of *Sara Johnson* her parents were convicted of their negative conduct i.e. for merely sitting with their dying daughter and failing to call medical assistance.⁵³⁵ The possible reason as to why her parents were held responsible for Sara's death could be because the court felt that they had a duty of

⁵³⁰ *Ibid.*

⁵³¹ *Ibid.*

⁵³² *Ibid.* at p. 390.

⁵³³ This according to Keown was due to misunderstanding the sanctity of life and the possible reason behind this misunderstanding is: counsel did not articulate the doctrine of sanctity of life to the House of Lords accurately. See Keown J. (1997) 'Restoring moral and intellectual shape to the law after Bland'. *Quarterly Law Review*, Vol. 113, pp.487-8.

⁵³⁴ *Ibid.*

⁵³⁵ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge. Cavendish. pp.67-71.

care towards their handicapped daughter.⁵³⁶ Sara was disable and dependent on her parents for help to perform her everyday life.⁵³⁷ In past she had attempted suicide and shown clear determination to end her life. This time she left a suicide note with clear instructions – not to save her life. Under these circumstances, arguably her parents should have been absolved from their duty of care.⁵³⁸ As it is done in the cases involving doctors, who are allowed to withhold treatment of patients, and to subsequently let them die, in the absence of duty to act.

However, laypersons who withdraw treatment from their loved ones because they think that it imposes an unnecessary burden on the patient, are treated as intruders by the law. This can be compared with the position of doctors who perform the same act in the same circumstances. For example, Mrs Watts, who allegedly disconnected a tracheotomy tube from her severally brain damaged young daughter, was charged with murder.⁵³⁹ Similarly, Mr Karapetian was charged with the attempted murder of his grandmother. It was found that he had disconnected the life support machine by cutting a tube with scissors. It was his argument that he felt his grandmother was being tortured by being kept alive artificially through tubes and machines.⁵⁴⁰ In other words, he probably thought that the treatment provided to her was burdensome. The jury found Mr Karpetian guilty. He was sentenced for 18 months, but given a 2 years suspended sentence.

The stated reason why Mr Karpetian disconnected the life support machine was the same reason doctors often provide when they decide to withdraw treatment in

⁵³⁶ See R v Smith [1979] Crim. L. R. 251. In this case, the court held that the husband has a duty of care towards his wife.

⁵³⁷ *Ibid.*, at p.71.

⁵³⁸ She had attempted suicide on previous occasions and shown clear sign of regret when her life was saved. Furthermore, she had left a letter clearly stating her wish to die. See, Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge. Cavendish. p. 71.

⁵³⁹ However, she was found guilty of manslaughter and subsequently on appeal, this verdict was quashed. Nevertheless, the basis of her case were that she had allegedly killed her daughter. See 'Manslaughter –ingredients of offence where death caused by gross negligence'. *Criminal Law Review*, 1998, Nov., pp. 830-833.

⁵⁴⁰ Finn, G. (1999) 'Graduate in Mercy killing bid freed'. *The Independent*, 21 August.

the best interest of the patient. However, as seen above, doctors under these conditions are treated differently under the law. The conduct of doctors is treated as an omission. This legal position is contrary to that of the layperson. Such conduct of the layperson is interpreted as an act rather than omission. As a result, the layperson is held responsible for commission of a crime unlike a doctor whose conduct is interpreted as omission. Furthermore, doctors are absolved from their duty to treat or to provide care to the patient. As a result, the failure to act does not attract any criminal liability.⁵⁴¹

The way that the doctrine of omission is used to ‘smuggle’ notions of justification has been criticised by Moore.⁵⁴² Moore is of the opinion that both the doctor and the intruder in the above circumstances ‘act’ rather than ‘omit to act’.⁵⁴³ This is because he understands omissions to mean “...simply absent actions”⁵⁴⁴. The conduct of the doctor in a case of withdrawal of treatment does not amount to an omission because it involves a muscular movement of the body.⁵⁴⁵ According to Moore, the conduct of the doctor amounts to killing, but it is of a lesser evil to that of active killing.⁵⁴⁶

Huxtable suggests that the problem to the solution could be found by holding that the conduct of the doctor as well as of the intruder amounts to an act. This would provide doctors with a defence. Alternatively, it is possible to say that the intruder is at wrong because he has a duty not to interfere with the life support machine.⁵⁴⁷

⁵⁴¹ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge. Cavendish. p.127; Williams Glanville (1983) *Textbook of Criminal Law*. Stevens.p.282.

⁵⁴² Moore M.S. (1993) *Act and Crime: The Philosophy of Action and its Implications for Criminal Law*. Oxford: Clarendon Press. p.27.

⁵⁴³ *Ibid.*

⁵⁴⁴ *Ibid.*, at p.28.

⁵⁴⁵ *Ibid.*

⁵⁴⁶ Moore M.S. (1997) *Placing Blame: A Theory of Criminal Law*. Oxford: Clarendon Press. p. 276.

⁵⁴⁷ Huxtable R. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge. Cavendish. p.121.

Glanville Williams, on the other hand, rests his distinction on either the relationship between the parties or on the status of the doctrine. In other words, the doctor has responsibility for the patient⁵⁴⁸ while the intruder does not.⁵⁴⁹

iv) Examining the Implications that can be drawn from the Acts that Kill and the Omissions that Kill: Should doctors be permitted to kill either by act or by omission in the best interest of the patient?

Under the current law of England and Wales, a person who intentionally and unlawfully causes the death of another person, either by act or omission, including when under a duty to act, commits the offence of murder.⁵⁵⁰ A person is said to have acted intentionally if his or her purpose is to kill, or the situation is such that the result is virtually certain, and the person involved foresees it to be virtually certain from whose state of mind the jury is entitled to infer intention.⁵⁵¹ Similarly, a person is said to be the cause of death when his or her conduct proves to be the factual as well as the legal cause of the death.⁵⁵²

It is apparent from the facts of the cases involving double effect, in the medical context, that the aim of the doctor who acts to relieve pain may not be to kill, but to treat the patient. But at the same time it is also possible to suggest that sometimes doctors may foresee the fatal consequences of their action virtually certain.⁵⁵³ Despite this, the doctors are hardly found guilty of their conduct that causes death. This is probably because the case of *Woollin* compromises the justificatory potential of double effect or because a jury can still refuse to find intention in cases of double effect.

⁵⁴⁸ Williams Glanville (1983) *Textbook of Criminal Law*. Stevens, p.282.

⁵⁴⁹ Huxtable Richard. (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. USA and Canada: Routledge. Cavendish. p.120.

⁵⁵⁰ *Airedale Hospital Trustees v Bland* [1992] UKHL 5.

⁵⁵¹ In which case the jury may find intention. *R v Woollin* [1998] 3 WLR 382.

⁵⁵² Wilson William. (2008) *Criminal Law: Doctrine and Theory*. Third Ed. Harlow; England; New York: Pearson Longman. p. 98.

⁵⁵³ Williams Glanville. (1958) *The Sanctity of Life and the Criminal Law*. London: Faber and Faber Ltd., p. 285.

As far as the rule of causation is concerned, arguably, even if the conduct of the doctor does not cause immediate death in most of the pain killing circumstances, it often allegedly accelerates the death of the patient. As a result, it is possible to argue that ‘but for’ the actions of the doctor the death would not have occurred at the time when it did occur. Arguably, this should prove sufficient to be in line with factual cause of death.⁵⁵⁴ However, whether such conduct could also fulfil the requirement of ‘legal cause’ would depend upon the way the policy rule is applied by the court. For example, Glenys Williams argues that since a doctor’s action is justified medically, it would not be seen as the legal cause of the death of the patient.⁵⁵⁵ On the other hand, if Judge Devlin’s observation in the case of *Dr Bodkin Adams* is applied i.e. “[i]f ...life was cut short by weeks or months; it is just as much murder as if it were cut short by years”⁵⁵⁶ then it is arguable that the doctor could be found to be the legal cause of death. In spite of this, it is evident from the cases of *Dr Bodkin Adams* and *Dr David Moor*, for example, that the court, by using a narrow construction of intention, as well as the rule of ‘common sense’, in relation to causation, helps the jury to find doctors not guilty of the charge. As a result, it is possible to argue that undertaking a killing by an action in the context of double effect is permissible under the law. However, as seen above, the principle of double effect is invoked only in the cases of doctors and not in the cases of laypersons in spite of the case of *Woollin* that leaves it open to the jury not to find intention in cases of double effect.⁵⁵⁷

Similarly, medical professionals are also permitted to withdraw treatment intentionally in order to terminate life.⁵⁵⁸ This is justified by adopting the doctrine of omission.⁵⁵⁹ For example, as argued by Moore, the possible justification provided in cases of withdrawal of treatment is that the patient is returned to

⁵⁵⁴ *Ibid.*

⁵⁵⁵ *Ibid.*

⁵⁵⁶ Arlidge Anthony. (2000) ‘The Trial of Dr David Moor’. *Criminal Law Review*, Vol. Jan, p. 34.

⁵⁵⁷ Mr. Saini Puspinder. (1999) ‘The Doctrine of Double Effect and the Law of Murder’. *Medical Legal Journal*, Vol. 67, pp. 106-120.

⁵⁵⁸ *Airedale Hospital Trustees v Bland* [1992] UKHL 5.

⁵⁵⁹ *Ibid.*

‘some baseline’ condition.⁵⁶⁰ It has been remarked that “[t]his condition according to courts is ‘natural’ condition the patient would have been in without any medical treatment, where ‘medical treatment’ includes intravenous (as opposed to oral nutrition and hydration)”⁵⁶¹. Likewise, with the help of the notion of ‘duty of care’, in cases of medical practice the courts have successfully shown that when the doctors act in the best interests of the patient, on the consent of the patient they are absolved from their existing duty of care. As a result, they cannot be held legally responsible for omitting to act in the cases of withdrawal of treatment.

Moore provides the following example in case of withdrawal of treatment, in order to show how the conduct of the doctors amounts to act and not omission.

“Suppose I throw a rope to an otherwise clearly drowning man. Is the relevant baseline ever after that he was dying when I first intervened? May I thus throw him back in the water, or shoot him a year later, and be said only to have omitted to save him?”⁵⁶²

If we agree with Moore, then the above conduct of doctors amounts to an act and therefore, the potential questions of duty do not arise because these are not cases of omission. Hence, a doctor’s conduct in a case of withdrawal of treatment effectively kills the patient, rather than merely lets the patient die.

With regard to active euthanasia, Keown argues that the objection raised by the British Medical Association (BMA) against legalising active euthanasia and assisted suicide is undermined by the BMA’s own guidelines.⁵⁶³ These guidelines

⁵⁶⁰ That is “...whatever makes the world morally worse (from some baseline state of affairs) is an action; whatever does not more than return things to the baseline state of affairs is an omission.” See, Moore M.S. (1993) *Act and Crime: The Philosophy of Action and its Implications for Criminal Law*. Oxford: Clarendon Press. p.26.

⁵⁶¹ Moore M.S. (1993) *Act and Crime: The Philosophy of Action and its Implications for Criminal Law*. Oxford: Clarendon Press. p.26.

⁵⁶² *Ibid.*, at p.27.

⁵⁶³ Withholding and Withdrawing Life-Prolonging Medical Treatment. Guidance for decision making (London: BMJ Books, 1999).

not only allow the withholding and withdrawing of treatment, such as tube-fed food and water from PVS patients, but also from non terminally ill people such as those with severe dementia or those suffering from a serious stroke.⁵⁶⁴

v) Conclusion

Over all, it is clear that the law in England and Wales has explicitly not accepted the legality of euthanasia.⁵⁶⁵ However, the cases discussed above show that the law does allow some forms of euthanasia⁵⁶⁶ by balancing the competing values and interests of the individuals, as stated by Simmillis.⁵⁶⁷ Nevertheless the law on euthanasia is still unclear except in the following circumstances. It is clear that a competent patient can refuse treatment, even if that would mean the patient would die. Similarly, doctors could withhold or withdraw treatment in the best interest of the patient even when they foresee or intend the death of the patient. Alternatively, although doctors are allowed to administer lethal doses of a painkilling drug knowing that it may lead to the death of the patient, they can be found guilty if a jury finds intention in cases of double effect.

Accordingly it is possible to argue that not only passive euthanasia is permitted under the current law, but also that active euthanasia is permitted, but only in special circumstances. These are the circumstances in which the death of the patient is caused as a side effect (which is merely foreseen consequence) of the good conduct of a doctor. Similarly, as seen in chapter 1 of the thesis, laypersons are permitted to assist in the suicide of another person as long as their actions amounts to a trivial level of assistance and their motives are compassionate.

Taking into account the current practice on euthanasia that permits doctors to kill under certain circumstances such as killing in the context of double effect; letting

⁵⁶⁴ Keown J. (2000) 'Beyond *Bland*: a critique of the BMA guidance on withholding and withdrawing medical treatment'. *Legal Studies*, Vol. 2, pp. 66-84.

⁵⁶⁵ Simmillis C. (2008) 'Euthanasia: A Summary of the Law in England and Wales'. *Medicine Science and the Law*, Vol. 48, p. 197.

⁵⁶⁶ See chapter 2.

⁵⁶⁷ Simmillis C. (2008) 'Euthanasia: A Summary of the Law in England and Wales'. *Medicine Science and the Law*, Vol. 48, p. 197.

die by way of withholding and withdrawing treatment in the best interest of the patient or in the circumstances of refusal of treatment. It would be appropriate to consider that the next step in this direction could be to codify this practice along with the practice of assisted suicide on the basis of ‘pain relief’ and ‘best interest of the patient’ rather than value of life.⁵⁶⁸

Alternatively, one could argue that since doctors do not have an absolute duty to save or prolong life, the above behaviour of doctors does not trump the sanctity of life. However, the question remains - how can this principle be codified? Cartwright suggests this could be achieved by balancing respect for autonomy with the need to protect vulnerable persons who may be persuaded to end their life. Thus, it is arguably time to consider the relevant options available in order to find out which form of protection is best i.e. procedural or substantive. In the following chapter, an attempt is made to set out the legal regimes adopted by the Netherlands, the State of Oregon and Switzerland in order to see whether it is possible to learn from the experiences in the foreign jurisdictions.

⁵⁶⁸ Price D. (1997) ‘Euthanasia, Pain Relief and Double Effect’. *Legal Studies*. Vol. 17, pp. 323-342.

Chapter 3

Exploring the Legal and Extra-Legal Regimes adopted by the Netherlands, the State of Oregon and Switzerland in relation to Assisted Suicide and Euthanasia

This chapter examines the practices of three different places: the Netherlands, the State of Oregon in the U.S. and Switzerland. In the Netherlands, both voluntary active euthanasia and physician-assisted suicide are permitted under special provisions. In contrast, the State of Oregon permits only physician-assisted suicide. In Switzerland, assisted suicide has been practiced since 1918.⁵⁶⁹ The peculiarity of Switzerland is that anybody, either a physician or a non-physician, may assist in suicide, provided that the person has no self-interest in compliance. In the Netherlands, and in Switzerland in particular, these practices have long been recognised. Hence, these practices are now deeply embedded in the culture of these countries. As briefly mentioned in chapter 1 of the thesis, the Swiss law does not restrict foreigners from making use of the services. People from other countries, and especially from Germany, France, Austria and England, are known to have travelled to Switzerland in order to die.

This chapter sets out the legal and extra-legal regime that exists in the Netherlands, the State of Oregon and Switzerland. The purpose of this chapter is

⁵⁶⁹ In 1918, the Swiss Federal government stated that assisting in suicide is criminated only if the assistant has been motivated to do so by selfish reasons (see Mauron A. and Hurst Samia A. (2003) 'Education and Debate'. Assisted Suicide and Euthanasia in Switzerland: allowing a role for non-physicians'. *BMJ*, Vol. 326, p. 271). Ziegler has stated that this tradition which started a century ago originated in a different context totally unrelated to its recent application with terminal illness and controversy stemming from the desire to regain control over the dying process. "Historically, the Swiss regarded assistance in suicide as an honourable deed to help a friend – an act motivated by unselfishness. Eventually this was reflected in their law". See Ziegler S.J. (2009) 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for its Potential to enhance oversight and demedicalize the dying process'. *Journal of Law, Medicine and Ethics*, Vol. 37, p. 323.

to analyse the liberal approach that has been adopted by these jurisdictions, in order to find out whether the jurisdiction of England and Wales can take any lessons from the experience of these foreign regimes, in light of the need to overcome the problems that currently arise in England and Wales as a result of a stricter regime.

3.1 The Legal Structure of the Regime of the Netherlands on Assisted Suicide and Euthanasia

Suicide is not illegal in the Netherlands, but both assisted suicide and euthanasia are offences under Articles 294 and 293 of the Dutch Penal Code respectively.⁵⁷⁰ However, it is noteworthy that these two articles have been amended by the ‘Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001’,⁵⁷¹ in order to exempt physicians, and *only* physicians, from criminal liability. Hence, a physician may perform an act of euthanasia, or partake in physician-assisted suicide (PAS), as per the requirements of the statutory Act 2001. Article 293 of the Dutch Penal Code reads as below:

“Any person who takes the life of another person at that other person’s express and earnest request shall be liable to a term of imprisonment not exceeding twelve years or a fifth category fine (that is, a fine not exceeding NLG 100 000).”⁵⁷²

And Article 294 reads:

⁵⁷⁰ Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. pp. 29-30.

⁵⁷¹ Hereafter referred to as the statutory Act 2001.

⁵⁷² De Haan Jurriaan (2002) ‘The New Dutch Law on Euthanasia’. *Medical Law Review*. Vol. 10, p. 58.

