



BRIEFING PAPER

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The Assisted Dying (No 2) Bill 2015

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Summary

Under the *Suicide Act 1961* it is an offence for one person to encourage or assist the suicide (or attempted suicide) of another. Suicide or attempted suicide are not in themselves criminal offences.

There have been several legal cases regarding the offence of assisted suicide, particularly in the context of disabled or terminally ill people who are unable to end their lives without assistance from family or friends. Of particular relevance is the case of Debbie Purdy, who in July 2009 obtained a House of Lords ruling ordering the Director of Public Prosecutions (DPP) to formulate an offence-specific policy setting out the public interest factors the Crown Prosecution Service will consider when deciding whether to prosecute assisted suicide offences. The DPP's policy was published in February 2010 following a public consultation.

In June 2014 the Supreme Court revisited the issue of assisted suicide in the cases of Tony Nicklinson, Paul Lamb and AM, who were seeking a declaration that the current law on assisted suicide was incompatible with their right to a private life under Article 8 of the European Convention on Human Rights. The Supreme Court decided against making such a declaration by a majority of seven to two. It took the view that Parliament was the most appropriate forum for considering changes to the law on this particular issue. Following the Supreme Court decision, in July 2015, the European Court of Human rights dismissed applications from Jane Nicklinson and Paul Lamb.

Rob Marris MP, after being drawn first in the Private Member's Bill ballot in this Parliament has tabled the *Assisted Dying Bill (No 2) 2015* which will have its second reading on 11 September 2015. The Bill aims to enable competent adults who are terminally ill to be allowed assistance with ending their life if they request it. Previous attempts to change the law in this area include the Assisted Dying Bill 2014, tabled by Lord Falconer in the House of Lords that reached Committee Stage in the last Parliament. Lord Falconer has also tabled the Assisted Dying Bill 2015 in this Parliament.

The Government has indicated that it considers this issue to be a matter of individual conscience, it has traditionally been the subject of a free vote.

This briefing paper will provide a background to the legal cases in this area and the DPP guidance on prosecutions for assisted suicide. It will also include an overview of the Assisted Dying (No 2) Bill 2015, and a summary of the 2014 Assisted Dying Bill's progress in the House of Lords in the last Parliamentary session. A brief discussion of stakeholder views is also included.

1. The Suicide Act 1961

Until 1961 it was a criminal offence to commit, or attempt to commit suicide; however, section 1 of the *Suicide Act 1961* provided that “the rule of law whereby it is a crime for a person to commit suicide is hereby abrogated”. Accordingly, committing suicide ceased to be a crime, as did attempting to commit suicide.

However, section 2(1) of the 1961 Act, which is still on the statute book (as amended by the *Coroners and Justice Act 2009*), provides:

- 2 Criminal liability for complicity in another’s suicide
 - (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.¹

Although suicide (or attempted suicide) itself is no longer an offence, it therefore remains an offence for a third party to encourage or assist a suicide or attempted suicide. Any proceedings under section 2(1) can only be brought by or with the consent of the Director of Public Prosecutions (DPP).²

In March 2015 the Crown Prosecution Service (CPS) published details of the number of assisted suicide cases it had considered since 2009:

From 1 April 2009 up to 24 April 2015, there have been **110** cases referred to the CPS by the police that have been recorded as assisted suicide.

Of these 110 cases, **70** were not proceeded with by the CPS. **25** cases were withdrawn by the police.

There are currently **8** ongoing cases. **1** case of assisted attempted suicide was successfully prosecuted in October 2013 and **6** cases were referred onwards for prosecution for homicide or other serious crime.³

An overview of the legal position in other selected jurisdictions (Switzerland, Oregon and Scotland) is set out in the Appendix to this note.

¹ For background on the changes made to the original wording of the 1961 Act by the *Coroners and Justice Act 2009*, see Ministry of Justice Circular 2010/03, [Encouraging or Assisting Suicide: Implementation of Section 59 of the Coroners and Justice Act 2009](#), and Library Research Papers 09/06, [Coroners and Justice Bill: Crime and Data Protection](#), and 09/27 [Coroners and Justice Bill: Committee Stage Report](#).

² s2(4) *Suicide Act 1961*

³ [CPS, Assisted Suicide, 24 April 2015](#)

2. Cases on assisted suicide

2.1 Dianne Pretty (2002)

Dianne Pretty suffered from motor neurone disease; she wished to end her own life but was unable to do so without help. She unsuccessfully sought an undertaking from the DPP that, if her husband aided her, he would not be prosecuted. She made the following claims relating to the European Convention on Human Rights (the ECHR):

- article 2 protected a right to self-determination, entitling her to commit suicide with assistance;
- failure to alleviate her suffering by refusal of the undertaking amounted to inhuman and degrading treatment proscribed by article 3;
- her rights to privacy and freedom of conscience under articles 8 and 9 were being infringed without justification; and
- she had suffered discrimination in breach of article 14, since an able-bodied person might exercise the right to suicide whereas her incapacities prevented her doing so without assistance.

The House of Lords unanimously dismissed her appeal, finding that article 2 could not be interpreted as conferring a right to self-determination in relation to life and death and assistance in choosing death. The DPP also had no power to undertake that a crime yet to be committed should be immune from prosecution, as the executive was unable to dispense with or suspend laws without parliamentary consent.⁴

Five months later, the European Court of Human Rights ruled unanimously that neither the blanket ban on assisted suicide nor the DPP's refusal to give an advance undertaking that no prosecution would be brought against Mrs Pretty's husband violated the ECHR.⁵ Less than two weeks after that, in May 2002, Mrs Pretty died in a hospice.⁶

2.2 Daniel James (2008)

As a result of injury during rugby training, 23 year old Daniel James lost the use of his body from the chest down. He ended his life at the Dignitas clinic in Switzerland in September 2008. His parents had assisted him to send documentation to Dignitas, made payments to Dignitas from their joint bank account, made travel arrangements to take him to Switzerland and accompanied him on the flight. In December 2008, the DPP announced that, while there was sufficient evidence for a realistic prospect of conviction of the parents (and a family friend who had assisted with travel arrangements), such a prosecution was not in the public interest and no further action should be taken against them.⁷

⁴ [Pretty v DPP and Secretary of State for the Home Department \[2001\] UKHL 61](#)

⁵ [Pretty v United Kingdom 2346/02 \[2002\] ECHR 427](#)

⁶ "[Diane Pretty dies](#)", *BBC News website*, 12 May 2002

⁷ CPS press release, [No charges following death by suicide of Daniel James](#), 9 December 2008

The DPP published his full decision on the CPS website. This was the first time that the full reasoning behind a decision not to prosecute an assisted suicide offence had been made public.⁸

2.3 Debbie Purdy (2009)

Debbie Purdy suffered from multiple sclerosis, for which there is no known cure, and she was confined to a wheelchair. She had said that when her condition became unbearable, she hoped to end her own life. Her husband said he was willing to help her and, if necessary, face a prison sentence; however, she said that she is not prepared to put him in that position.

In contrast to Diane Pretty, she did not bring legal action to seek immunity from prosecution for her husband. Instead, she sought a declaration that the DPP should be required to publish an offence-specific policy outlining the circumstances in which a prosecution under s2(1) of the 1961 Act would or would not be appropriate.

Judgment was delivered on 29 October 2008.⁹ Lord Justice Scott Baker emphasised that the case was not about whether it should continue to be a criminal offence in this country to help another person, whatever the circumstances, to take their own life: that was a matter for Parliament and not the courts. Nor was it about whether someone could obtain in advance immunity from prosecution for helping another person to travel to another country where assisted suicide is lawful, for the purpose of an assisted suicide: that question had already been decided in the negative by the House of Lords in the case of Diane Pretty.

The court held that Article 8(1) of the ECHR (the right to private and family life) was not engaged. The Article 8(1) guarantee only prohibited interference in the way a person lived their life, not on how they wished to die. However, even if it had been engaged, any interference with the right by the operation of s2 of the 1961 Act would be lawful, as the combination of the Code for Crown Prosecutors and the administrative law principles and remedies developed under the common law satisfied the ECHR's standards of clarity and foreseeability. There were special reasons why the DPP had produced specific codes for other types of offences, such as domestic and football-related crime, which concerned a particularly prevalent social problem and were more easily identifiable, whereas the number of cases of assisting suicide was not large.