“‘[A] person who intentionally incites another to commit suicide, assist in the suicide of another, or ...[procures] for that other person the means to commit suicide’ is guilty of a serious offence....”⁵⁷³

How did the practices of Assisted Suicide and Euthanasia enter the Legal System?

In 1984, in the case of *Schoonheim*, (a general practitioner performed an act of euthanasia on the request of a 95 year old woman owing to her bad medical condition), a defence of necessity was claimed under Article 40 of the Dutch Penal Code. Article 40 states: “‘A person who commits an offence as the result of a force he could not be expected to resist is not criminally liable’”.⁵⁷⁴ Thus, the Dutch Supreme Court delivered the judgement in *Schoonheim*’s favour. It held that

“...a doctor, confronted by the request of a patient who is unbearably and hopelessly suffering, can be regarded as caught in a situation of conflict of duties. On the one hand, there is the duty to respect life, as reflected in articles 293 and 294 of the Penal Code. On the other hand, there is the doctor’s duty to relieve suffering. If, in such a situation of conflict of duties, the doctor chooses a course of action that considering the norms of medical ethics, is ‘objectively’ justifiable, he is not guilty of an offence....”⁵⁷⁵

This result represented a u-turn in relation to the existing law on assisted suicide and euthanasia. Article 40 of the Penal Code was used in the defence of a doctor. Since then, it has informally been the case that the practices of physician-assisted

⁵⁷³ Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 30.

⁵⁷⁴ De Haan Jurriaan (2002) ‘The New Dutch Law on Euthanasia’. *Medical Law Review*. Vol. 10, p. 59.

⁵⁷⁵ Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 77.

suicide and euthanasia have formed part of the Dutch tradition, but only when performed in the medical context.⁵⁷⁶

Over the years, contributions have been made on the subjects of PAS and euthanasia, not only by the courts decisions, but also by Parliament and the prosecution services:

“Parliament ... enacted a change to the Burial and Cremation Act, which reflects the decision of the Supreme Court in the *Schoonheim* case. A reporting procedure was created for doctors who had performed euthanasia; they had to fill in a form with so-called points requiring attention, which largely corresponded to the jurisprudential rules of careful practice, and report themselves to the prosecutorial authorities. And the Board of Procurators-General of the Public Prosecution Services had adopted the policy of not prosecuting doctors who had reported themselves after having performed euthanasia in accordance with the rules of ‘careful practice’.”⁵⁷⁷

Finally, in 2001, the ‘Termination of Life on Request and Assisted Suicide (Review Procedures) Act’ was enacted. This Act was based on the output of the “jurisprudence from the Supreme Court, statute law and prosecutorial policy”.⁵⁷⁸ The statutory Act 2001 came into force in April 2002. It consists of three parts. “The first codifies the ‘requirements of due care’ and makes the Regional Review Committees [RRCs] principally responsible for reviewing reported cases.”⁵⁷⁹

⁵⁷⁶ It is to be noted that the first case of euthanasia to come before the court was in 1971. Dr. Geertruida Postma killed her patient (her mother) on request, who was in a very bad medical state. Court found Dr. Postma guilty under article 293 of the Penal Code for intentionally causing death of the patient. However, her case was treated in a special way by ordering only a week’s suspended sentence and one year’s probation. See Euthanasia in Holland. <http://www.euthanasia.cc/dutch.html>

⁵⁷⁷ De Haan Jurriaan (2002) ‘The New Dutch Law on Euthanasia’. *Medical Law Review*. Vol. 10, pp. 59-60.

⁵⁷⁸ *Ibid.*

⁵⁷⁹ It is relevant to note that apart from the above responsibilities the RRCs who play an important role in the control of the Dutch regime also have other responsibilities and duties specified under

In relation to the second part, the following has been noted:

“The second amends articles 293 (euthanasia) and 294 (assisted suicide) of the Penal Code to make euthanasia and assisted suicide legal if performed by a doctor who has conformed to the requirements of due care and has reported what he did to the municipal pathologist. And the third part amends the Burial and Cremation Law to provide for the forms and the procedure to be used in reporting a case of euthanasia or assisted suicide.”⁵⁸⁰

As stated earlier it is relevant to note that both euthanasia and assisted suicide are still ‘crimes’. However, a physician who performs such an action can successfully claim a defence under Article 20 A or B of the statutory Act 2001, which addresses the amended articles of the Penal Code i.e. Article 293 and 294 respectively. A physician can claim this defence provided that he or she complies with the ‘due care’ requirements⁵⁸¹ and all the other requirements of the statutory Act 2001. As far as Article 293 and 294 of the Penal Code are concerned these are amended as follows:

“Article 293

Article 8, 9 and 10 of the statutory Act 2001. The RRC (to which the case is reported) make final judgements on the matter without involvement of criminal law institutions. Only those matters are referred to the Board of Procurators General which fails to carry out the requirement of the due care and those which raise doubt on the conduct of the physician who carries out euthanasia (see Haan Jurriaan De. (2002) ‘The New Dutch Law on Euthanasia’. *Medical Law Review*, Vol. 10, pp. 65-66). They are also responsible for the registration of basic data concerning the cases reported to them and for an annual joint report of their work. This is said to provide transparency in the system (see Griffiths J. and others (2008) *Euthanasia and law in Europe*. p. 82). Similarly, they have set their own opinions and views over period of time in dealing with the practice of euthanasia and assisted suicide where law has remained silent. This is mainly pertaining to the procedure and working method. Article 11, 12 and 13 of the statutory Act 2001 provide them power in this matter. More on this aspect is said further in this chapter.

⁵⁸⁰ Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. pp. 82-83.

⁵⁸¹ Stated under Article 2 of the statutory Act 2001.

1. A person who terminates the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than twelve years or a fine of the fifth category.
2. The offence referred to in the first paragraph shall not be punishable if it has been committed by a physician who has met the requirements of due care as referred to in Article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act and who informs the municipal autopsyist of this in accordance with Article 7 second paragraph of the Burial and Cremation Act.”⁵⁸²

“Article 294

1. A person, who intentionally incites another person to commit suicide, is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where the suicide ensues.
2. A person who intentionally assist in the suicide of another or procures for that other person the means to commit suicide, is liable to a term of imprisonment of not more than three years or a fine of the fourth category, where the suicide ensues. Article 293 second paragraph applies *mutatis mutandis*.”⁵⁸³

In this way, the statutory Act 2001 acts as an exception to the prohibited behaviour i.e. killing on request and providing assistance in suicide. These conditions comprise both substantive and procedural requirements, as outlined by the statutory Act 2001:

- “the patient's request was ‘voluntary and carefully considered’
- the ‘patient's suffering was unbearable, and ...there was no prospect of improvement’

⁵⁸² De Haan Jurriaan (2002) ‘The New Dutch Law on Euthanasia’. *Medical Law Review*. Vol. 10, p. 73.

⁵⁸³ *Ibid.*

- the doctor informed the patient concerning ‘his situation and his prospects’
- the doctor and the patient were convinced that there was ‘no reasonable alternative in light of the patient’s situation’
- the doctor consulted ‘at least one other, independent physician who must have seen the patient and given a written opinion on the due care criteria ([ie the preceding four items])’
- the doctor ‘terminated the patient’s life or provided assistance with suicide with due medical care and attention’
- the doctor reported the case to the municipal pathologist’⁵⁸⁴

The Request

Although, the law is silent as to the nature (written or oral) of the request, it is evident according to Griffiths, Wayer and Adams⁵⁸⁵ through case laws, and also from the RRCs decisions (in cases) the request must be written especially in the patient’s own handwriting on the printed form.⁵⁸⁶ The time gap between the request made and the act of euthanasia performed should not be less than one day, except in special circumstances.⁵⁸⁷ Similarly, the RRCs are of the opinion that a request made several weeks in advance should be reaffirmed shortly before euthanasia is to be performed.⁵⁸⁸ In addition, the RRCs have also specified that the physicians should consult the patient and ensure that the patient’s request is free from any pressures. It is also necessary to assess whether the patient is in a

⁵⁸⁴ Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 84.

⁵⁸⁵ *Ibid.*, at p. 85.

⁵⁸⁶ *Ibid.*, at pp. 85-86.

⁵⁸⁷ *Ibid.*, at p. 86.

⁵⁸⁸ *Ibid.*

sound state of mind.⁵⁸⁹ However, this does not necessarily exclude those who have a “cognitive or communicative impairment or existence of a psychiatric disorder...” from consenting to euthanasia.⁵⁹⁰

Finally, in cases where a patient is incompetent at the time of the performance of the act of euthanasia, but has left a written request for euthanasia, (especially in cases of dementia) a doctor can avail himself of the defence under this statutory law.⁵⁹¹ However, the RRCs takes the position that ““it is generally necessary that communication between the doctor and patient continues right to the end””⁵⁹². In this case, the request applies in the same way as an ‘advance treatment directive’, where time of the written request is not an issue.

Unbearable suffering

Since what can amount to ‘unbearable suffering’ depends upon the perspective of each individual, it is assessed ‘subjectively’. However, the assessment is said to be objective in the sense that it should be ‘understandable’ to a doctor. Furthermore, the RRCs should also be able to comprehend it. It has been held that the ‘suffering’ of the patient must be conscious. Thus, a patient in a coma cannot be brought under the umbrella of the statutory Act 2001.⁵⁹³ At the same time the condition of the patient must be ‘hopeless’. This relates to the prospect of improvement. What also matters is whether there is any alternative treatment available, including palliative care. It is also important to assess the reason why the patient has refused the available treatment options. According to the Annual Report 2000 of the RCCs

“if a patient’s refusal of treatment is ‘understandable’, it does not stand in the way of euthanasia (thus morphine can be refused by a patient who

⁵⁸⁹ *Ibid.*, at p. 87.

⁵⁹⁰ *Ibid.*

⁵⁹¹ Article 2 (2) of the statutory Act 2001. See De Haan Jurriaan (2002) ‘The New Dutch Law on Euthanasia’. *Medical Law Review*. Vol. 10, p. 69

⁵⁹² Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 89.

⁵⁹³ *Ibid.*, at p. 90.

does not want to become less clear-headed, and radiation by a patient for whom the side-effects outweigh the benefits)”.⁵⁹⁴

Consultant

As stated above, an independent consultant must be approached for the examination of the patient in order to have a second opinion in the matter. However, in a case of disagreement between the physician and the independent consultant, the physician may go ahead with the act of euthanasia as long as he can explain his decision. This is probably because physician knows the patient best (compared with independent consultant) and who is convinced that the patient suffers unbearably.⁵⁹⁵ Furthermore, the physician remains responsible for his actions, because he is the one who is entrusted with the final decision. In other words, the consultant’s opinion has the status of an advice which doctor need not follow.⁵⁹⁶

Other requirements of due care

The continuous presence of a doctor is required after performing the act of euthanasia.⁵⁹⁷ The physician is required to keep all the records. He or she is also required to file a registration form with the RRC and to report the death to the municipal pathologist.

Cases involving minors

⁵⁹⁴ *Ibid.*, at p. 91. Here it is relevant to note that prior to 2000, “it was forcefully argued (and generally supposed) that a patient’s refusal to treatment was no obstacle to legal euthanasia, although in the *Chabot* case [in 1994] the Supreme Court did make an exception for the case of non-somatically based suffering” (*Ibid.*). This is probably because “[a] person who is not psychiatrically ‘sick’ may suffer unbearably as the result of a traumatic experience, and there may be no treatment acceptable to the person concerned, or none with so favourable a prognosis that its benefits can be considered to outweigh the burden to the patient. (This was the situation in the *Chabot* case, on Chabot’s view.)” *Ibid.*, at p. 122.

⁵⁹⁵ Rietjens. J.A.C., Tol D.G. Van and Schermer M. (2009) ‘Judgement of Suffering in the case of a Euthanasia request in the Netherlands’. *J. Med Ethics*, Vol. 35, p. 506.

⁵⁹⁶ This has come to the light through past cases of euthanasia. See footnote 211 of Griffiths John, Weyers Heleen and Adams Maurice’ book *Euthanasia and law in Europe*. (2008) Oxford and Portland, Oregon: Hart Publishing.

⁵⁹⁷ Except when a patient may desire to die in private or among intimates. *Ibid.*, at p. 101.

The statutory Act 2001 also covers children between the ages of 12 to 18. However, children are divided into two categories. Those who are between the ages of 12 to 15 have the right to make a request, but the consent of parents or guardians is mandatory. On the other hand, those who are between the ages of 16 to 17 also have the right to make a request. However, whilst in such situations it is not mandatory to require the consent of the parents or guardians they should nevertheless, be informed and consulted.⁵⁹⁸

Apart from holding the RRCs responsible for the smooth functioning of the regime, the statutory Act 2001 also gives a statutory power to the RRCs, whose judgement on the report provided by the doctor is final and authoritative.⁵⁹⁹

The RRCs are also given the liberty to conduct investigation. They may call on the doctor in order to get further clarifications on the report submitted or to rectify any error or in order to recommend ways to improve the service provided by the doctors to their patient in this regard. In addition, the RRCs have imposed a special rule with regard to those who suffer only from a non-somatic disorder. It is their decision that in such cases patients can avail themselves of only physician-assisted suicide. Thereby making a distinction between the cases of euthanasia and the cases of physician-assisted suicide, despite the fact that the statutory Act 2001 is silent in this respect. However, it is noteworthy that the way 'non-somatic disorders' came to be recognised under the 'termination of life' practices is through the case of *Chabot*. In this case, it was held that the reason that non-somatic patients might not be in a proper frame of mind to make a voluntary decision is not a good reason not to include such cases because even in somatic cases patients may suffer from diminished competence.⁶⁰⁰

⁵⁹⁸ De Haan Jurriaan (2002) 'The New Dutch Law on Euthanasia'. *Medical Law Review*. Vol. 10, p. 64; Marker R.L. (2006) 'Euthanasia and Assisted Suicide Today'. *Society*, Vol. 43, p. 60.

⁵⁹⁹ Griffiths John, Weyers Heleen and Adams Maurice (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 130.

⁶⁰⁰ Otlowski M. F.A. (1997) *Voluntary Euthanasia and the Common Law*. Oxford: Clarendon Press. p. 404.

a) The Extra-Legal Procedure in cases of the Termination of Life on Request and Assisted suicide

The practice of assisted suicide and euthanasia in the Netherlands is standardised and formal. Thus, the doctors must comply with the guidelines set out in the statutory Act 2001, to avail themselves of the defence provided to them under this law. However, in the context of use, it can only be set in motion by the patient's request i.e. the patient must state "I want to die"⁶⁰¹. This desire must be repeated over a period of time in order to ascertain that such a wish has been well considered by the patient. In the Netherlands, the act of euthanasia, as well as the act of physician-assisted suicide, is carried out in almost every hospital⁶⁰², nursing home, residential home, and hospice. It sometimes takes place in the homes of the patients. Apart from the doctor who is directly involved in the practice, nurses, and the patients' family members, also play some minimal role in making such a practice successful and facilitating a 'good death'.⁶⁰³

As stated above, any physician who is willing to perform an act of euthanasia or assisted suicide must meet the substantive and procedural requirements. If he breaches these requirements, a physician takes the risk of exposing himself to criminal liability. Thus, the substantive requirements are requirements of 'careful practice'⁶⁰⁴. The substantive requirements are as follows. There must be a voluntary request from the patient, there must be no alternative treatment available, the patient's suffering be 'unbearable' and his or her condition must be 'hopeless', as noted earlier. On the other hand, the procedural requirements often involve briefing the patient, taking advice from an independent consultant,

⁶⁰¹ Cohen- Almagore R. (2008) 'The Right to Die with Dignity: An argument in Ethics and Law'. *Health Law and Policy*. Vol. 2, p.4.

⁶⁰² These hospitals (most of them) are private and run by non-profit organisations, who are free to determine their own policy and most of these hospitals permit euthanasia. See Griffiths John, Weyers Heleen and Adams Maurice (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 6.

⁶⁰³ The doctors consult nurses when they receive a request (to put an end to the misery) from the patient under whose care the patient is. Family member (s) remains present at the time of the death of their love ones. Sometimes even family member makes a request on behalf of the patient. See Kimsma G.K. and Leeuwen E.V. (2007) 'The Role of Family in Euthanasia Decision Making'. *HEC Forum*, Vol.19, No.4, pp. 365-373.

⁶⁰⁴ This is referred as the 'requirements of Due Care' under Article 2 of the statutory Act 2001.

remaining present on the scene, unless there is a good reason not to, record keeping, reporting the death to the municipal pathologist and filing a report to the RRC. Once the physician is satisfied that the request made by the patient is voluntary and well considered, the next step is to examine the patient to make sure that the patient's suffering is 'unbearable' and 'hopeless'. Furthermore, the doctor must establish that there is no alternative treatment available. If the above requirements are successfully complied with, the doctor then must consult the patient. This is one of the most important steps in fulfilling the procedural requirements. The physician is expected to discuss the situation with the patient, including whether any possible alternative treatment is available. Both the doctor and the patient must be convinced that either there is no alternative treatment available to cure the illness or that every effort has failed. This is best seen in the case of *Chabot*, in which Dr Chabot, a psychiatrist assisted a middle-aged woman to commit suicide owing to "her persistent grief at the death of her two sons"⁶⁰⁵. Her position was such that she suffered mentally as a result of a traumatic experience and there was no treatment that was acceptable to her.⁶⁰⁶ Every effort made by Dr Chabot in her case had failed. As a consequence Dr Chabot fulfilled her desire to end her life via assisted suicide.