Ms Purdy appealed to the Court of Appeal, but on 19 February 2009 her appeal was dismissed.¹⁰ In a sympathetic judgment, the Lord Chief Justice referred to her "terrible predicament", the "distressingly stark" facts of her case and the "impossible dilemma" facing the couple.

A further appeal to the House of Lords followed. On 30 July 2009, the House of Lords allowed Ms Purdy's appeal. Departing from its previous

⁸ CPS/DPP, [Decision On Prosecution - The Death By Suicide Of Daniel James](#), 9 December 2008

⁹ [R v DPP ex p Purdy \[2008\] EWHC 2565 \(Admin\)](#)

¹⁰ [R v DPP ex p Purdy \[2009\] EWCA Civ 92](#)

decision in the Diane Pretty case, the House of Lords considered that the right to respect for private life under article 8(1) was engaged in Ms Purdy's case. In the lead judgment, Lord Hope went on to consider article 8(2), and the requirement that any interference with the right to respect for private life be "in accordance with the law":

40. The Convention principle of legality requires the court to address itself to three distinct questions. The first is whether there is a legal basis in domestic law for the restriction. The second is whether the law or rule in question is sufficiently accessible to the individual who is affected by the restriction, and sufficiently precise to enable him to understand its scope and foresee the consequences of his actions so that he can regulate his conduct without breaking the law. The third is whether, assuming those two requirements are satisfied, it is nevertheless open to the criticism that it is being applied in a way that is arbitrary because, for example, it has been resorted to in bad faith or in a way that is not proportionate. (...)

41. (...) So far as it goes, section 2(1) of the 1961 Act satisfies all these requirements. It is plain from its wording that a person who aid, abets, counsels or procures the suicide of another is guilty of criminal conduct. It does not provide for any exceptions. It is not difficult to see that the actions which Mr Puente will need to take in this jurisdiction in support of Ms Purdy's desire to travel to another country where assisted suicide is lawful will be likely to fall into the proscribed category.

42. The issue that Ms Purdy raises however is directed not to section 2(1) of the Act, but to section 2(4) and to the way in which the Director can be expected to exercise the discretion which he is given by that subsection whether or not to consent to her husband's prosecution if he assists her.

43. This is where the requirement that the law should be formulated with sufficient precision to enable the individual, if need be with appropriate advice, to regulate his conduct is brought into focus in this case.¹¹

Lord Hope set out the steps that the DPP had already taken "to provide a measure of consistency" when deciding whether to prosecute assisted suicide offences. One of these was the *Code for Crown Prosecutors*, issued under section 10 of the *Prosecution of Offences Act 1985*, which sets out the general principles to be applied by the CPS in determining whether to institute proceedings for an offence. However, the Code applies to criminal offences in general, rather than assisted suicide cases in particular. Lord Hope drew attention to the fact that in the Daniel James case the DPP himself had decided that "many of the factors identified in the Code in favour or against a prosecution do not really apply in this case". Other steps were also highlighted, for example the creation of a "Special Crimes Division" within the CPS and the publication of the DPP's decision in the Daniel James case. Counsel for the DPP submitted that, taking these steps together, there was now sufficient guidance available as to how decisions were likely to be taken in assisted suicide cases.

¹¹ Ibid, at paras 40-43

The House of Lords, however, stated that “these developments fall short of what is needed to satisfy the Convention tests of accessibility and foreseeability”.¹² It therefore ordered the DPP to:

...promulgate an offence-specific policy identifying the facts and circumstances which he will take into account in deciding, in a case such as that which Ms Purdy’s case exemplifies, whether or not to consent to a prosecution under section 2(1) of the 1961 Act.¹³

It is worth emphasising that the judgment did not legalise assisted suicide, nor did the Law Lords express any views on whether Parliament should do so.¹⁴

Debbie Purdy died in December 2014 following an extended admission to a hospice during which she been refusing food.¹⁵ She wrote an article in the weeks before her death outlining her support for a change in the law on assisted suicide.¹⁶

2.4 Tony Nicklinson, Paul Lamb and AM (2014)

Tony Nicklinson suffered a stroke in 2005 which left him suffering with ‘locked in’ syndrome. His condition was not life threatening and he had a reasonable expectation of living for many years. In 2007 he expressed a desire to end his own life but would only have been able to do so by refusing all food and liquids. He wanted a doctor to help him end his life by giving him a lethal injection, but if necessary he was prepared to kill himself using a machine invented by a Dr Nitschke (which would have been loaded with a lethal drug and activated by Mr Nicklinson via an eye blink computer). However, any doctor actively injecting Mr Nicklinson would have been open to a charge of murder, and anyone assisting him to commit suicide would have been liable to charges under s2(1) of the *Suicide Act 1961*.

Mr Nicklinson applied to the High Court for a declaration that a doctor who injected him with a lethal drug or who assisted him in terminating his own life would be able to make use of the defence of “necessity” and so would not be liable to criminal charges. The defence of necessity says that an act which would otherwise be a crime may (in very limited circumstances) be excused where it was done to avoid a greater evil: “the evil represented by committing the offence is outweighed by the greater evil which would ensue if the offence were not to be committed”.¹⁷

If the first declaration was refused, Mr Nicklinson sought an alternative declaration that the current state of the law on murder and assisted

¹² Ibid, at para 53

¹³ [R v DPP ex p Purdy \[2009\] UKHL 45](#) at para 56

¹⁴ Ibid, at para 26

¹⁵ The Guardian, [Assisted suicide campaigner Debbie Purdy dies aged 51](#), 29 December 2014

¹⁶ The Independent, [Debbie Purdy: Right-to-die campaigner's last article calls for more legal protection for those who assist suicide](#), 4 January 2015

¹⁷ *Blackstone's Criminal Practice*, 2014 edition, para A3.47

suicide was incompatible with his right to a private life under Article 8 of the ECHR.

Alongside Mr Nicklinson's case the court also considered the case of another man, referred to as Martin, who is virtually unable to move following a brain stem stroke. He would be capable of physically assisted suicide and wishes to travel to Dignitas to undertake this. His wife, a nurse, is not prepared to help him achieve this, although she would wish to be with him to provide comfort if he were to succeed in his purpose with the help of others. Martin therefore sought a declaration that the DPP should clarify his policy on prosecuting cases of assisted suicide so that other people with no personal connection to him who might be willing to help on compassionate grounds – for example members of the public, health professionals or solicitors – would know whether they were more likely to face prosecution than not.

The High Court refused Mr Nicklinson both forms of relief.¹⁸ He died six days later from pneumonia, having refused food following the judgment.¹⁹ It also refused Martin's application. Lord Justice Toulson said:

To do as Tony wants, the court would be making a major change in the law. To do as Martin wants, the court would be compelling the DPP to go beyond his established legal role. These are not things which the court should do. It is not for the court to decide whether the law about assisted dying should be changed and, if so, what safeguards should be put in place. Under our system of government these are matters for Parliament to decide, representing society as a whole, after Parliamentary scrutiny, and not for the court on the facts of an individual case or cases. For those reasons I would refuse these applications for judicial review.²⁰

Mr Nicklinson's widow was added as a party to the proceedings and pursued an appeal to the Court of Appeal. Paul Lamb, another man with locked in syndrome, was added as a claimant in the Court of Appeal. Martin also appealed.