As noted above, an independent opinion from a consultant is another requirement. This requirement functions as 'quality control'. The physician is required to contact the independent consultant soon after he or she has examined and briefed the patient. The current position is such that the trained independent consultants who form part of Support and Consultation of Euthanasia in the Netherlands (SCEN) provide a second opinion, as legally required, regarding the case in hand. They are supposed to examine the patient and give a written report regarding 'due care', not only to the physician concerned, but also to the RRC.⁶⁰⁷

⁶⁰⁵ Keown J. (2002) *Euthanasia, Ethics and Public Policy*. Cambridge: Cambridge University Press. p. 87.

⁶⁰⁶ Griffiths John, Weyers Heleen and Adams Maurice (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 122.

⁶⁰⁷ *Ibid.*, at pp. 94 -96 and 98 -99.

The continuous presence of the physician is essential. This condition ensures that the patient dies without any further complications or difficulties. There is an exception to this requirement if it is the patient's wish to die only in the presence of his family members. In this case, the physician is expected to make himself or herself available at short notice.⁶⁰⁸

Record-keeping is another requirement which physicians must fulfil. This normally comprises a patient's written consent and his medical history. Other than this, the physician must also report the death to the municipal pathologist as a 'non-natural' death and a registration form must be filed at the RRC. This registration form covers every possible detail with regard to the patient, including the illness and the 'due care' procedure adopted by the physician. The death must also be reported to the medical examiner who examines the body in order to ascertain the way in which life was brought to an end and also, the type of medicine used. The Medical examiner is also required to file his own report to the RRC.⁶⁰⁹

Once the physician has complied with the 'due care' requirements, as per the statutory Act 2001, and the physician has submitted the registration form to the RRC, he or she then must set the RRC procedure into motion. The Committee assesses the report provided, in order to ensure that the doctor has fulfilled the requirements of 'due care'. If necessary, the Committee can request additional information if the report is not clear or even summon the doctor's attendance. It may also make remarks on the manner and the conduct of the doctor who performed the act of euthanasia or physician-assisted suicide. These remarks will mainly be in relation to how to make the practice more effective. The Committee may also cross-check the facts by comparing the reports filed by the medical examiner, or the consultant in the case, or even by contacting the nurses regarding

⁶⁰⁸ This requirement originated from the Medical Disciplinary College of Amsterdam in 1994. See Adams Maurice and Nys Herman (2003) 'Comparative Reflections on the Belgian Euthanasia Act 2002'. *Medical Law Review*, Vol. 11, p. 361.

⁶⁰⁹ Griffiths John, Weyers Heleen and Adams Maurice (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. pp. 101-103.

the matter,⁶¹⁰ in order to confirm the accuracy of the report filed by the doctor. This could potentially happen in the case where the RRC has a doubt as to the conduct of the doctor or his practice. Once satisfied, within 6 weeks from the receipt of the report, the RRC passes a judgment and it also notifies the physician of the decision.⁶¹¹ The case then will be closed, but if, on any account, there is a failure on the part of the physician to comply with the statutory requirements, the prosecutorial authority and the Regional Inspector for Health Care will be informed to conduct further investigations in the matter.⁶¹² In other words, the main function of the RRCs is to make sure that every doctor reports the cases and follows the required procedures.

Apart from the 'due care' requirements imposed by the statutory Act 2001 on the RRCs, the RRCs have set down standards in response to court decisions with regard to the practices of assisted suicide and euthanasia. As briefly stated earlier, two such decisions are particularly remarkable. First, those who do not suffer from a somatic illness can only avail themselves of physician-assisted suicide. This scenario emerged from the case of *Chabot*. The Supreme Court in this case held that assistance with suicide is legally justifiable in the case of a patient whose suffering does not have a somatic basis and who is not in the 'terminal phase'.⁶¹³ The Court also held that the decision of a person suffering from psychiatric sickness or disorder can legally be considered the result of an autonomous i.e. competent and voluntary judgement and that the justification of necessity in this case is met by requirement of consultation.⁶¹⁴ However, the court further held that if such a person refuses a realistic (therapeutic) alternative, then it cannot be said that his or her case is lacking any prospect of improvement.⁶¹⁵ Since then, psychiatrists have assisted such people with suicide on request and reported their

⁶¹⁰ As per Article 8 of the statute Act 2001.

⁶¹¹ As per the article 9 of the statute Act 2001.

⁶¹² As per the article 9 of the statute Act 2001.

⁶¹³ Griffiths J., Weyers H. and Adams M. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 114.

⁶¹⁴ *Ibid.*

⁶¹⁵ *Ibid.*

assistance to the concerned authorities.⁶¹⁶ In 2003, the RRCs took the “...position that the request of a person whose suffering is primarily of psychiatric origin in principle falls under the law of 2002 [i.e. the statutory Act 2001] and hence within the committee’s jurisdiction”.⁶¹⁷ The requirements in this case i.e. in non-somatic disorder are the same as in the case of somatic disorder except that in the former case, the ‘unbearable’ suffering should be ‘understandable’ to a psychiatrist, who may also assist in suicide.⁶¹⁸ The above distinction between euthanasia and physician-assisted suicide springs solely from the RRCs decision. As far as the statutory Act 2001 is concerned, it makes no distinction between the two. Secondly, the RRCs have accepted that dementia patients may also make a request for euthanasia. Their requests made in the form of advance directives can be considered to be valid in cases where they have become incapacitated or incapable.⁶¹⁹

As far as children are concerned, a special regime is applied in these cases. It is a regime based on age. Under section 2, clauses 2, 3 and 4 of the statutory Act 2001, a physician may perform an act of euthanasia on request of the child between the ages of 12 to 15 as long as the child has his or her parents’ or guardians’ consent. For those who are between the ages of 16 and 17, and who make a request for euthanasia, the issue shall be discussed with their parents or guardians. A request can be fulfilled in relation to those who are aged 16 and above, who have slipped into an ‘incapacitate’ stage, and who have left a written request for euthanasia prior to entering this stage. All other requirements of ‘due care’, as already discussed, apply to both of these cases.⁶²⁰

In this way, the regime is subject to strict control through legal and administrative bodies. As seen above, the function of the RCCs as institution of legal control is

⁶¹⁶ *Ibid.*, at p. 115.

⁶¹⁷ *Ibid.*

⁶¹⁸ Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. pp. 115-121.

⁶¹⁹ *Ibid.*, at pp. 45- 46, 87-88, 175- 176.

⁶²⁰ De Haan Jurriaan (2002) ‘The New Dutch Law on Euthanasia’. *Medical Law Review*, Vol. 10, pp. 64, 69.

vital. Apart from working to ensure abuse free system, it also focuses on encouraging effective rule following, rather than issuing sanctions, in order to make the system more effective and transparent. Thus, it plays the role of a watchdog. In addition, the involvement of the RRCs provides legal security to physicians who can be certain that the police will not investigate their conduct, unless they commit a felony. In this way, it encourages physicians to report cases to the regulating body. However, since the physicians⁶²¹ act as ‘gatekeepers’ of the law i.e., they decide whether to fulfil the request of the patient or not, as stated by Rietjens, Tol and Schermer, the whole system is based on trust of a physician’s ability and willingness to be transparent about his or her acts.⁶²²

It is alleged by the proponents of the ‘slippery slope’ argument that the previous tendency of doctors to be cautious regarding ‘end of life’ issues in the Netherlands is currently heading downhill.⁶²³ In line with this, it is claimed that the “strict guidelines, requiring patient’s consent are not consistently respected which results in involuntary euthanasia....”⁶²⁴ In addition, it has been alleged that there has been inconsistency in reporting some deaths that have occurred due to active euthanasia.⁶²⁵

Gerrit van der Wal and Robert Dillmann on the other hand, have mounted a defence of the new laws. They stated that firstly, as far as the practice of euthanasia is concerned, the practice “is not fuelled by a scarcity of health care resources. Most such deaths take place at home in patients with a life expectancy

⁶²¹ Who bear the full responsibility to perform euthanasia carefully. See Rietjens J.A.C., Tol D. G. van and Schermer M. (2009) ‘Judgement of Suffering in the case of a Euthanasia request in the Netherlands’. *J Med Ethics*, Vol. 35, p. 506.

⁶²² Rietjens J.A.C., Tol D. G. van and Schermer M. (2009) ‘Judgement of Suffering in the case of a Euthanasia request in the Netherlands’. *J Med Ethics*, Vol. 35, p. 506.

⁶²³ Burgess J.A. (1993) ‘The great slippery-slope argument’, *Journal of Medical Ethics*, Vol. 19, pp. 169-174; Wal G. V.D and Dillmann R.J.M. (1994) ‘Euthanasia in the Netherlands’, *BMJ*, Vol.308, pp. 1346-1349; Harris N.M. (2001) ‘The Euthanasia Debate’, *Journal of The Royal Army Medical Corps*, Vol. 147, pp.367-370.

⁶²⁴ Harris N.M. (2001) ‘The Euthanasia Debate’, *Journal of The Royal Army Medical Corps*, Vol. 147, pp.367-370.

⁶²⁵ *Ibid.* , at p.368.

of less than a month, after hospital treatment has proved ineffective.”⁶²⁶ Furthermore, the relevant death rate in nursing homes remains very low. Similarly, the majority of the population of the country has good health insurance. As a result, it can be said that money is not a motivating factor in decisions concerning the ‘end of life’.⁶²⁷ Furthermore, the analysis of Rietjens, Tol and Schermer shows,

“that fears of slippery slope practice due to this system seem to be unfounded, because GPs are not inclined to judge patient’s suffering that is outside the reach of the law to be unbearable. As such, GPs can be considered the ‘gatekeepers’ of the legal system”.⁶²⁸

Regarding the issue of palliative care in the Netherlands, it is arguable that even if the Netherlands failed to provide these facilities, it would not lead to an increase in the rate of euthanasia.⁶²⁹ According to Gerrit van der and Robert Dillmann, it is clear that “in only about 5% of cases is pain the most important reason for requesting euthanasia”.⁶³⁰ In addition, they further suggest that “[t]here are no indications that palliative care in general is insufficient”.⁶³¹ Hence, it is their view that there is evidence to suggest that doctors obey the correct policy guidelines and that the trend in obeying the relevant laws on these issues in the Netherlands is not going downhill, but uphill. For instance, there has been an increase in the number of reported situations, which is arguably a positive thing, as in the past many cases may have gone unreported.⁶³² Furthermore, doctors are said to generally observe the “the rules of careful practice”⁶³³ when performing

⁶²⁶ Wal G. V.D and Dillmann R.J.M. (1994) ‘Euthanasia in the Netherlands’, *BMJ*, Vol.308, p. 1348.

⁶²⁷ *Ibid.*

⁶²⁸ Rietjens J.A.C., Tol D G van and Schermer M. (2009) ‘Judgement of Suffering in the case of a euthanasia request in the Netherlands’. *J Med Ethics*, Vol. 35, p.506.

⁶²⁹ Wal Gerrit van der and Dillmann R.J.M. (1994) ‘Euthanasia in the Netherlands’. *British Medical Journal*, Vol. 308, pp.1346-1349.

⁶³⁰ *Ibid.*, at p. 1348.

⁶³¹ *Ibid.*

⁶³² *Ibid.*, at pp. 1346-1349.

⁶³³ Haan De (2002) ‘The New Dutch Law on Euthanasia’, *Medical Law Review*, Vol.10, p. 59.

euthanasia. Although it is possible to suggest that the doctors might not perform their function of gatekeepers effectively,⁶³⁴ since doctors are open to criminal prosecution,⁶³⁵ they could still be kept under control by imposing stricter regulations and by thoroughly supervising their conduct. In addition, as suggested by Harris, “[s]tipulating the requirement for an advanced directives, a so-called living will, would decrease the chances of abuse of any guidelines for active euthanasia”.⁶³⁶ Similarly, holding that the consent of the patient must be a prerequisite condition in instances of termination of life or in the instances of assisted suicide, and in addition, the eligibility and notification process acts as a safeguard against the abuse of the system.

In addition, the current law of the Netherlands on assisted suicide and euthanasia serves two purposes: ensuring that the doctors do not abuse the permission given to them and respecting the value of life.⁶³⁷ It permits the practice of assisted suicide and euthanasia only under special circumstances and it justifies this practice in the context of the conflict of physicians’ duties⁶³⁸.

On the other hand, it is possible to argue that the above law exists because the Netherlands is a secular country where “unlimited freedom of thought and expression” is highly valued.⁶³⁹ The state encompasses a democratic, liberated and permissive society that encourages the rejection of dogmas and the

⁶³⁴ Simon C. (1998) ‘Last Rights: Euthanasia, the Sanctity of Life, and the Law in the Netherlands and the Northern Territory of Australia’. *International and Comparative Law Quarterly*, Vol. 47, p. 392.

⁶³⁵ Wal G. V.D and Dillmann R.J.M. (1994) ‘Euthanasia in the Netherlands’, *BMJ*, Vol.308, p. 1347.

⁶³⁶ Harris N.M. (2001) ‘The Euthanasia Debate’, *Journal of The Royal Army Medical Corps*, Vol. 147, p.369.

⁶³⁷ See p. 114 of the thesis.

⁶³⁸ Bossbard Georg, Fisher Susanne and Bar Walter states that “[t]he analysis of the different normative concepts underlying legislation reveals that in the Netherlands the basis for non-prosecution lies in the conflict of the physician’s duties to respect life versus relief of suffering....” See Bossbard Georg, Fisher Susanne and Bar Walter. (2002) ‘Open regulation and practice in assisted suicide’. *Swiss medical weekly*, Vol. 132, p. 527.

⁶³⁹ Fenigsen Richard. (1989) ‘A Case Against Dutch Euthanasia’. *The Hastings Center Report*, Vol. 19, p. 24.

overthrowing of taboos that uphold sacredness of human life.⁶⁴⁰ As a result, this may be another reason that has led to judge the sanctity of life or value of life in terms of the quality of life, as well as the suffering a patient or person has to undergo.

Although relief from suffering is no doubt an essential condition in justification of the statutory Act 2001,⁶⁴¹ the justification of autonomy is weak according to George, Finlay and Jeffery. This is because the final decision to assist rests with the doctor.⁶⁴² A doctor may deny a patient's request in a situation where a patient is "not suffering enough".⁶⁴³ This arguably shows how crucial the role of physicians is in relation to 'end of life' issues in the Netherlands.

The issue of life and death is also attached to religion in the Netherlands. However, the Netherlands is a country of believers and non-believers and hence, a religious motivation tends to weaken the stance of opponents.⁶⁴⁴ It has been stated: "Secular reasons – moral, rational, and medical – for rejecting euthanasia are still unknown to the Dutch people."⁶⁴⁵

From the above analysis, it is clear that the Netherlands, who faced similar problem as of the England and Wales today, opted for an honest approach rather "than an outright denial of the practice of euthanasia...."⁶⁴⁶ It made an effort to resolve the conflict (faced over the 'end of life' issue which would carry on unofficially, even if illegal⁶⁴⁷) by modifying the existing law in its Penal Code⁶⁴⁸

⁶⁴⁰ *Ibid.*

⁶⁴¹ Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 93.

⁶⁴² George R J D., Finlay I G and Jeffery David. (2005) 'Legalised euthanasia will violate the rights of the vulnerable patients'. *BMJ*, Vol.331, p. 684.

⁶⁴³ *Ibid.*

⁶⁴⁴ Fenigsen Richard. (1989) 'A Case Against Dutch Euthanasia'. *The Hastings Center Report*, Vol. 19, p. 24.

⁶⁴⁵ *Ibid.*

⁶⁴⁶ Simon C. (1998) 'Last Rights: Euthanasia, the Sanctity of Life, and the Law in the Netherlands and the Northern Territory of Australia'. *International and Comparative Law Quarterly*, Vol. 47, p. 392.

⁶⁴⁷ It was evident that since 1970 such practice was carried out by doctors and tolerated by the legal authorities such as prosecutors and courts.

and by passing a special legal regime and extra-legal regime to govern the practice of assisted suicide and euthanasia, and to ensure that the system is not abused and the respect for human life is not undermined.⁶⁴⁹

3.2 The Legal Structure of the Regime of the State of Oregon applied in cases of PAS

Like in the Netherlands, the Criminal Law in the State of Oregon also prohibits assisted suicide. The Oregon Revised Statute (ORS) 163.125 (1) (b) reads as: “Criminal homicide constitutes manslaughter in the second degree when a person intentionally causes or aids another person to commit suicide”.⁶⁵⁰ However, the construction of the Oregon Death with Dignity Act 1994⁶⁵¹ makes assistance in suicide possible in the medical context. The physician who performs the task in good faith and under the prescribed guidelines is not criminally liable. Physicians also escape civil sanctions, as well as any professional sanctions, under the State law. This immunity is defined under 127.885 s. 4.01 of the ORS.

1. No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

⁶⁴⁸ Simon C. (1998) ‘Last Rights: Euthanasia, the Sanctity of Life, and the Law in the Netherlands and the Northern Territory of Australia’. *International and Comparative Law Quarterly*, Vol. 47, p. 392.

⁶⁴⁹ It is relevant to note that “[t]he sanctity of life position is the view that the law in most western countries reflects...” and it is considered the most fundamental factor in decisions about life and death. See Stevens Christine A. (1992) ‘Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners and Nurses in South Australia’. Available at, <http://www.criminologyresearchcouncil.gov.au/reports/22-90-pdf>

⁶⁵⁰ ‘InternationalTaskForce.org’ See http://www.internationaltaskforce.org/assisted_suicide_laws.htm

⁶⁵¹ The Oregon Death with Dignity Act (ODWDA) was passed in a referendum in November 1994. The implementation of it was delayed owing to “a court challenge to its constitutionality. On 27 October 1997 the injunction preventing its implementation was lifted by the Federal Court of Appeals for the Ninth Circuit. In November 1997 voters rejected a proposal to repeal the Act by 60% to 40%. Since then, several people have made use of the legislation to end their lives by PAS.” See Keown J. (2002) *Euthanasia, Ethics and Public Policy*. Cambridge: Cambridge University Press. p.167.