The Court of Appeal dismissed the Nicklinson/Lamb appeal but Martin's appeal was partially successful.²¹ In relation to the first appeal, it reiterated the views of the High Court:

The repeated mantra that, if the law is to be changed, it must be changed by Parliament, does not demonstrate judicial abnegation of our responsibilities, but rather highlights fundamental constitutional principles.²²

In relation to Martin's appeal, the Court of Appeal ruled (by a majority of two to one) that the DPP's policy was insufficiently clear regarding what it referred to as "class 2" helpers, being persons with no close or

¹⁸ [R on the application of Tony Nicklinson v Ministry of Justice](#) [2012] EWHC 2381

¹⁹ The Guardian, [Tony Nicklinson dies six days after losing 'right to die' case](#), 22 August 2012

²⁰ [R on the application of Tony Nicklinson v Ministry of Justice](#) [2012] EWHC 2381, at para 150

²¹ [R on the application of Nicklinson and Lamb v Ministry of Justice](#) [2013] EWCA Civ 961

²² *Ibid*, at para 154

emotional connection to the person seeking assistance with suicide.²³
The Master of the Rolls and Lord Justice Elias said:

In our view, the Policy should give some indication of the weight that the DPP accords to the fact that the helper was acting in his or her capacity as a healthcare professional and the victim was in his or her care. In short, we accept the submission of Mr Havers [counsel for Martin] that the Policy does not provide medical doctors and other professionals with the kind of steer in class 2 cases that it provides to relatives and close friends acting out of compassion in class 1 cases.²⁴

In a dissenting judgment, the Lord Chief Justice said he would have dismissed Martin's appeal in its entirety. He said that there was a "clear demarcation" between responsibility for the processes leading to the decision to prosecute, which lies with the DPP alone, and the process of the court, to which the DPP is subject, and that this should not be blurred. He added:

With great respect, we cannot keep ordering and re-ordering the DPP to issue fresh guidelines to cover each new situation. Prosecutorial Policy decisions must remain fact specific and certainty about the Policy which can be no more than indicative of the eventual decision if a crime is committed is not to be equated with the certainty required of provisions which create or identify criminal offences.²⁵

Mrs Nicklinson and Mr Lamb appealed to the Supreme Court. The DPP appealed against the Court of Appeal's majority ruling in Martin's case, and Martin cross-appealed against the Court of Appeal's dismissal of the remainder of his application.

The cases were heard together in December 2013 by nine Justices and judgment was handed down on 25 June 2014.²⁶ A press summary is also available.²⁷ The Supreme Court dismissed the Nicklinson/Lamb appeal by a majority of seven to two. The Justices were divided as to whether the Supreme Court had the constitutional authority to make a declaration that the current law on assisted suicide is incompatible with Article 8, or whether this should be left to Parliament. The Justices were also divided as to whether such a declaration should in fact be made.

Three Justices (Lord Neuberger, Lord Mance and Lord Wilson) held that the Supreme Court had the constitutional authority to make a declaration of incompatibility, but should not do so in this particular case. In relation to authority, Lord Neuberger said:

The interference with Applicants' article 8 rights is grave, the arguments in favour of the current law are by no means overwhelming, the present official attitude to assisted suicide

²³ As compared to "class 1" helpers, being friends or family with emotional ties to the person seeking assistance who act in good faith out of compassion

²⁴ [R on the application of Nicklinson and Lamb v Ministry of Justice](#) [2013] EWCA Civ 961, at para 140

²⁵ Ibid, at para 179

²⁶ [R on the application of Nicklinson and Lamb v Ministry of Justice](#) [2014] UKSC 38

²⁷ Supreme Court, [Press Summary: R \(on the application of Nicklinson and another\) \(Appellants\) v Ministry of Justice \(Respondent\); R \(on the application of AM\) \(AP\) \(Respondent\) v The Director of Public Prosecutions \(Appellant\)](#) [2014] UKSC 38 [On appeal from \[2013\] EWCA Civ 961](#), 25 June 2014

seems in practice to come close to tolerating it in certain situations, the appeal raises issues similar to those which the courts have determined under the common law, the rational connection between the aim and effect of section 2 is fairly weak, and no compelling reason has been made out for the court simply ceding any jurisdiction to Parliament.²⁸

In relation to whether such a declaration ought to in fact be made, all three Justices considered that Parliament should instead be given the opportunity to consider the issue first. Lord Neuberger said there were four reasons why it would be “institutionally inappropriate at this juncture” for the Supreme Court to issue a declaration of incompatibility before giving Parliament the opportunity to consider the position:

First, the question whether the provisions of section 2 should be modified raises a difficult, controversial and sensitive issue, with moral and religious dimensions, which undoubtedly justifies a relatively cautious approach from the courts. Secondly, this is not a case ... where the incompatibility is simple to identify and simple to cure: whether, and if so how, to amend section 2 would require much anxious consideration from the legislature; this also suggests that the courts should, as it were, take matters relatively slowly. Thirdly, section 2 has, as mentioned above, been considered on a number of occasions in Parliament, and it is currently due to be debated in the House of Lords in the near future; so this is a case where the legislature is and has been actively considering the issue. Fourthly, less than thirteen years ago, the House of Lords in *Pretty v DPP* gave Parliament to understand that a declaration of incompatibility in relation to section 2 would be inappropriate, a view reinforced by the conclusions reached by the Divisional Court and the Court of Appeal in this case: a declaration of incompatibility on this appeal would represent an unheralded volte-face.²⁹

Four Justices (Lord Sumption, Lord Hughes, Lord Reed and Lord Clarke) held that the Supreme Court should defer to Parliament on this matter given the issues involved. It would therefore be inappropriate to consider the question of whether to grant a declaration of incompatibility. Lord Sumption said:

...the social and moral dimensions of the issue, its inherent difficulty, and the fact that there is much to be said on both sides make Parliament the proper organ for deciding it. If it were possible to say that Parliament had abdicated the task of addressing the question at all, so that none of the constitutional organs of the state had determined where the United Kingdom stood on the question, other considerations might at least arguably arise. As matters stand, I think it is clear that Parliament has determined for the time being the law should remain as it is.

(...)

In my opinion, the issue is an inherently legislative issue for Parliament, as the representative body in our constitution, to decide. The question what procedures might be available for mitigating the indirect consequences of legalising assisted suicide, what risks such procedures would entail, and whether those risks

²⁸ Ibid, at para 111

²⁹ Ibid, at para 116

are acceptable, are not matters which under our constitution a court should decide.³⁰

Only Lady Hale and Lord Kerr concluded that the Supreme Court both had the authority to make a declaration of incompatibility and should in fact do so in this case. Lady Hale said:

...I have reached the firm conclusion that our law is not compatible with the Convention rights. Having reached that conclusion, I see little to be gained, and much to be lost, by refraining from making a declaration of incompatibility. Parliament is then free to cure that incompatibility, either by a remedial order under section 10 of the Act or (more probably in a case of this importance and sensitivity) by Act of Parliament, or to do nothing. It may do nothing, either because it does not share our view that the present law is incompatible, or because, as a sovereign Parliament, it considers an incompatible law preferable to any alternative.

Why then is the present law incompatible? Not because it contains a general prohibition on assisting or encouraging suicide, but because it fails to admit of any exceptions.”³¹

In Martin’s case, the nine Justices unanimously allowed the DPP’s appeal and dismissed Martin’s cross-appeal:

It is one thing for the court to decide that the DPP must publish a policy, and quite another for the court to dictate what should be in that policy. The exercise of judgment by the DPP, the variety of relevant factors, and the need to vary the weight to be attached to them according to the circumstances of each individual case, are all proper and constitutionally necessary features of the system of prosecution in the public interest.³²

Jane Nicklinson, and Paul Lamb, following the decision from the Supreme Court lodged applications with the European Court of Human Rights. In July 2015, the Court declared the applications inadmissible. More information on this decision is provided in a European Court of Human Rights press release:

Mrs Nicklinson’s complaint

The ECtHR did not accept that Article 8 imposes procedural obligations which require the domestic courts to examine the merits of a challenge brought in respect of primary legislation as in the present case. It explained that States are generally free to determine which of the three branches of government should be responsible for taking policy and legislative decisions which fall within their margin of appreciation. In the United Kingdom, the assessment as to the risk and likely incidence of abuse if the prohibition on assisted suicide were to be relaxed was made by Parliament in enacting section 2(1) of the 1961 Act, a provision that has been reconsidered several times by Parliament in recent years. Requiring courts to give a judgment on the merits of a complaint about the prohibition could have the effect of forcing upon them an institutional role not envisaged by the domestic

³⁰ Ibid, at paras 233-4

³¹ Ibid, at paras 300-1

³² Supreme Court, [Press Summary: R \(on the application of Nicklinson and another\) \(Appellants\) v Ministry of Justice \(Respondent\); R \(on the application of AM\) \(AP\) \(Respondent\) v The Director of Public Prosecutions \(Appellant\) \[2014\] UKSC 38 On appeal from \[2013\] EWCA Civ 961](#), 25 June 2014

constitutional order. It would also be odd to deny domestic courts charged with examining the compatibility of primary legislation with the Convention the possibility of concluding, like the Strasbourg Court, that Parliament is best placed to take a decision on the issue in question in light of the sensitive ethical, philosophical and social issues which arise.

In any case, the ECtHR found that the majority of the Supreme Court judges had dealt with the substance of Ms Nicklinson's claim by concluding that she had failed to show that there had been any relevant developments since the judgment in *Pretty v. the United Kingdom*. The fact that in making their assessment they attached considerable weight to the views of Parliament did not mean that they failed to carry out any balancing exercise. They were entitled to conclude that in light of the sensitive issue at stake and the absence of any consensus among Contracting States the views of Parliament weighed heavily in the balance.

The ECtHR therefore concluded that Ms Nicklinson's application was manifestly ill-founded and declared it inadmissible.

Mr Lamb's complaint

The ECtHR noted that before the Court of Appeal, challenges had been made to both the prohibition on assisted suicide and law on murder, which made no exception for voluntary euthanasia.

However, before the Supreme Court Mr Lamb had only pursued his complaint about the ban on assisted suicide and not his argument that there should be a judicial procedure to authorise voluntary euthanasia in certain circumstances. It could not be assumed that the Supreme Court would have disposed of the argument concerning voluntary euthanasia in the same way as it disposed of the claim in respect of the prohibition of assisted suicide. Recalling that those who wish to complain to the ECtHR against a State first have to use remedies provided for by the national legal system, the ECtHR dismissed Mr Lamb's application as inadmissible for non-exhaustion of domestic remedies.³³

2.5 AM v GMC (2015)

In a further case brought by Martin,³⁴ the General Medical Council's (GMC) guidance for doctors on assisted suicide was challenged. Martin wished to obtain an up-to-date medical report covering his medical history, diagnosis, prognosis and actual and suggested treatments. Such a report would be necessary in order to access the services of Dignitas. Martin also wished to obtain medical advice about methods of committing suicide at home. GMC guidance on assisted suicide has the effect that if a doctor were to give assistance of the kind sought, he or she would be in breach of the guidance and at risk of facing Fitness to Practise proceedings. Martin argued that the guidance constituted an interference with his Article 8 right to choose the time and manner of his own death.

Lord Justice Elias accepted that Article 8 was engaged and the question for the court was whether the GMC had adopted unduly restrictive

³³ ECtHR, [Case concerning UK ban on assisted suicide and voluntary euthanasia declared inadmissible](#), 16 July 2015

³⁴ [R\(AM\) v GMC](#) [2015] EWHC 2096

guidance which disproportionately interfered with Martin's rights. Rejecting this view, Lord Justice Elias stated

[I]t cannot possibly be contrary to article 8 for the GMC to take as its starting point the principle that a doctor has a duty to obey the law, and to structure its guidance accordingly. The reason why the section 2 interference with article 8 is justified, which the Supreme Court held was the protection of vulnerable patients, equally justifies the GMC's guidance which seeks to reflect and give effect to that principle.³⁵

Martin further argued that it was irrational for the GMC not to amend its policy so as to bring it in line with that adopted by the DPP. This argument was also rejected, on the grounds that, as a specialist regulatory body, the GMC was better placed than the Court to assess what was in the public interest with regard to medical discipline, and there was no constitutional reason why the GMC guidance must accord with DPP guidance, given the very different roles of the two bodies.