2. No professional organisation or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

At the same time, the ODWDA prohibits acts of active euthanasia and mercy killing, including killing by lethal injection. The law reads as follows:

“The construction of the Act⁶⁵² shall in no way be construed to authorize a physician or any other person to end a patient’s life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”

In other words, physicians are exempted from prosecution, provided that their conduct falls within the provisions of the ODWDA. Moreover, pharmacists are also protected by the Act from handing a patient (on the production of the prescription) a controlled drug.⁶⁵³ This mechanism of assistance in suicide is recognised as a form of medical treatment and hence, it is not classed as suicide.

The ODWDA is the outcome of a people’s initiative’ rather than an act of judicial creation. However, it could be argued that its base is derived from the American Constitution, wherein concepts such as autonomy, liberty, freedom, and dignity play a fundamental role. However, it is to be noted that there is no constitutional right to PAS.⁶⁵⁴ The said ODWDA was implemented in 1997 under the following conditions. The act states:

⁶⁵² Eight Annual Report on Oregon’s Death with Dignity Act. Available at: <http://www.oregon.gov/DHS/ph/pas/index.shtml>

⁶⁵³ *Ibid.*

⁶⁵⁴ The Supreme Court of the United States ruled this decision in 1997.

“[a]n adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.”⁶⁵⁵

The ODWDA does not impose any obligation on a physician or a pharmacist to assist in suicide, or to hand over the medication to the patient, knowing the purpose of the use. The ORS 127.885 s.4.01 (4)⁶⁵⁶ reads as follows:

“No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient’s request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient’s relevant medical records to the new health care provider.”

Lastly, the ODWDA also makes a legal provision that aims to punish those who may maliciously interfere with the patient’s medical records or put pressure on the patient to end his or her life. The liability is defined 127.890 s.4.02 as follows:

“1. A person who without authorization of the patient wilfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient’s death, [or]

⁶⁵⁵ Oregon Revised Statute 127.805 s. 2.01, see <http://egov.oregon.gov/DHS/ph/pas/ors.shtml>

⁶⁵⁶ *Ibid.*

2. A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a ...felony".

Finally, it could be said that the ODWDA is framed with the layperson in mind. It carries a simple and clear message that is comprehensible to all those who would seek medication under the ODWDA.

a) The Extra-Legal Procedure to be followed in compliance with the ODWDA

The act of PAS in Oregon is officially recognised as a request for medication to end life in a human and dignified manner. This is legal under the ODWDA. The law enables the people of Oregon not only to choose death, out of their own free will, in cases of terminal disease, but also gives them the right to choose the time and place of their death. It envisages a process whereby a physician prescribes lethal medication⁶⁵⁷ to a patient, who then self-administers it. However, in order to request a prescription, the ODWDA requires that a patient must be:

- an adult (18 years of age or older),
- a resident of Oregon,
- capable (defined as able to make and communicate health care decisions), and
- diagnosed with a terminal illness that will lead to death within six months.⁶⁵⁸

On the other hand, in order to receive a prescription a patient must fulfil the other requirements, stated as follows:

⁶⁵⁷ That is, controlled drugs banned by the legislation.

⁶⁵⁸ 'Eight Annual Report on Oregon's Death with Dignity Act' p. 7, <http://www.oregon.gov/DVS/ph/pas/index.shtml>

1. A patient must make two oral requests and a written request. There must be at least 15 days gap between the two oral requests made. An oral request comprises of the following words by the patient to the physician:

“‘I’ve been given a diagnosis, what I want to do is to be assisted in dying and I would like a prescription from you to make that happen.’”⁶⁵⁹

2. The written request is a declaration made on the form provided by the Department of the Health in the presence of two witnesses.
3. The terminal illness diagnosed by a physician must be confirmed by a consultant.
4. Whether the patient is of a sound mind, capable of making competent decision, must be determined by both the prescribing physician and also by a consulting physician.
5. If either of the physicians thinks that the patient is suffering from a psychological disorder, the patient shall be referred to a psychiatrist for examination.

Finally, apart from the above mentioned requirements, the attending physician is also required to “report to the Department of Human Services (DHS) all prescriptions for lethal medications”.⁶⁶⁰ This helps to ensure compliance with the law. However, a physician need not file a report in cases where a patient made a request, but did not make it to the stage of prescription. In 1999, the Oregon legislature added another requirement that must be complied with by the physicians, in addition to the existing ones. It requires that the relevant pharmacist must be informed of the prescribed medication’s intended use. As far as criminal liability is concerned, neither a pharmacist nor a physician who adheres to the

⁶⁵⁹LaFrance Arthur B. (2008) ‘Physician Assisted Death: The Oregon Experience’. *Wyoming L. Rev.* Vol. 8, p. 337.

⁶⁶⁰ Oregon Administrative Rules 333-009-000 to 333-009-0030.
<http://egov.oregon.gov/DHS/ph/pas/oars.shtml>

rules and regulations of the ODWDA shall be criminally liable. In addition, this type of activity would also not affect the relevant health insurance policy of the patient. It has also been made clear in the revised statute that neither the doctor nor the pharmacist is under any obligation to participate in the ODWDA⁶⁶¹.

In Oregon, most of the patients (93%) die at home. Some may choose to die at a hospice.⁶⁶² Their death is reported as a natural death, caused by illness. As a result, it is not possible to know by looking at the death certificate whether the person died a 'suicidal' death. The only place where the full details of the medical history of the patient can be found is the Oregon DHS.

Normally the relationship between the doctor and the patient does not last long. It may vary from 12 weeks to 3 months. The role of the physician ends at the stage of prescription of the drug, although the physician may remain present at the time when the patient commits the final act. The nature of the practice is purely medical.⁶⁶³ Unlike in the Netherlands, in Oregon the ODWDA does not extend the treatment to a patient who suffers from a mental disorder, and it is limited only to cases of terminal illness. As a result, people with severe disability or with diseases such as motor neurone do not qualify under the ODWDA. The regime applied in the case of PAS in Oregon is clear and straightforward when compared to the Dutch regime.⁶⁶⁴ Keown is of the opinion that the "Oregon Act can claim to be the most permissive regime for PAS yet devised".⁶⁶⁵

⁶⁶¹ Oregon Revised Statute 127.800-127.995. <http://egov.oregon.gov/DHS/ph/pas/ors.shtml>

⁶⁶² It is relevant to note that most hospices which supports dying people, do not "participate in assisted death, because the practice is limited to Oregon" and they might care for the patients who are 'non-residents' of the state. See LaFrance Arthur B. (2008) 'Physician Assisted Death: The Oregon Experience'. *Wyoming L. Rev.* Vol. 8, p. 341.

⁶⁶³ Only physicians may assist in suicide under the ODWDA. As a result only physician enjoy the immunity from the law on assisted suicide which otherwise is a crime. Same is the case under the Dutch law on termination of life.

⁶⁶⁴ Further detailed comparison between the Netherlands and the state of Oregon is dealt in the concluding part of the thesis.

⁶⁶⁵ Keown J. (2002) *Euthanasia, Ethics and Public Policy*. Cambridge: Cambridge University Press. p. 179.

The means by which the State of Oregon has tried to control this practice is explained as follows. Firstly, Oregon has maintained the law proscribing assisted suicide.⁶⁶⁶ Secondly, it has implemented an extra-legal regime that sets out the conditions under which a doctor is permitted to prescribe a lethal drug to a patient, as well as the conditions under which a patient is recognised as a fit candidate for such treatment. Similarly, the Act requires the patient to take full responsibility for his or her death by signing a declaration.⁶⁶⁷ This condition could be significant for two reasons. It could prove to be a barrier to stop abuse and it could also prevent the implication of another person in a patient's death.

In addition, as far as the principle of sanctity of life is concerned, under the Oregon legislation this principle is understood from the perspective of 'quality of life' rather than the perspective of life as an intrinsic good.⁶⁶⁸ Another reason in support of this argument could be that since the option to end one's life is recognised as a medical treatment, ending life in this context is viewed as a natural death.

Hence, it is suggested that the above measures, as adopted by the State of Oregon, appear to provide safer and more restrictive options in comparison with the law in the Netherlands. Nevertheless, Wesley Smith argues that it is not 'abuse free'. A study conducted in 1998 by Georgetown University's Center for Clinical Bioethics found "a strong link between cost-cutting pressures on physicians and their willingness to prescribe lethal drugs to patients".⁶⁶⁹ Similarly, Wesley Smith has expressed fears that vulnerable people could be bullied into assisted

⁶⁶⁶ Ziegler S.J. (2009) 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for its Potential to enhance oversight and demedicalize the dying process'. *Journal of law, Medicine and Ethics*, Vol. 37, p. 320.

⁶⁶⁷ A request form, 'Request for medication to end my life in a humane and dignified manner'. <http://oregon.gov/DHS/ph/pas/index.shtml>.

⁶⁶⁸ Goy E.R. and others (2006) 'Determinants of Oregon hospice chaplains' views on physician-assisted suicide', *Journal Palliative Care*, Vol.22, pp. 83-90.

⁶⁶⁹ 'Death Drugs Cause Uproar in Oregon: Terminally Ill Denied Drugs for Life, But can Opt for Suicide'. <http://abcnews.go.com/Health/Story?id=5517492&page=2>

suicide.⁶⁷⁰ He has made this allegation on the basis of the instances of Barbara Wagner⁶⁷¹ and Randy Stroup⁶⁷². Both of these patients were denied treatment by the state's health insurance plan for the poor. However, they were told that the state's plan would pay for their assisted suicide.⁶⁷³ In other words, there is a potential financial incentive in the State favouring the death of the patient. This is a cause of concern for the people of the State of Oregon, and especially for patients who desire help in order to live a pain-free life; some of these patients are instead offered help to end their lives.⁶⁷⁴ Dr David Jeffery is a palliative specialist. He conducted empirical research in Oregon and undertook an investigation of a range of 'end of life' care. He concluded that similar measures on assisted suicide should not be extended in the UK.⁶⁷⁵ He formed this opinion based on a case study which showed that people in Oregon who had attempted to end their life by taking a lethal drug, as prescribed by a doctor, did not die immediately. As a result, this was said to have often had an adverse effect on the family of the dying person. Similarly, it appears that some physicians talked some people, who were terminally ill, into ending their lives prematurely, in order to avoid the unpleasant death that could follow from allowing the illness to run its course. It has also been alleged that the law in the state of Oregon currently fails to protect those people whose choices are influenced by depression.⁶⁷⁶

⁶⁷⁰ Wesley Smith (2009) 'Right to die' can become a 'duty to die', published in Telegraph.co.uk 20th Feb.

⁶⁷¹ Who suffered from recurrent lung cancer.

⁶⁷² Who had prostate cancer.

⁶⁷³ Wagner eventually received free medication from the drug manufacture and the denial of chemotherapy to Randy Stroup was reversed on appeal after his story hit the media. See 'Death Drugs Cause Uproar in Oregon: Terminally Ill Denied Drugs for Life, But can Opt for Suicide'. <http://abcnews.go.com/Health/Story?id=5517492&page=2>

⁶⁷⁴ Smith Wesley J. (2008) 'Another Assisted Suicide Abuse in Oregon: No Money to Help Live-Will Pay to Make Dead'. <http://www.firstthings.com/blogs/secondhandsmoke/2008/07/29/another-assisted-suicide-abuse-in-oregon-no-money-to-help-live-will-pay-to-make-dead/>

⁶⁷⁵ 'Problems with Oregon Assisted Suicides are Real' by Smith Wesley J. <http://www.firstthings.com/blogs/secondhandsmoke/2007/11/06/problems-with-oregon-assisted-suicides-are-real/>

⁶⁷⁶ Alex Carlie (2009) 'The Law as it stands could not be clearer'. *BMJ*, Vol.339, p.3169.

However, while refuting the allegations made, the spokesperson for the State argued that the Oregon Health Plan properly looks after the needs and the interests of patients in relation to potential treatments, no matter what the cost of the treatment is. He acknowledged there were some genuine issues of concern in the matter of Barbara Wagner⁶⁷⁷ and he stated that this case “was a public relations blunder and something the state is ‘working on’”⁶⁷⁸. Steinbrook Robert reports that a large number of people in Oregon die while under the care of a hospice program.⁶⁷⁹ A number of these patients had requested assistance.⁶⁸⁰ Possible reasons for patients making such requests for assistance in suicide include the desire for control⁶⁸¹ and to provide “a potential source of comfort for terminally ill patients, regardless of whether they ever choose to make use of it”.⁶⁸² According to Ann Jackson of the Oregon Hospice Association, the rate of hospice death increased from 21 percentages to 39 percentages from 1993 to 2000.⁶⁸³ Linda Gansini and others have stated that, based on the research data, it appears that only one in six requests are granted by physicians and only one in ten requests actually results in a case of suicide.⁶⁸⁴ Thus, Steinbrook Robert states that, according to Oregon Health Division, there is no evidence that the law has been abused.⁶⁸⁵ It has been noted:

⁶⁷⁷ The person who was denied treatment but instead was told that the State plan would pay for his assisted suicide.

⁶⁷⁸ ‘Death Drugs Cause Uproar in Oregon: Terminally Ill Denied Drugs for Life, but can Opt for Suicide’. <http://abcnews.go.com/Health/Story?id=5517492&page=2>

⁶⁷⁹ Steinbrook Robert. (2002) ‘Physician-Assisted Suicide in Oregon – An uncertain future’. *The New England Journal of Medicine*, Vol. 346, p. 461.

⁶⁸⁰ Gansini L. and others (2002) ‘Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested assistance with suicide’. *The New England Journal of Medicine*, Vol.347, p. 506.

⁶⁸¹ *Ibid.*, at pp.557-563.

⁶⁸² Steinbrook Robert. (2002) ‘Physician-Assisted Suicide in Oregon – An uncertain future’. *The New England Journal of Medicine*, Vol. 346, p. 460.

⁶⁸³ *Ibid.*, at p. 461.

⁶⁸⁴ Gansini L. and others. (2002) ‘Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested assistance with suicide’. *The New England Journal of Medicine*, Vol.347, pp.557-563.

⁶⁸⁵ Steinbrook Robert. (2002) ‘Physician-Assisted Suicide in Oregon – An uncertain future’. *The New England Journal of Medicine*, Vol. 346, p. 461.

“Oregon’s seven years of experience with this law⁶⁸⁶ have been, for the most part, reassuring: medical and legal safeguards established during implementation appear to have prevented abuse, and most patients have had expected outcome.”⁶⁸⁷

Further to this, the recent report published under the ODWDA shows that in the year 2009, out of 95 patients who took prescriptions, only 59 took medications to end their life.⁶⁸⁸ According to the report, during the period from 1997-2009, only 460 patients have died from ingesting medication prescribed to them under the ODWDA.⁶⁸⁹

3.3 The Law on Assisted Suicide in Switzerland

The legal position of Switzerland with regard to assisted suicide is unique compared to that of the Netherlands and the State of Oregon. Assisted suicide is not a crime in Switzerland, provided that a person who aids or assists does it for humane reasons. In other words, any person may assist another in committing the act of suicide. It need not be a physician. Article 115 of the Swiss Penal Code (SPC) 1937, in force since 1942, defines assisted suicide as:

“Art 115: Inciting and assisting someone to commit suicide (*Verleitung und Beihilfe zum Selbstmord*)

A person who, for selfish reasons, incites someone to commit suicide or who assists that person in doing so will, if the suicide was carried out or attempted, be sentenced to a term of imprisonment (*Zuchthaus*) of up to 5 years or a term of imprisonment (*Gefangnis*).”⁶⁹⁰

⁶⁸⁶ That is from the year 1997 to 2000.

⁶⁸⁷ Okie Susan. (2005) ‘Physician-Assisted Suicide – Oregon and Beyond’. *The New England Journal of Medicine*, Vol. 352, pp. 1627-1628.

⁶⁸⁸ ‘2009 Summary of Oregon’s Death with Dignity Act’. <http://oregon.gov/DHS/ph/pas/index.shtml>.

⁶⁸⁹ *Ibid.*

⁶⁹⁰ Schwarzenegger Christian and Summers Sarah J. ‘Criminal Law and Assisted Suicide in Switzerland’. www.rwi.unizh.ch/schwarzenegger

Although it does not state in specific terms that assisted suicide is legal, neither does it prohibit it, except in conditions where the motive behind such an act or behaviour is self-interest. Hence as argued by Bosshard, "...the legality of assisting suicide, in the absence of self-interest, holds good for any person".⁶⁹¹ Moreover, in 2001, the Swiss Parliament rejected a bill that would have banned the physicians from assisting suicide.⁶⁹² Euthanasia, on the other hand, remains a crime which is punishable under Article 114 of the SPC as killing on the explicit request of the person concerned.⁶⁹³ Article 114 of the SPC defines euthanasia as murder upon request by the victim. The law does not recognise the concept of euthanasia.⁶⁹⁴ Apart from this provision, Article 11 of the Narcotics imposes a prerequisite on the doctors who prescribe the drug to the patient. A doctor must evaluate the competence of the person concerned.⁶⁹⁵ Another important point is that, as is the case in Holland, Switzerland allows assisted suicide in mental disorder cases. This position was recognised by the Federal Supreme Court in 2006. The court stated:

"[A]n incurable, permanent, serious mental disorder can be the cause of suffering comparable to that of a physical disorder. The court ruled that a doctor who prescribes a lethal dose of pentobarbital in a case like this does not necessarily violate the rules of medical practice. However, the Federal Supreme Court held, this requires a report by an expert in psychiatry providing evidence that the patient's desire to die is not the expression of a curable, psychiatric disorder but a well-considered and permanent decision based on rational judgment." ⁶⁹⁶

⁶⁹¹ Bosshard G. (2008) 'Switzerland', in Griffiths John, Weyers Heleen and Adams Maurice (eds), *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 471.

⁶⁹² Available at: http://www.chninternational.com/switzerland_and_assisted_suicide.htm

⁶⁹³ Bosshard G. (2008) 'Switzerland', in Griffiths John, Weyers Heleen and Adams Maurice (eds), *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 468.

⁶⁹⁴ Mauron Alex and Hurst Samia A. (2003) 'Education and Debate'. 'Assisted Suicide and Euthanasia in Switzerland: allowing a role for non-physicians'. *British Medical Journal*, Vol. 326, p. 272.

⁶⁹⁵ Bosshard G. (2008) 'Switzerland', in Griffiths John, Weyers Heleen and Adams Maurice (eds), *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 473.

⁶⁹⁶ *Ibid.*, at p. 473.

Bosshard further explains that:

“The court based its decision not only on the Swiss Penal Code and the Swiss Constitution, but also on the European Convention of human rights. The fundamental idea underlying Swiss law on suicide is that of the autonomous human individual who has the right to decide on the circumstances and the time of his own death. A right to die in this sense, however, is a negative right (liberty right): it protects the individual against legal prohibitions and interventions. Such negative rights can be restricted if other basic rights are at risk. No positive right (claim right) is involved. The court explicitly rejected the view of Ludwig Minelli, lawyer and founder of the right-to-die society *Dignitas*, that there is an individual right to a pain-free death (using pentobarbital).”⁶⁹⁷

The prime consideration that must be given in the case of the above practice is that the person who is being assisted must have the capacity to make such a decision. In addition, the person who wishes to die must perform the final act. Finally, the person helping with the performance of this act must lack a selfish motive. As long as the ‘right to die’ societies, as mentioned above, fulfil these requirements they can be assured that their acts will not come under criminal liability. Therefore, it is not surprising that a psychiatrist who allowed a media team i.e. TV cameras to be present when a patient was assisted in committing suicide, and who allowed the film to be broadcast thereafter, was found guilty of an offence against Article 115.⁶⁹⁸

In short, the legal structure of the regime applied in Switzerland is without ambiguity. It is controlled by the SPC and the Criminal Justice System (CJS). The police and the prosecutors play an active role in keeping the system abuse-free.

⁶⁹⁷ *Ibid.*, at p. 473.

⁶⁹⁸ *Ibid.*, at p. 476.

The authorities get directly involved, on the spot in every case of assisted suicide. These cases are registered as unnatural deaths and are investigated like any other case of unnatural death. Similarly, the 'right to die' societies, who provide the service of assistance to autonomous individuals under special circumstances, remain in the constant focus of the authorities. Although Article 115 of the SPC protects these societies, their conduct is closely observed by the concerned authorities. They are required to intimate the police of any cases of assisted suicide they deal with immediately upon death of the patient. In this way, these societies also help the regime to function effectively. In the following part of the chapter, the extra legal procedures adopted by these societies in conducting the practice of assisted suicide is set out.

a) The Extra-Legal Procedure: Switzerland and 'Right to Die' Societies

In Switzerland, the Criminal Law is liberal in relation to assisted suicide. There are no formal rules or guidelines to be adopted, except that the abettor should not act with a selfish motive, as explained above. Moreover, assisted suicide in Switzerland does not find a home in the medical context, unlike in the other two jurisdictions assessed above.⁶⁹⁹ Hence, one need not be a physician to assist in suicide. The unique feature of this practice, which occurs under the SPC, is that it can be performed by anybody, anywhere. The presence of independent organisations, which are known as right to die societies, makes the Swiss situation unique. These organisations are non-profit and non-governmental namely Exit Deutsche Schweiz (Exit), Association pour le Droit de Mourir dans la Dignité (Exit ADMD), Dignitas and Exit International. These organisations have framed their own guidelines, which must be complied with by any person who wishes to have assistance, and also by the member of their staff. Although each organisation has its own set of rules and requirements, they share one common requirement i.e. every person who wishes to have the services provided must be competent to make such a decision. The volunteers of these societies are comprised of

⁶⁹⁹ Bosshard G. and others (2008) 'Suicide assisted by two Swiss right-to-die organisations'. *J Med Ethics*, Vol. 34, p. 810.

clergymen, social workers and nurses, all of whom are responsible for the effective service of the organisation. These are the people with whom the candidate comes into contact with first. In this way, the volunteers play an important role in the preliminary assessment of a candidate for assisted suicide. A request is first made to a volunteer, often by telephone, and not directly to the doctor.

Following the preliminary assessment, the person concerned is then required to approach a doctor. He or she will usually be advised to ask for the cooperation of a family doctor who will prescribe a lethal dose of sodium pentobarbital. The doctor who prescribes the drug may either decide to remain present at the time of the final act, which is performed by the patient, or the doctor may decide to assist, without the aid of an organisation. It has been observed that only a few doctors have been willing to participate in the final act. Most doctors prefer to prescribe the drug and then let the organisation participate in the final act.⁷⁰⁰ The prescribed drug is stored at the organisation until the final act. This is different to the case of Oregon, where the drug is stored at the patient's own home. As it is clear that the final act is a self-administered act, whereby the candidate swallows the drug, this becomes a problem in cases of candidates who are unable to swallow the pill. In this case, the organisation moves a step forward in assisting such patients to commit suicide. In these types of cases, the organisation provides assistance by using iv-drips or stomach tubes. This is the case mostly with those who are already being fed using artificial nutrition methods or have had tube feeding devices administered. Sometimes, in the absence of these devices, a nurse will put an intravenous drip in place. The volunteer will then add the lethal dose to the fluid in the drip container. This process is viewed as a preparatory activity. The last step is considered to be vital as far as the law is concerned. This final step is to open the tap of the drip or tube. This must be carried out by the dying person. Furthermore, this must be attested to by a witness. Lastly, the death must be

⁷⁰⁰ Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 475.

reported to the criminal authorities. These authorities lay down procedural requirements. The requirement of competence of the candidate or patient is shared by all the organisations. However, as far as the substantive internal rules are concerned, each organisation has their own set of criteria.⁷⁰¹

Exit which caters for the German speaking part of Switzerland, and which has its headquarters in Zurich, requires that the person who wishes assistance must have a poor prognosis, and suffering that is ‘unbearable or be suffering from unreasonable disability.’⁷⁰²

Exit ADMD which is the sister concern of Exit, operates in the other region i.e. the French speaking part. It provides a service only to those people who suffer from an incurable disease or those people that are terminally ill. Otherwise its conditions are the same i.e. it requires that “...the person wanting assistance be competent”⁷⁰³.

Dignitas, which not only caters for the Swiss, but also for foreigners, requires that the person must suffer from a fatal disease or from an unacceptable disability.⁷⁰⁴

Exit International is another organisation which also offers suicide assistance to people who do not live in Switzerland.

Even under the Swiss law, the applicant must perform the final act. This usually occurs in the venue provided by the organisation i.e. the ‘right to die’ society. It is an action carried out “by the ingestion of a lethal dose of barbiturates prescribed by a physician with explicit intention of enabling the patient to end his or her life”⁷⁰⁵. As is the case in the Netherlands, it is not only people suffering from a physical disease that are considered to be fit candidates for assistance, but also

⁷⁰¹ *Ibid.*, at p. 471.

⁷⁰² *Ibid.*

⁷⁰³ *Ibid.*

⁷⁰⁴ *Ibid.*

⁷⁰⁵ *Ibid.*, at p. 472.

those who suffer from a mental illness. However, since in Switzerland anyone can assist in suicide of another, the question remains as to what extent the implied requirement of competence is fulfilled in cases where the third party is non-physician.⁷⁰⁶ Arguably, since the ‘right to die’ societies are non-profit organisations, they would provide assistance in most of the cases that fulfils their eligibility requirements. Hence, the number of people (non-physicians) who help in suicide of another would be less and they should be subject to the same legal requirements as that of the ‘right to die’ societies. The same safeguards, as mentioned above, should apply to the case of a layperson as apply in the case of a ‘right to die’ society.

Although, as stated above, the law has not set any limits or restrictions on the practice of assisted suicide, the Swiss Academy of Medical Science, in their new Medical Ethics Guidelines for the Care of Patients at the End of Life, has introduced certain guidelines. “The Academy states that ‘a personal decision of a doctor in accordance with his or her conscience to assist a terminally ill patient in suicide has to be respected as such’”⁷⁰⁷. However, doctors should follow certain guidelines set by the Academy. Firstly, the only cases that should be considered are cases in which “the patient is approaching the end of life;”. Secondly, the doctor must discuss both the availability of alternative options and whether the candidate desires any alternative option. Thirdly, the patient must be competent to make a decision and the decision must be well thought through and it must be made without any external pressures being exerted on the patient.⁷⁰⁸ However, the Academy makes it clear that assistance in suicide does not form part of a doctor’s usual tasks – there is no duty to assist. In addition, the Academy requires that the first and the second points be fulfilled by analysis based on medical expertise.

⁷⁰⁶ Because even though the volunteers of the ‘right to die’ societies are non-physicians, the applicant are examined by their physicians. For example, those who travel to Switzerland to die with the assistance of Dignitas have to provide a medical certificate that discloses the competence and health history of the applicant. This is one of the requirements of ‘right to die’ societies that apply in all cases foreigners as well as their residents.

⁷⁰⁷ Griffiths John, Weyers Heleen and Adams Maurice. (2008) *Euthanasia and law in Europe*. Oxford and Portland, Oregon: Hart Publishing. p. 473.

⁷⁰⁸ *Ibid.*, at p. 481.

Apart from the above set requirements, the academy also states that “...‘the final act in the process leading to death must always be undertaken by the patient him or herself’ and thereby clearly reject euthanasia in any circumstances”⁷⁰⁹.

Presumably, in the cases where doctor is not willing to provide help i.e. the doctor is unwilling to write a prescription, other sources are used by the ‘right to die’ societies. As far as the place where such an action can be performed is concerned, it is open to the individual, unless it is organised through one of the societies. As long as such an action is not performed in a banned institution or hospital. Most of the hospitals in Switzerland do not permit assistance in suicide on their premises. Nevertheless, in 2000, “the Zurich City Council decided to lift an existing ban on assisted suicide in nursing homes”.⁷¹⁰ At the same time the council reiterated that assistance in suicide is not allowed in the city hospitals.

However, it has been noted:

“In 2006, the Lausanne University Hospital decided to allow right-to-die societies on to their premises to help terminally ill, non-ambulatory patients who seek suicide assistance but are unable to leave the hospital”.⁷¹¹

Furthermore, another hospital, the Zurich Cantonal University Hospital, which does not entertain this kind of activity on their premises, reaffirmed the ban in 2007 and it adopted a policy of ‘studied neutrality’. According to this policy, no health care professional currently working at the Zurich University Hospital is allowed to directly engage in assistance. However, if a competent patient seeks assistance from a ‘right to die’ society from outside the hospital walls, he or she should not be prevented from seeking assistance. Such a patient has, as in any other circumstances, the right to a report. This report gives medical information

⁷⁰⁹ *Ibid.*, at p. 474.

⁷¹⁰ *Ibid.*

⁷¹¹ *Ibid.*

such as the diagnosis and prognosis and, if necessary, the patient can be transported by ambulance to a facility of his or her choosing, including a 'right to die' society.⁷¹²

Clearly, there is no uniform regime. Furthermore, there are no set guidelines or requirements stated by either the criminal law, or by any special provision of legal jurisprudence. The only relevant condition within the criminal law is under section 115. This condition is that the assistance ought to be for an altruistic purpose. The requirement of competence is implied from the nature of the act itself. The existence of the negative right to die is legally open to all, including foreigners as seen above.

It is suggested that this approach is much more progressive in comparison to the approaches taken by the Netherlands and the State of Oregon. The Swiss model not only establishes the concept of a person's right to die, which plays a major role in the non-prosecution of the person who assists,⁷¹³ but it has also effectively 'de-medicalised' death. Furthermore, it has made the whole process transparent.⁷¹⁴ Under Swiss law, no medical precondition is required to assist another person in suicide.⁷¹⁵ Similarly, a doctor's participation is not necessary.⁷¹⁶ However, a doctor is free, like any other citizen of the country, to

⁷¹² *Ibid.*

⁷¹³ Bossbard G. and others. (2002) 'Open regulation and practice in assisted suicide'. *Swiss medical weekly*, Vol. 132, p. 527. It is relevant to note that in the Netherlands the basis for non-prosecution lies in the conflict of the physician's duties to respect life versus to relief of suffering and in Oregon it is like in Switzerland (right to die concept).

⁷¹⁴ Ziegler S.J. (2009) 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for its Potential to enhance oversight and demedicalize the dying process'. *Journal of Law, Medicine and Ethics*, Vol. 37, p. 319.

⁷¹⁵ Fischer S. and others. (2009) 'Reasons why people in Switzerland seek assisted suicide: the view of patients and physicians'. *Swiss Medical Weekly*, Vol. 139, p. 333.

⁷¹⁶ As already seen any person may assist in suicide in Switzerland which dates back to 1981 when attitudes of the people towards suicide was motivated by honour and romance. This is when the Swiss federal government declared suicide not to be a crime and assisted suicide would be a crime unless the author (assistant) is motivated by selfish reasons. At this time, motives related to health were not a concern and hence the involvement of the physician was not required. See Mauron Alex and Hurst Samia A. (2003) 'Education and Debate'. Assisted Suicide and euthanasia in Switzerland: allowing a role for non-physicians'. *BMJ*, Vol. 326, p. 271.

assist in suicide if he or she so desires.⁷¹⁷ Although ‘right to die’ societies generally prefer and rely in favour of a requirement for the assistance of a doctor in order to prescribe a lethal dose of barbiturates (sodium pentobarbital)⁷¹⁸, it is arguable that the ‘right to die’ societies could rely on other sources or means to achieve this, as discussed in chapter 1 of the thesis. However, the possible reason why ‘right to die’ societies favour doctor’s assistance is that the provision of a controlled substance ensures a quick and painless death. As seen above in many scenarios, it is the family doctor of the patient who provides the lethal prescription. The person is then able to end his or her life, with the help of the ‘right to die’ societies, at home, in an institution or in a nursing home.⁷¹⁹

Any possible exploitation of the above right to die is safeguarded by the demedicalisation of death and the direct involvement of the authorities. Possible cases of abuse are also prevented by keeping the concepts of competence and motive at the heart of the practice of assisted suicide. For example, all of the organisations that are set up to provide assistance in suicide are non-profit organisations.⁷²⁰ Hence, there is little or no potential for commercial exploitation of the issue. Similarly, measures⁷²¹ have been taken to ensure abuse-free practice of assisted suicide in the country. These measures have proven successful, except

⁷¹⁷ Mauron Alex and Hurst Samia A. (2003) ‘Education and Debate’. Assisted Suicide and euthanasia in Switzerland: allowing a role for non-physicians’. *BMJ*, Vol. 326, p. 272.

⁷¹⁸ As it is, controlled substance and one can avail of it only with the prescription of a doctor. See Ziegler S.J. (2009) ‘Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for its Potential to enhance oversight and demedicalize the dying process’. *Journal of Law, Medicine and Ethics*, Vol. 37, p.333.

⁷¹⁹ Bosshard G. and others. (2008) ‘Suicide assisted by two Swiss right to die organisations’. *J Med Ethics*, Vol. 34, pp. 810-811. It is to be noted that all foreigners who are assisted by Dignitas for example die in a hotel room or a flat rented by Dignitas.

⁷²⁰ ‘Organised assisted suicide to be regulated’.

<http://www.ejpd.admin.ch/ejpd/en/home/dokumentation/mi/2009/2009-10-28.html> ; Assisted Suicide statistics: the numbers Dignitas helps to die, by country. 25 Feb. 2010, Guardian.co.uk

⁷²¹ Such as follows: a) the barbiturate is obtainable only on a doctor’s prescription; b) it is never directly handed to the applicant or available for supplies, but only handed to doctor, right to die societies or the attendant; c) applicant can postpone or cancel time and date of planned assisted suicide; d) applicant is required to sign a declaration in front of the witnesses registered on file; d) the attendant calls the police on the site once death occurs to conduct investigation and required formalities as per the law on non-natural death; e) the attendant possess required knowledge to perform the task. See Baezner-Sailer Elke. (2008) ‘Physician-assisted suicide in Switzerland: A personal report’ in *Giving Death a helping hand: Physician-assisted suicide and public policy. An International Perspective*, Vol. 38, pp. 141-148.

in the instances of development of ‘death tourism’. This ‘death tourism’ has created anger among the residents of Switzerland and its authorities.⁷²² The main cause of this concern is the financial burden that Swiss taxpayers and its authorities are forced to incur. Elke has noted that the procedural cost to the state, is CHF 3,000 – 5,000 per assisted suicide.⁷²³ It has been stated:

“According to the public prosecutor’s office, the accumulated costs for assisting foreigners in a suicide in the Canton of Zurich amount to CHF 273,000 per annum!”⁷²⁴

This financial problem, coupled with the concern that ‘right to die’ societies such as Dignitas are increasingly testing the boundaries of assisted suicide, has given reason for the Swiss authorities to reflect on the current laws governing assisted suicide. Although the Federal council is not in favour of ending the country’s liberal laws, it is currently in favour of limiting the practice of assisted suicide. For instance, it has proposed that the government should impose guidelines and restrictions as to when, and under what conditions, a person can be assisted in suicide.⁷²⁵

Hence, although the Swiss law on assisted suicide has not led to abuse in cases of vulnerable people, it has indirect implications on the residents of the country who are forced to bear the financial burden towards those who contribute nothing to the country’s economy except in paying compensation to Dignitas for providing them with the service.

Furthermore, as far as the principle of sanctity of life is concerned, it has been stated that the Federal council “believes in the paramount importance of

⁷²² Baezner-Sailer Elke. (2008) ‘Physician-assisted suicide in Switzerland: A personal report’ in *Giving Death a helping hand: Physician-assisted suicide and public policy. An International Perspective*, Vol. 38, pp. 141-148.

⁷²³ *Ibid.*, at p. 145.

⁷²⁴ *Ibid.*

⁷²⁵ *Ibid.*

protecting human life”⁷²⁶. However, as argued by Mauron and Hurst, in most cases “the permissibility of altruistic assisted suicide cannot be overridden by a duty to save life”⁷²⁷.

Having examined the liberal foreign regimes in relation to assisted suicide and euthanasia, in the following part of the thesis an attempt is made to discover whether these foreign regimes provide any information that could potentially inform the debate surrounding the strict regime in England and Wales. In doing so, the concluding part of the thesis will try to answer the following questions. Is the fear of abuse groundless? Are there different ways to respond to fears of abuse? Have the above regimes experienced further problems resulting from liberalisation of the law? Do other countries have different views on the sanctity of life in comparison to the territories of England and Wales?

⁷²⁶ ‘Organised assisted suicide to be regulated’.

<http://www.ejpd.admin.ch/ejpd/en/home/dokumentation/mi/2009/2009-10-28.html>

⁷²⁷ Mauron A. and Hurst Samia A. (2003) ‘Education and Debate’. Assisted Suicide and euthanasia in Switzerland: allowing a role for non-physicians’. *BMJ*, Vol. 326, p. 271.

Conclusion

What can the Jurisdiction of England and Wales learn from the Foreign Regimes discussed above?

As discussed in chapters 1 and 2 of the thesis, the restrictive approach towards assisted suicide and euthanasia, taken under the law of England and Wales, is currently being relaxed to some extent. It is clear that the judges in recent cases have tried to balance the ethics of personal autonomy and human suffering with the sanctity of life. For instance, it is clear that the DPP's guidelines have made it possible for people in England and Wales to take assistance in suicide without the fear of prosecution of the person who provides assistance.⁷²⁸ However, the person who assists must ensure that his or her conduct does not go beyond assisted suicide. Furthermore, his or her motive must be good, in order not to fall foul of the existing law covering assisted suicide.⁷²⁹ On the other hand, the courts have openly accepted voluntary passive euthanasia, non-voluntary passive euthanasia and the provision of care at the end of life i.e. making the dying process painless.⁷³⁰

However, unlike the situation in Switzerland, the conduct of the assistant in suicide cases in England and Wales typically attracts criminal liability, irrespective of his or her good motive. Furthermore, doctors whose action to

⁷²⁸ For detail analysis on this aspect, see chapter 1 of the thesis.

⁷²⁹ It is relevant to note that the method adopted by the DPP via guidance to remove certain types of deeds or actions such as booking tickets, escorting the applicant to Switzerland to die with assistance, or helping in making other arrangements which could come under 'trivial' assistance, would include far more interventionist tactics that could be deemed 'lawful' by virtue of the DPP's discretion. For example, on 24th May 2010, the DPP in the case of Mr Bateman, who assisted his wife to die by helping her put a plastic bag over her head and to put together the helium gas apparatus, decided not to bring prosecution against Mr Bateman in the public interest. The DPP said, although there was sufficient evidence to charge Mr Bateman with the offence of assisted suicide, his actions were purely motivated by compassion. It was found that his wife performed the last act that resulted in her death. Mrs Bateman tightened the strings of the bag and turned on the helium supply. See 'No charges in West Yorkshire assisted death case'. http://news.bbc.co.uk/1/hi/england/bradford/8701173.stm?utm_source=twitterfeed&utm_medium=twitter

⁷³⁰ This practice has given way to statuses as seen in chapter 2 of the thesis.

relieve pain, results in the death of the patient, or a shortening of their life, still face risk of prosecution of murder or attempted murder or even assisted suicide. Conversely, the law remains incoherent. The guidance provided by the DPP addresses part of this problem, but it still leaves areas of ambiguity which could penalise bona fide assistance. Hence, there is a need under the current law of England and Wales to provide legal security to those who would assist in suicide of another as well as to doctors whose conduct may lead to foreseen, but unintended consequences. These consequences may include causing death while treating the pain and suffering of the patient. In the same way, it is necessary to address the issue of 'act or omission distinction' that is currently used as a shield to justify the conduct of doctors and to protect them from any kind of criminal responsibility.

As seen above, doctors in the Netherlands have faced similar problems as doctors in England and Wales. Doctors in the Netherlands begun to assist their patients (on request) in dying by active means. However, the model adopted by the Netherlands is most liberal in the sense that it not only permits assisted suicide but also euthanasia. The impact of this model is far reaching in the sense that it sets no limit as to who can be assisted in suicide or in the termination of life as long as the patient consents and he or she suffers unbearably and hopelessly. As a result, old people tired of life⁷³¹ and depressed people⁷³² have been helped to die under the new law, as well as seriously ill people. Although the guidelines set by the DPP resemble the criteria set under the statutory Act 2001, the jurisdiction of England and Wales will probably not find the Dutch model suitable for the reason that it permits deliberate killing, the prohibition of which is said to form a corner stone of the criminal law of England and Wales.⁷³³ Similarly, setting no speed limit on who can be assisted in dying, except requiring that the suffering must be

⁷³¹ Moller M. and Huxtable R. (2001) 'Euthanasia in the Netherlands: the case of "life fatigue"'. *New Law Journal*, Vol. 151, pp. 1600-1601; Huxtable R. and Moller M. (2007) 'Setting a Principled Boundary?' Euthanasia as a Response to Life Fatigue. *Bioethics*, Vol.21, pp. 117-126.

⁷³² *Ibid.*

⁷³³ See 'Extracts from the Report of the House of Lords Select Committee on Medical Ethics' in (eds) Keown J. (1995) *Euthanasia Examined: ethical, clinical and legal perspective*. Cambridge: Cambridge University Press. p. 102.

unbearable and hopeless, makes it difficult to control the practices. As a result, allowing active killing under the Dutch eligibility criteria would probably mean a wide liberalisation of the law of assistance in ending life in England and Wales.

As far as the State of Oregon is concerned, this model seems to deal with the issues surrounding the current debate on assisted suicide more carefully. The Oregon model has embraced the value of life from the perspective of quality of life. Furthermore, this model treats assisting in dying as a treatment, which is optional, and it is available to the terminally-ill *only*. Oregon has set safeguards to prevent abuse by limiting the level of degree of help provided i.e. only with prescription. It has also limited the categories of patients who can avail of this option i.e. only those who suffer from terminal illness. As a result, less people are able to make use of it. Furthermore, some of these patients do not in fact make use of it and most of them die in a hospice under care. Hence, this model could prove to be more suitable and safe when compared with the Netherlands. However, this model also has drawbacks in relation to dealing with what exactly morally justifies cases of assisted suicide in the State of Oregon. Is it suffering or autonomy? If it is suffering, then all who suffer should be able to have this option available to them and if it is autonomy, then irrespective of whether one suffers or not the patient should have the option available to him or her. Hence, this model may give rise to discrimination if it is adopted as it is into the law of England and Wales.

Finally, the Swiss model is the one that most clearly upholds the liberty and autonomy of the individual. This is a fairer system compared to the model chosen by the Netherlands and the State of Oregon. The Swiss model not only respects individual autonomy and humanity, but it also shows respect for human life by not allowing deliberate killing. In addition, it provides a clear and transparent system that effectively de-medicalises death. In this way, the scope for potential abuse is reduced. However, death tourism is an increasing concern in Switzerland. The authorities of the country are currently preparing to deal with this concern.

Other than this, Switzerland appears to deal with the practice of assisted suicide more efficiently and openly than the other two jurisdictions. Furthermore, the Swiss model has provided for this situation without implicating a third person in the death of the person, nor depriving people who can do very little to help themselves of availing of assistance.⁷³⁴

Which Regime would best suit the current situation of England and Wales?

Although the current position of England and Wales on assisted suicide and euthanasia substantially overlaps with the practice of the Netherlands prior to the enactment of the statutory Act 2001, it most resembles the Swiss model which prohibits euthanasia (like England and Wales), but allows assistance in suicide with altruistic motive, the condition which also forms part of the DPP's guidelines on assisted suicide in England and Wales. Both the DPP's guidelines and the SPC, make motive of the person who assists in suicide of another the most relevant aspect. In each case the motive establishes the criminal responsibility of the author. Although, motives does not correspond with autonomy, unless motive is defined as the desire to respect the wishes of the person making the request. The use of it (i.e. motive) in this context, in both jurisdictions could mean a desire not *only* to help, but a desire *also* to respect the wishes of the person who make the request. This is visible from the situation of Daniel James and also from other scenarios discussed in the chapter 1 of the thesis. As far as Switzerland is concerned, as stated earlier, the practice of providing assistance in suicide originated from the concept of honourable deed. Those who desired to end their life by way of suicide, their wishes were respected by providing them assistance in doing so.

The Swiss regime addresses the concerns faced by England and Wales. It not only respects individual autonomy by providing assistance in suicide, but it also

⁷³⁴ This is done with the help of the modern technology and sometimes by lifting a glass to the mouth of the person who is assisted to die. See Ziegler S.J. (2009) 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for its Potential to enhance oversight and demedicalize the dying process'. *Journal of Law, Medicine and Ethics*, Vol. 37, p. 322.

ensures that the value of life is not undermined by limiting its freedom to patients approaching the end of life⁷³⁵ and by restricting a right to die as a negative right and not a positive right⁷³⁶. Similarly, it has addressed the fear of abuse by making its system transparent and ensuring that the CJS is directly involved in situations of assisted suicide. Furthermore, the involvement of the ‘right to die’ societies has made it possible to help even those patients who can do very little to help themselves commit suicide. The role played by the ‘right to die’ societies helps others to have control over place and time of their death. This makes dying more humane and dignified.

As a result, this model fulfils the needs of most of the people who desire to have control over time and place of their death. At the same time, it proves the need for euthanasia is unnecessary as long as a person who desires to die is able to either swallow the lethal drug or is able to turn on the button of intravenous tube. In this way, a person who is assisted in dying would not only be competent at the time of his death, but he or she would also be in a position to have control over his death. If this option is made available to the people in England and Wales, it will not only help people die a dignified death with assistance, but it would also do away with the scope for covert euthanasia as well as the need for euthanasia.

Hence, this thesis ultimately proposes the adoption of the Swiss model into England and Wales. However, in order to adopt this model, the current guidelines as promulgated by the DPP, would require modification and codification. By maintaining the *status quo* of the existing law on assisted suicide and euthanasia, parliament should aim to enact a special law in relation to assisted suicide. This special law could be drafted by codifying the existing guidelines promulgated by the DPP. However, as said earlier, some necessary amendments and insertions would have to be undertaken in order to ensure adequate protection, safeguards and respect for human life. At the same time, the law could ensure that a person in

⁷³⁵ This limit is imposed by the Swiss Academy of Medical Science. See pp. 140-141 of the thesis.

⁷³⁶ See p. 136 of the thesis.

the circumstances described above would die a 'good death' i.e. one that is easy and painless as well as humane and dignified.

Appendix A

Policy for Prosecutors in respect of Cases of Encouraging and Assisting Suicide

Issued by the Director of Public Prosecutions on 25 February 2010.

Introduction

1. A person commits an offence under section 2 of the Suicide Act 1961 if he or she does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and that act was intended to encourage or assist suicide or an attempt at suicide. This offence is referred to in this policy as "encouraging or assisting suicide". The consent of the Director of Public Prosecutions (DPP) is required before an individual may be prosecuted.
2. The offence of encouraging or assisting suicide carries a maximum penalty of 14 years' imprisonment. This reflects the seriousness of the offence.
3. Committing or attempting to commit suicide is not, however, of itself, a criminal offence.
4. This policy is issued as a result of the decision of the Appellate Committee of the House of Lords in *R (on the application of Purdy) v Director of Public Prosecutions* reported at [2009] UKHL45, which required the DPP "to clarify what his position is as to the factors that he regards as relevant for and against prosecution" (paragraph 55) in cases of encouraging and assisting suicide.
5. The case of *Purdy* did not change the law: only Parliament can change the law on encouraging or assisting suicide.
6. This policy does not in any way "decriminalise" the offence of encouraging or assisting suicide. Nothing in this policy can be taken to amount to an assurance that a person will be immune from prosecution if

he or she does an act that encourages or assists the suicide or the attempted suicide of another person.

7. For the purposes of this policy, the term "victim" is used to describe the person who commits or attempts to commit suicide. Not everyone may agree that this is an appropriate description but, in the context of the criminal law, it is the most suitable term to use.
8. This policy applies when the act that constitutes the encouragement or assistance is committed in England and Wales; any suicide or attempted suicide as a result of that encouragement or assistance may take place anywhere in the world, including in England and Wales.

The investigation

9. The police are responsible for investigating all cases of encouraging or assisting suicide. The Association of Chief Police Officers (ACPO) intends to provide all Police Forces with guidance on dealing with cases of encouraging or assisting suicide soon after the publication of this policy. Prosecutors who are involved in such cases should ensure that they familiarise themselves fully with the ACPO guidance when it is available.
10. The ACPO guidance will specifically recommend that police officers liaise with the reviewing prosecutor to seek his or her advice at an early stage and throughout their enquiries so that all appropriate lines of investigation, in the context of the individual case, are discussed and agreed by the Prosecution Team. This is to ensure that all relevant evidence and information is obtained to allow a fully informed decision on prosecution to be taken.
11. The reviewing prosecutor must ensure that he or she has sufficient evidence and information in order to reach a fully informed decision about the evidential and public interest stages of the Full Code Test (see paragraph 13 below). The reviewing prosecutor will need detailed information about the mental capacity of the person who committed or attempted to commit suicide and about any relevant public interest factor.

12. The reviewing prosecutor should only make a decision when he or she has all the relevant material that is reasonably capable of being obtained after a full and thorough investigation. The reviewing prosecutor should tell the police if any further evidence or information is required before a decision can be taken.

The decision-making process

13. Prosecutors must apply the Full Code Test as set out in the Code for Crown Prosecutors in cases of encouraging or assisting suicide. The Full Code Test has two stages: (i) the evidential stage; and (ii) the public interest stage. The evidential stage must be considered before the public interest stage. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be. Where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.
14. The DPP will only consent to a prosecution for an offence of encouraging or assisting suicide in a case where the Full Code Test is met.

The evidential stage

15. Section 2 of the Suicide Act 1961 was amended with effect from 1 February 2010. It is therefore essential that prosecutors identify the timing of any act of encouragement or assistance that it is alleged supports the bringing of a criminal charge relating to the suicide or attempted suicide of the victim.
16. Where the act of encouragement or assistance occurred on or after 1 February 2010, section 2 of the Suicide Act 1961 as amended by section 59 and Schedule 12 of the Coroners and Justice Act 2009 applies.
17. In these cases, for the evidential stage of the Full Code Test to be satisfied, the prosecution must prove that:

- the suspect did an act capable of encouraging or assisting the suicide or attempted suicide of another person; and
 - the suspect's act was intended to encourage or assist suicide or an attempt at suicide.
18. "Another person" referred to in section 2 need not be a specific person and the suspect does not have to know or even be able to identify that other person. The offence of encouraging or assisting suicide can be committed even where a suicide or an attempt at suicide does not take place.
 19. It is no longer possible to bring a charge under the Criminal Attempts Act 1981 in respect of a section 2 Suicide Act 1961 offence by virtue of paragraph 58 of Schedule 21 of the Coroners and Justice Act 2009. Attempts to encourage or assist suicide are now captured by the language of section 2, as amended.
 20. In the context of websites which promote suicide, the suspect may commit the offence of encouraging or assisting suicide if he or she intends that one or more of his or her readers will commit or attempt to commit suicide.
 21. Section 59(4) of the Coroners and Justice Act 2009 adds section 2A into the Suicide Act 1961.
 22. Section 2A provides that a person who arranges for someone else to do an act capable of encouraging or assisting the suicide or attempted suicide of another person will also be liable alongside that second person for the encouragement or assistance.
 23. Section 2A also makes it clear that a person may encourage or assist another person even where it is impossible for the actual act undertaken by the suspect to provide encouragement or assistance - for example, where the suspect believes he or she is supplying the victim with a lethal drug which proves to be harmless.
 24. Finally, section 2A also makes it clear that a suspect who threatens or puts pressure on the victim comes within the scope of the offence under section 2.

25. The amendments to section 2 of the Suicide Act 1961 are designed to bring the language of the section up-to-date and to make it clear that section 2 applies to an act undertaken via a website in exactly the same way as it does to any other act.
26. Prosecutors should consult the Ministry of Justice Circular 2010/03 which provides further detail about the changes made to section 2 of the Suicide Act.
27. Where the act in question occurred on or before 31 January 2010, the former offence of aiding, abetting, counselling or procuring the suicide of another, or an attempt by another to commit suicide, contrary to the then section 2 of the Suicide Act 1961, applies.
28. In these cases, for the evidential stage to be satisfied, the prosecution must prove that:
- the victim committed or attempted to commit suicide; and
 - the suspect aided, abetted, counselled or procured the suicide or the attempt.
29. The prosecution also has to prove that the suspect intended to assist the victim to commit or attempt to commit suicide and that the suspect knew that those acts were capable of assisting the victim to commit suicide.
30. In relation to an act done prior to 1 February 2010, it is possible in law to attempt to assist a suicide. Such an offence should be charged under the Criminal Attempts Act 1981.
31. This enables an individual to be prosecuted even where the victim does not go on to commit or attempt to commit suicide. Whether there is sufficient evidence of an attempt to assist suicide will depend on the factual circumstances of the case.

Encouraging or assisting suicide and murder or manslaughter distinguished

32. The act of suicide requires the victim to take his or her own life.

33. It is murder or manslaughter for a person to do an act that ends the life of another, even if he or she does so on the basis that he or she is simply complying with the wishes of the other person concerned.
34. So, for example, if a victim attempts to commit suicide but succeeds only in making him or herself unconscious, a person commits murder or manslaughter if he or she then does an act that causes the death of the victim, even if he or she believes that he or she is simply carrying out the victim's express wish.

Explaining the law

35. For the avoidance of doubt, a person who does not do anything other than provide information to another which sets out or explains the legal position in respect of the offence of encouraging or assisting suicide under section 2 of the Suicide Act 1961 does not commit an offence under that section.

The public interest stage

36. It has never been the rule that a prosecution will automatically follow where the evidential stage of the Full Code Test is satisfied. This was recognised by the House of Lords in the *Purdy* case where Lord Hope stated that: "[i]t has long been recognised that a prosecution does not follow automatically whenever an offence is believed to have been committed" (paragraph 44). He went on to endorse the approach adopted by Sir Hartley Shawcross, the Attorney General in 1951, when he stated in the House of Commons that: "[i]t has never been the rule... that criminal offences must automatically be the subject of prosecution".
37. Accordingly, where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.

38. In cases of encouraging or assisting suicide, prosecutors must apply the public interest factors set out in the Code for Crown Prosecutors and the factors set out in this policy in making their decisions. A prosecution will usually take place unless the prosecutor is sure that there are public interest factors tending against prosecution which outweigh those tending in favour.
39. Assessing the public interest is not simply a matter of adding up the number of factors on each side and seeing which side has the greater number. Each case must be considered on its own facts and on its own merits. Prosecutors must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment. It is quite possible that one factor alone may outweigh a number of other factors which tend in the opposite direction. Although there may be public interest factors tending against prosecution in a particular case, prosecutors should consider whether nonetheless a prosecution should go ahead and for those factors to be put to the court for consideration when sentence is passed.
40. The absence of a factor does not necessarily mean that it should be taken as a factor tending in the opposite direction. For example, just because the victim was not "under 18 years of age" does not transform the "factor tending in favour of prosecution" into a "factor tending against prosecution".
41. It may sometimes be the case that the only source of information about the circumstances of the suicide and the state of mind of the victim is the suspect. Prosecutors and investigators should make sure that they pursue all reasonable lines of further enquiry in order to obtain, wherever possible, independent verification of the suspect's account.
42. Once all reasonable enquiries are completed, if the reviewing prosecutor is doubtful about the suspect's account of the circumstances of the suicide or the state of mind of the victim which may be relevant to any factor set out

below, he or she should conclude that there is insufficient information to support that factor.

Public interest factors tending in favour of prosecution

43. A prosecution is more likely to be required if:

1. the victim was under 18 years of age;
2. the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;
3. the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;
4. the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
5. the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;
6. the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;
7. the suspect pressured the victim to commit suicide;
8. the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;
9. the suspect had a history of violence or abuse against the victim;
10. the victim was physically able to undertake the act that constituted the assistance him or herself;
11. the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication;
12. the suspect gave encouragement or assistance to more than one victim who were not known to each other;

13. the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;
 14. the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care;
 15. the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;
 16. the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.
44. On the question of whether a person stood to gain, (paragraph 43(6) see above), the police and the reviewing prosecutor should adopt a common sense approach. It is possible that the suspect may gain some benefit - financial or otherwise - from the resultant suicide of the victim after his or her act of encouragement or assistance. The critical element is the motive behind the suspect's act. If it is shown that compassion was the only driving force behind his or her actions, the fact that the suspect may have gained some benefit will not usually be treated as a factor tending in favour of prosecution. However, each case must be considered on its own merits and on its own facts.

Public interest factors tending against prosecution

45. A prosecution is less likely to be required if:
- a. the victim had reached a voluntary, clear, settled and informed decision to commit suicide;
 - b. the suspect was wholly motivated by compassion;

- c. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
- d. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
- e. the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;
- f. the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

- 46. The evidence to support these factors must be sufficiently close in time to the encouragement or assistance to allow the prosecutor reasonably to infer that the factors remained operative at that time. This is particularly important at the start of the specific chain of events that immediately led to the suicide or the attempt.
- 47. These lists of public interest factors are not exhaustive and each case must be considered on its own facts and on its own merits.
- 48. If the course of conduct goes beyond encouraging or assisting suicide, for example, because the suspect goes on to take or attempt to take the life of the victim, the public interest factors tending in favour of or against prosecution may have to be evaluated differently in the light of the overall criminal conduct.

Handling arrangements

- 49. Cases of encouraging or assisting suicide are dealt with in Special Crime Division in CPS Headquarters. The Head of that Division reports directly to the DPP.

50. Any prosecutor outside Special Crime Division of Headquarters who receives any enquiry or case involving an allegation of encouraging or assisting suicide should ensure that the Head of Special Crime Division is notified.
51. This policy comes into effect on 25 February 2010 and supersedes the Interim Policy issued on 23 September 2009.

Bibliography

Books and Journal articles

- Adams M. and Nys H. (2003) 'Comparative Reflections on the Belgian Euthanasia Act 2002'. *Medical Law Review*, Vol. 11, pp. 353-376.
- Arlidge A. (2000) 'The Trial of Dr David Moor'. *Criminal Law Review*, Jan, pp. 31-40.
- Ashworth A. (2009) *Principles of Criminal Law*'. Oxford: Oxford University Press.
- Bar W., Ulrich Esther and Bosshard G. (2003) '748 cases of Suicide assisted by a Swiss right-to-die organisation'. *Swiss Medical Weekly*, Vol. 133, pp. 310-317.
- Battin M.P. (2008) 'Safe, Legal Rare? Physician-Assisted Suicide and Cultural Change in the Future' in Birnbacher Dieter and Dahl Edgar (eds). *Giving Death a Helping Hand: Physician-Assisted Suicide, Terminal Sedation and Public Policy. An International Perspective*. The Netherlands: Springer, Vol. 36.
- _____ (2005) *Ending Life: Ethics and the way we die*. Oxford: Oxford University Press.
- Bennion F. (2009) 'Assisted Suicide: A Constitutional Change'. *Criminal Law and Justice Weekly*. Vol. 173, pp. 519-523.
- Bennett J. (1980) 'Morality and Consequences'. The Turner Lectures on Human Values Delivered at Brasenose College, Oxford University. May 9th, 16th and 23rd.

_____ (1966) 'Whatever the Consequences'. *Analysis*, Vol. 26, No.3, pp. 83-102.

Biggs H. (2001) *Euthanasia, Death with Dignity and the Law*. Oxford; Portland and Oregon: Hart Publishing.

Bossbard G., Ziegle S.J., Furter M., Imhof R.M., Imhof L., Huber C.A. and Fischer S. (2008) 'Suicide assisted by two Swiss right-to-die organisations'. *J Med Ethics*, Vol. 34, pp. 810-814.

Bossbard Georg, Fisher Susanne and Bar Walter. (2002) 'Open regulation and practice in assisted suicide'. *Swiss medical weekly*, Vol. 132, pp. 527-534.

Boyle J.M. (1980) 'Toward Understanding the Principle of Double Effect'. *Ethics*, Vol. 90, No.4, pp. 527-538.

Burgess J.A. (1993) 'The great slippery-slope argument'. *Journal of Medical Ethics*, Vol. 19, pp. 169-174;

Burns Seamus. (2008) 'Public: Fettered Flexibility?' *New Law Journal*, Vol. 158, p. 1708.

Childress J.F. (1980) 'Negative and Positive Rights'. *The Hastings Center Report*, Vol. 10, No. 1, p. 19.

Chrispin E., English V., Harrison C., Sheather J. and Sommerville A. (2009) 'Ethics Briefings'. *J. Med. Ethics*, Vol. 35, pp. 335-336.

Cohen-Almagor R. (2001) *The Right to Die with Dignity: An argument in ethics, medicine, and law*. New Brunswick, New Jersey, and London: Rutgers University Press.

- Coggon John. (2006) 'Could the Right to Die with Dignity represent a New Right to Die in English Law?' *Medical Law Review*, Vol. 14, pp. 219-237.
- Cotterrell R. (1992) *The Sociology of Law: An Introduction*. London; Dublin; Edinburgh: Butterworths.
- Dahl E. and Levy N. (2006) 'The Case for Physician assisted suicide: how ca it possibly be proven?' *J Med Ethics*, Vol. 32, pp. 335-338.
- Dave Powell. (2009) 'Assisting Suicide and the Discretion to Prosecute: Hard Cases and Good law?' *The Journal of Criminal Law*, Vol. 73, pp. 8-11.
- Devis M., Croall H. and Tyrer J. (2010) *Criminal Justice*. Harlow; England; etc.,: Pearson Educational Ltd.
- De Haan J. (2002) 'The New Dutch Law on Euthanasia'. *Medical Law Review*, Vol. 10, pp. 57-75.
- Devettere R. (1995) *Practical Decision Making in Health Care Ethics*. Washington, D.C.: Georgetown University Press.
- Devlin Patrick. (1985) *Easing the Passing: The Trial of Dr John Bodkin Adams*. London: The Bodley Head. pp. 171-172.
- Dickenson D., Johnson M. and Katz J.S. (eds), (2000) *Death, Dying and Bereavement*. Second Edition. London; Thousand Oaks and New Delhi: SAGE Publications.
- Doyal Len. (2001) 'Why should euthanasia and physician assisted suicide should be legalised'. *British Medical Journal*, Vol. 323, 1079-80.

Draper H. (1998) 'Euthanasia'. In Chadwick R. (Ed.) *Encyclopaedia of Applied Ethics*, Vol. I. San Diego, Academic Press.

Dworkin G., Frey R.G. and Bok S. (eds), (1998) *Euthanasia and Physician-assisted Suicide*. Cambridge: Cambridge University Press.

Dworkin R. (ed), (1977) *The Philosophy of Law*. Oxford: Oxford University Press.

_____ (1994) *Life's Dominion: An argument about Abortion, Euthanasia, and Individual Freedom*. New York: Vintage Books.

Dziewas R., Kellinghaus C. and Soros P. (2003) 'The Principle of Double-Effect in a Clinical Context'. *Poiesis Prax*, Vol. 1, pp. 211-218.

Easton Susan. (2008) 'Constructing Citizenship: Making Room for Prisoners' Rights'. *Journal of Social Welfare and Family Law*, Vol. 30, No. 2, pp. 127-146.

FaFrance Arthur B. (2008) 'Physician Assisted Death: The Oregon Experience'. *Wyoming L. Rev*, Vol. 8, pp. 333 – 346.

Fenigsen Richard. (1989) 'A Case Against Dutch Euthanasia'. *The Hastings Center Report*, Vol. 19, pp. 22-30.

Finnis J.M. (1993) 'Bland: Crossing the Rubicon? *Law Quarterly Review*, Vol. 109, pp. 329-337.

_____ (1991) 'Intention and Side-Effects' in Frey R.G. and Morris C.W. (eds) *Liability and Responsibility: Essays in Law and Morals*. Cambridge: Cambridge University Press.

- Fischer S. Huber Carola A., Furter M., Imbof L., Imbof R. M., Schwarzenegger C., Ziegler S. and Bossbard G. (2009) 'Reasons why people in Switzerland seek assisted suicide: the view of patients and physicians'. *Swiss Medical Weekly*, Vol. 139, pp. 333-338.
- Foot P. (1977) 'Euthanasia'. *Philosophy and Public Affairs*, Vol. 6, No. 2, pp. 85-112.
- _____ (2008) 'Safe, Legal Rare? Physician-Assisted Suicide and Cultural Change in the Future' in Birnbacher Dieter and Dahl Edgar (eds). *Giving Death a Helping Hand: Physician-Assisted Suicide, Terminal Sedation and Public Policy*. The Netherlands: Springer, Vol. 36.
- Freeman, Michael. (2002). 'Denying Death its Dominion: Thoughts on the Diane Pretty Case'. *Medical Law Review*. Vol. 10, pp. 245-270.
- Gansini L., Harvath T., Jackson Ann, Goy E.R., Miller L.L. and Delorit M.A. (2002) 'Experiences of Oregon Nurses and Social Workers with Hospice Patients who requested assistance with Suicide'. *The New England Journal of Medicine*, Vol. 347, pp. 557-563.
- Gansini L., Nelson H.D., Schmidt T.A., Kraemer D.F., Delorit M. A. and Lee M.A. (2000) 'Physician' Experiences with the Oregon Death with Dignity Act'. *The New England Journal of Medicine*, Vol. 342, pp. 557-563.
- George R. J. D., Finlay I.G. and Jeffrey D. (2005) 'Legalised euthanasia will violate the rights of vulnerable patients'. *British Medical Journal*, Vol. 331, pp. 684-685.
- Gillon Raanan. (1986) 'Acts and Omission, Killing and Letting Die'. *British*

Medical Journal, Vol.292, pp. 211-218.

Goff Robert. (1995) 'A Matter of Life and Death'. *Medical Law Review*, Vol. 3, pp. 1-21

Goss James. (2000) 'A Postscript to the Trial of Dr. David Moor'. *Criminal Law Review*, July, pp. 568-570.

Goy ER, Carlson B, Simopoulos N, Jackson A and Ganzini L. (2006) 'Determinants of Oregon hospice chaplains' views on physician-assisted suicide', *Journal Palliate Care*, Vol.22, No. 2, pp. 83-90.

Griffiths, J., Weyers, H. and Adams, M. (2008) *Euthanasia and Law in Europe*. Oxford: Oxford University Press.

Haan J.D. (2002) 'The New Dutch Law on Euthanasia'. *Medical Law Review*, Vol.10, pp. 57-75.

Hale, D.B. (Lady Justice of Appeal) (2003) 'A Pretty Pass: when is there a right to die?' *Comm. L. World Rev.* Vol. 32, pp. 1-14.

Hall M., Trachtenberg F. and Dugan E. (2005) 'The Impact on patient trust of legalising physician aid in dying'. *J Med Ethics*, Vol. 31, pp. 693-697.

Harris N.M. (2001) 'The Euthanasia Debate'. *Journal of the Royal Army Medical Corps*, Vol. 147, pp. 367-370.

Heywood, R. (2010) 'R. (on the application of Purdy) v DPP: clarification on assisted suicide'. *Law Quarterly Review*, Vol. 125, pp. 393-396.

Hirst M. (2009) 'Assisted Suicide after Purdy: The Unresolved Issue'. *Criminal*

Law Review, p. 870.

_____ (2009) 'Suicide in Switzerland: Complicity in England?' *Criminal Law Review*, p. 335.

Humphry, D. (2002) *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. Third Edition. New York: Dell Publishing.

Hurst S.A. and Mauron A. (2003) 'Assisted Suicide and Euthanasia in Switzerland: allowing a role for non-physicians'. Available at: http://www.chninternational.com/switzerland_and_assisted_suicide.htm

Huxtable R. and Moller M. (2007) 'Setting a Principled Boundary?' Euthanasia as a Response to Life Fatigue. *Bioethics*, Vol.21, pp. 117-126.

_____ (2007) *Euthanasia, Ethics and the Law: From Conflict to Compromise*. New York: Routledge. Cavendish.

_____ (2004) 'Get out of jail free? The doctrine of double effect in English law'. *Palliative Medicine*, Vol. 18, pp. 62-65.

Jackson Emily. (2010) *Medical Law: Text, Cases and Materials*. Second edition. Oxford: Oxford University Press.

_____ (2008) 'Secularism, Sanctity and the Wrongness of Killing'. *BioSocieties*, Vol. 3, pp. 125-145.

Kennedy Ian. (1997) 'Commentary 3: A Response to Lowe'. *J. Med Ethics*, Vol. 23, pp. 161-163.

Keown, J. (2009) 'In Need of Assistance?' *New Law Journal*, Vol. 159(7387)

1340-1341.

_____ (2003) 'European Court of Human Rights: Death in Strasbourg – assisted suicide, the *Pretty* case, and the European Convention on Human Rights'. *International Journal of Constitutional Law*, Vol. 1, pp. 722-730.

_____ (2002) *Euthanasia, Ethics and Public Policy*. Cambridge: Cambridge University Press.

_____ (2000) 'Beyond *Bland*: a critique of the BMA guidance on withholding and withdrawing medical treatment'. *Legal Studies*, Vol. 20, No.1, pp. 66-84.

_____ (1997) 'Restoring moral and intellectual shape to the law after *Bland*'. *Law Quarterly Review*, Vol. 113, pp. 482-503.

_____ (1995) *Euthanasia Examined: Ethical, clinical and legal perspectives*. Cambridge University Press.

_____ (1992) 'The Law and Practice of Euthanasia in the Netherlands', *Law Quarterly Review*, Vol. 108, p. 78.

Kugler I. (2003) 'Two Concepts of Omission'. *Criminal Law Forum*, Vol. 14, pp. 421-447.

_____ (2002) *Direct and Indirect Intention in the Criminal Law: And Inquiry into Degrees of Blameworthiness*. England: Ashgate.

Klein M. (2004) 'Voluntary Active Euthanasia and the Double Effect Doctrine: A View from Germany'. *Health Care Analysis*, Vol. 12, No.3, pp. 225-240.

Lady Hale Dame Brenda (2003) 'A Pretty Pass: When is there a right to die?'

Comm. L. World Rev., Vol. 32, pp. 1-14.

LaFrance A.B. (2008) 'Physician Assisted Death: From Rhetoric to Reality in Oregon'. *Wyoming Law Rev*, Vol. 8, pp 333-346

Leeuwen E.V. (2007) 'The Role of Family in Euthanasia Decision Making', *HEC Forum*, Vol. 19, No. 4, pp. 365-373.

Lowe S.L. (1997) 'The Right to Refuse Treatment is not a Right to be Killed'. *J Med Ethics*, Vol. 23, pp. 154-163.

Marker R.L. (2006) 'Euthanasia and Assisted Suicide Today'. *Society*, Vol. 43, pp. 59-67.

McGee A. (2005) 'Finding a Way Through the Ethical and Legal Maze: Withdrawal of Medical Treatment and Euthanasia'. *Medical Law Review*, Vol. 13, pp. 357-385.

McLean S. A. M. (1996) *Death, Dying and the Law*. Aldershot; Brookfield USA; Singapore; Sydney: Dartmouth.

Meisel, Alan. (2003) 'Quality of Life and End-of-Life Decisionmaking'. *Quality of Life Research*. Vol. 12, pp. 91-94.

Mitchell J.B. (2007) *Understanding Assisted Suicide*. The University of Michigan Press.

Moore M.S. (1997) *Placing Blame: A Theory of Criminal Law*. Oxford: Clarendon Press.

_____ (1993) *Act and Crime: The Philosophy of Action and its Implications*

for Criminal Law. Oxford: Clarendon Press.

Morris Dan. (2003) 'Assisted Suicide under the European Convention on Human Rights: a critique'. *European Human Rights Law Review*, Vol.1, 65-91.

Mullock Alexandra. (2009) 'Prosecutors Making (bad) Law?' *Medical Law Review*, Vol. 17, pp. 290 – 299.

Narveson, J. (1999). *Moral Matter*. Canada: Broad View Press Ltd.

Nys H. and Adams M. (2003) 'Comparative Reflection on the Belgian Euthanasia Act 2002'. *Medical Law Review*, Vol. 11, pp 353-376

Otlowski, M.F.A. (1997) *Voluntary Euthanasia and the Common Law*. Oxford: Clarendon Press.

Palmer, Henry. (1975). 'Dr. Adams' Trial for Murder' in (ed) Burke, J., and Allsop, P. *The Criminal Law Review*. London: Sweet and Maxwell Limited.

Pedain Antje. (2003) 'Intention and the Terrorist Example'. *Criminal Law Review*, Sept., pp. 579-593.

Price David. (2009) 'What Shape to Euthanasia after Bland? Historical, Contemporary and Futuristic Paradigms'. *Law Quarterly Review*, Vol. 125, pp. 142-174.

_____ (1997) 'Euthanasia, Pain relief and Double effect'. *Legal Studies*, Vol. 17, pp. 323-342.

_____ (1996) 'Assisted Suicide and Refusing Medical Treatment:

Linguistics, Morals and Legal Contortions'. *Medical Law Review*, Vol. 4, pp. 270-299.

Quill E.T., Dresser R. and Brock W.D. (1997) 'The Rule of Double Effect – A Critique of its Rule in End-of-Life Decision Making'. *The New England Journal of Medicine*, Vol. 337, pp. 1768-1771.

Richard Nobles and David Schiff. (2010) 'Disobedience to Law – Debbie Purdy's Case'. *Modern Law Review*, Vol. 73, pp. 282-304.

Sanderson, M.A. (2002) 'Pretty v United Kingdom. App. No. 2346/02'. *The American Journal of International Law*, Vol. 96, pp. 943-949.

Saini Pushpinder (1999) 'The Doctrine of Double Effect and the Law of Murder'. *Medico-legal Journal*, Vol. 67, part 3, pp. 106-120.

Scorer Richard. (2008) 'Time for Change'. *New Law Journal*, Vol. 158, p. 193.

_____ (2008) 'Assisting Death'. *New Law Journal*, Vol. 158, p. 960.

Shaw D.M. (2009) 'Euthanasia and Eudaimonia'. *J Med Ethics*, Vol. 35, pp. 530-533.

Simillis Constantinos. (2008) 'Euthanasia: A Summary of the Law in England and Wales'. *Medicine Science and the Law*, Vol. 48, pp. 191-198.

Simon C. (1998) 'Last Rights: Euthanasia, the Sanctity of Life, and the Law in the Netherlands and the Northern Territory of Australia'. *International and Comparative Law Quarterly*, Vol. 47, p. 392.

Skegg (1978) 'The Termination of Life-Support Measures and the Law of

Murder'. *Modern Law Review*, Vol. 41, pp. 423-436.

Smith J.C. (2000) 'A Comment on Moor's Case'. *Criminal Law Review*, p. 41.

Smith P. (1987) *Criminal Law Essays in Honour of J.C. Smith*. London:

Butterworths. Somerville M. (2006) 'Against Euthanasia' Arts and Opinion Magazine, Vol. 5, No. 4.

Somerville M. (2001) *'Death Talk': The Case against Euthanasia and Physician-assisted Suicide*. Montreal: McGill-Queen's University Press.

Steinbock B. (2005) 'The case for physician assisted suicide: not (yet) proven'. *J Med Ethics*, Vol. 31, pp. 235-241.

Steinbock B. and Norcross A., (eds), (1994) *Killing and Letting Die*. New York: Fordham University Press.

Steinbrook R. (2002) 'Physician-Assisted Suicide in Oregon – An Uncertain Future'. *The New England Journal of Medicine*, Vol. 346, pp. 460-464.

Stephens G.C. (2008) 'From Pretty to Purdy: Suicide and Assistance from across the border – R (on the application of Purdy) v Director of Public Prosecutions'. *Scots Law Times*, Vol. 39, pp. 267-270.

Suzanne Uniacke. (1994) *Permissible Killing: The Self-Defence Justification of Homicide*. Cambridge: Cambridge University Press.

Torda A. (2005) 'How far does a doctor's "duty of care" go?' *Internal Medicine Journal*, Vol.35, pp. 295-296.

Tripp J.H. (1997) 'Commentary.1: The Right to Refuse Treatment'. *J. Med*

Ethics, Vol. 23, pp. 159.

Tur R.H.S. (2003) 'Legislative Technique and Human Rights: the Sad Case of Assisted Suicide'. *Criminal Law Review*, Jan, pp. 3-12.

Wal G. V.D and Dillmann R.J.M. (1994) 'Euthanasia in the Netherlands', *BMJ*, Vol.308, pp. 1346-1349.

Wellman C. (1999) *Proliferation of Rights: Moral Progress or Empty Rhetoric?* US: Westview Press.

Williams Glanville (1977) 'Letters to the Editor: Switching off life support machines'. *Criminal Law Review*, p.635.

_____ (1973) 'Euthanasia'. *The Medico Legal Society*, Vol.41, pp. 14-34.

_____ (1958) *The Sanctity of life and the Criminal Law*. London: Faber and Faber Ltd.

Williams Glenys. (2007) *Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide*. London; New York: Routledge. Cavendis.

_____ (2001) 'The Principle of Double Effect and Terminal Sedation'. *Medical Law Review*, Vol. 9, pp. 41-53.

Wilson William. (2008) *Criminal Law: Doctrine and Theory*. Third Edition. England; New York etc: Pearson Longman.

_____ (2002) *Central Issues in Criminal Theory*. Oxford-Portland: Hart

Publishing.

_____ (1995) 'Is life sacred?' *Journal of Social Welfare and Family Law*, Vol. 17, No.2, pp. 131-148.

Wilson W and Smith K.J.M (1995) 'The Doctors' Dilemma: Necessity and the Legality of Medical Intervention'. *Medical Law International*, Vol. 1, pp. 387-410.

Young R. (2007) *Medically Assisted Death*. Cambridge: Cambridge University Press.

Ziegler S.J. (2009) 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for its potential to enhance oversight and demedicalize the dying process'. *Journal of Law, Medicine and Ethics*, Vol. 37, pp. 318-330.

List of Cases

A v United Kingdom [1984] 6 E.H.R.R. CD 140.

Airedale Hospital Trustees v Bland [1992] UKHL 5.

Attorney-General v Abel and others [1984] 1 QB 795.

B v An NHS Trust [2002] 2 All ER 449.

Pretty v United Kingdom [2002] 35 E.H.R.R. 1.

R v Hough [1984] 6 Cr App R (S) 406.

R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening) [2002] 1. A.C. 800.

R (Purdy) v Director of Public Prosecutors (Society for the Protection of Unborn Children Intervention) [2009] 3. W.L.R. 403.

R (Purdy) v Director of Public Prosecutions [2009] 1 Cr. App. R. 32.

R. (on the application of Purdy) v DPP [2008] EWHC 2565 (Admin)

R v Wallis [1983] 5 Cr App R (S) 342.

R v Woollin [1998] 3 WLR 382.

Re A (Children) (Conjoined Twins: Surgical Separation) [2001] Fam. 147.

Re C (Adult: Refusal of Treatment) (1994) 1 WLR 290.

Re T (Adult: Refusal of Treatment) [1992] 3 Cr App. WLR, at 782.

R Z (Local Authority: Duty) [2005] 1. W.L.R. 959.

Case Comments

Allen N. (2009) 'Saving Life and Respecting Death: A Savage Dilemma'.
Medical Law Review, 17, pp. 262-273.

Buxton Richard. (2010) 'R (on the application of Purdy) v DPP: Complicity in Suicide abroad'. *Law Review*, Vol. 126, pp. 1-5.

Cartwright N. (2009) '48 Years on: Is the Suicide Act fit for purpose?'
Commentary. *Medical Law Review*, Vol. 17, pp. 467-476.

- Chrispin E., English V., Harrison C., Sheather J. and Sommerville A. (2009) 'Ethics briefings'. *J Med Ethics*, Vol. 35, pp. 335-336.
- Cruz de Peter. (2005) 'The Terminally Ill adult seeking assisted suicide abroad: the extent of the duty owed be a local authority.' Commentary. *Medical Law Review*, Vol. 13, pp. 257-267.
- 'Health Care: Refusal of DPP to undertake not to prosecute applicant's husband if he assisted applicant's suicide'. (2002) *European Human Rights Law Review*, Vol. 5, 686-688.
- 'Manslaughter-ingredients of offence where death caused by gross negligence'. *Criminal Law Review*, 1998, Nov. p. 833.
- Mason J.K. (2009) 'Unlike as two peas? R (on the application of Purdy) v DPP'. *Edinburgh Law Review*, Vol. 13, pp. 298-302.

Reports and Bills

Assisted Dying for the Terminally Ill Bill. Available at <http://www.publications.parliament.uk/pa/ld200405/ldasdy/86/5012004.htm>

HC Deb 14 July 1961 vol 644 cc833-45. 'Suicide Bill [Lords]' at <http://hansard.millbanksystems.com/commons/1961/jul/14/suicide-bill-lords>

Report of the Select Committee on Medical Ethics HL Paper 21-I HMSO, 1994 at para 242.

Select Committee on Assisted Dying for the Terminally Ill Bill (First Report).

Available at:

<http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8607.htm>

List of Statues

The Criminal Attempts Act 1981

Coroners and Justice Act 2009

European Convention of Human Rights 1950

Homicide Act 1957

Human Rights Act 1998

Mental Capacity Act 2005

Prosecution of Offences Act 1985

Suicide Act 1961

Websites and Newspaper articles

Alexander Larry. (2000-2001) 'Criminal Liability for Omissions: An Inventory of Issues'. Working Paper 22, available at:
http://papers.ssrn.com/paper.taf?abstract_id=270451.

Assisted Suicide statistics: the numbers Dignitas helps to die, by country'. (25 Feb. 2010) Available at: Guardian.co.uk

'Corrections and Clarifications'. (6 March 2010). Available at:
<http://www.guardian.ac.uk/theguardian/2010/mar/06/corrections-clarifications>

'Crime File-Famous Criminal: Dr John Bodkin Adams'. Available at,
<http://www.crimeandinvestigation.co.uk/crime-files/dr-john-bodkin-adams/biography.html>

David Brown (3 April 2009) *Dignitas founder condemned over plans to help healthy woman commit suicide*. The Times Friday.

‘Death Drugs Cause Uproar in Oregon: Terminally Ill Denied Drugs for Life, But can Opt for Suicide’. Available at:

<http://abcnews.go.com/Health/Story?id=5517492&page=2>

Decision on Prosecution - ‘The Death by Suicide of Daniel James’. (9 December 2008). Available at:

www.cps.gov.uk/news/nationalnews/death_by_suicide_of_daniel_james.html.

‘Decision to charge loving mother Kay Gilderdale with attempted murder of ME daughter was right, says DPP’. (26 Jan. 2010). Available at:

<http://www.dailymail.ac.uk/news/article-1246222/Keir-Starmer-says-decision-charge-Kay-Gilderdale-attempted-murder-daughter-Lynn-public-interest.html#ixzz0zrNK>

‘Dr Moor: Landmark Verdict’. (28 November 2000). Available at:

http://news.bbc.co.uk/1/hi/health/background_briefings/euthanasia/331263.stm

‘Guardian Daily: Assisted suicide and the law’. Available at:

<http://www.guardian.co.uk/world/audio/2010/jan/29/guardian-daily-podcast>

Finn G. (21 August 1999) ‘Graduate in Mercy killing bid freed’. Available at: The Independent.

‘Harold Shipman: Timeline’ Available at,

<http://news.bbc.co.uk/1/hi/uk/2136444.stm>

Hirsch Afua. (25 Jan. 2010) ‘Kay Gilderdale Case: A Clear verdict on the Law’s Confusion on Assisted Suicide’ Available at: Guardian.co.uk

‘I helped my daughter die’. (1 Feb. 2010) Available at:

[http://www.bbc.co.uk/iplayer/episode/b00qs930/b00qs8mk/panorama I Helped My Daughter Die/](http://www.bbc.co.uk/iplayer/episode/b00qs930/b00qs8mk/panorama_I_Helped_My_Daughter_Die/)

‘Interim Policy for Prosecutors in Respect of Cases of Assisted Suicide’.

Available at:

www.cps.gov.uk

‘InternationalTaskForce.org Available at:

http://www.internationaltaskforce.org/assisted_suicide_laws.htm

Mother ‘injected brain-damaged son with fatal dose of heroin to end misery’. (5

Jan. 2010). Available at: <http://www.telegraph.co.uk/news/uknews/crime>

Ninemsn staff. (15 Jan. 2010). Available at:

<http://news.ninemsn.com.au/world/1000181/mother-explains-why-she-killed-son-with-heroin>

‘Organised assisted suicide to be regulated’. Available at

<http://www.ejpd.admin.ch/ejpd/en/home/dokumentation/mi/2009/2009-10-28.html>

Polly Toynbee. (31 July 2009) ‘The 1961 Suicide Act instrument of State torture’.

Available at: The Guardian.

‘Prosecution of Offences Act 1985’. Available at: <http://www.statutelaw.gov.uk>

‘Respecting Patient Choices- What is a Doctors duty of care regarding end-of-life

care?’ Available at, <http://www.respectingpatientchoices.org.au/medico-legal-general-faqs/what-is-a-doctors-duty-of-care-re>

Schwarzenegger C. and Summers S. J. (2005) ‘Criminal Law and Assisted

Suicide in Switzerland'. Available at: www.rwi.unizh.ch/schwarzenegger

Should law be changed on 'Mercy Killing'? (26 Jan. 2010). Available at: BBC News Online.

Smith Wesley (20 Feb. 2009) 'Right to die' can become a 'duty to die'. Available at: Telegraph.co.uk.

Smith Wesley (2008) 'Another Assisted Suicide Abuse in Oregon: No Money to Help Live-Will Pay to Make Dead'. Available at:
<http://www.firstthings.com/blogs/secondhandsmoke/2008/07/29/another-assisted-suicide-abuse-in-oregon-no-money-to-help-live-will-pay-to-make-dead/>

Smith Wesley. 'Problems with Oregon Assisted Suicides are Real'. Available at:
<http://www.firstthings.com/blogs/secondhandsmoke/2007/11/06/problems-with-oregon-assisted-suicides-are-real/>

The Oregon Death with Dignity Act: Oregon Revised Statutes. Available at:
<http://www.oregon.gov/DHS/ph/pas/index.shtml>

'The Suicide Act 1961'. Available at: <http://www.statutelaw.gov.uk>

'UK Statute Law Database'. Available at: <http://www.statutelaw.gov.uk>

Walsh Fergus (2009). *How Julie brought back memories of a brave woman whose story I told*. Available at:
<http://www.guardian.co.uk/society/2009/jan/25/assisted-suicide-short-stay-switzerland>