³⁵ Ibid, [42]

3. The DPP's policy for prosecuting cases of assisted suicide

Following the House of Lords judgment in the Debbie Purdy case, the DPP indicated that an interim policy would be published by the end of September 2009. Given the sensitivity of the subject, and in the absence of a legislative framework, he also said that the CPS would undertake a full public consultation before publishing a final policy in spring 2010.³⁶

The DPP clarified this policy with specific reference to the involvement of health professionals in 2014, following the decision in the Supreme Court in the Nicklinson and Lamb case.

3.1 The interim policy and public consultation

On 23 September 2009, the DPP published an interim policy setting out the factors he would take into account when deciding whether to prosecute assisted suicide cases.³⁷ He emphasised that the interim policy did *not* provide any guarantees against prosecution, nor did it legalise assisted suicide or euthanasia.³⁸ The interim policy took immediate effect and applied to all cases of assisted suicide that were ongoing between 23 September 2009 and the publication of the final policy on 25 February 2010.

On the same day that the interim policy was issued, the CPS also launched a public consultation seeking views on the public interest factors for and against prosecuting assisted suicide offences.³⁹ Consultation respondents were asked to indicate whether they agreed with the factors identified in the interim policy, whether any additional factors should be included and whether the weighting of factors was appropriate.

The consultation closed on 16 December 2009. A summary of responses was published on 25 February 2010, together with the final policy.⁴⁰ The consultation received a total of 4,710 responses, of which nearly 4,000 came from individual members of the public. Other respondents included healthcare professionals, faith representatives, academics, lawyers, politicians and over 100 organisations.⁴¹

³⁶ CPS press release, [CPS statement on Debbie Purdy](#), 30 July 2009

³⁷ CPS, [Interim Policy for Prosecutors in respect of Cases of Assisted Suicide](#), September 2009

³⁸ CPS press release, [DPP publishes interim policy on prosecuting assisted suicide](#), 23 September 2009

³⁹ CPS website, [A public consultation on the DPP's interim policy for prosecutors on assisted suicide](#) [accessed 20 August 2014]

⁴⁰ CPS, [Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide: Summary of Responses](#), February 2010

⁴¹ CPS, [DPP's Introductory Remarks on Assisted Suicide Policy](#), 25 February 2010

For an overview of the changes that were made to the interim policy as a result of the consultation, please see CPS, [DPP's Introductory Remarks on Assisted Suicide Policy](#), 25 February 2010.

3.2 The final policy 2010

The final policy was published (and took effect) on 25 February 2010. It emphasises that the act of suicide requires the victim to take his or her own life: it is murder or manslaughter for a person to do an act that ends the life of another, even if this is at the latter's express wish.⁴²

The public interest factors tending **in favour** of a prosecution are as follows:

- (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;

⁴² CPS, [Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide](#), February 2010, p4

(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.⁴³

The public interest factors tending **against** prosecution are as follows:

(1) the victim had reached a voluntary, clear, settled and informed decision to commit suicide;

(2) the suspect was wholly motivated by compassion;

(3) the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;

(4) the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;

(5) 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;

(6) 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.⁴⁴

None of these factors is weighted, and assessing the public interest will not simply be a "tick box" exercise of adding up the factors on either side and seeing which has the greater number.⁴⁵

The DPP again emphasised that the policy does not change the law on assisted suicide, nor does it open the door for euthanasia:

It does not override the will of Parliament. What it does is to provide a clear framework for prosecutors to decide which cases should proceed to court and which should not.⁴⁶

3.3 Parliamentary debate on the policy

In March 2012, the Commons debated a motion tabled by Conservative Member Richard Ottaway which asked the House to "welcome" the DPP's policy in respect of assisting or encouraging suicides.⁴⁷

Dame Joan Ruddock moved an amendment to the motion to invite the Government to consult as to whether to put the guidance on a statutory basis. In the debate she stated:

As it stands, the policy could be changed by the DPP, who is after all an individual who holds the role of DPP for a term of five years. It is unlikely that a future DPP would make significant changes to the policy, but it is always possible. That is why placing the DPP's policy on a statutory footing would mean that this sensible,

⁴³ Ibid, pp5-6

⁴⁴ Ibid, p7

⁴⁵ Ibid, p5

⁴⁶ CPS press release, [DPP publishes assisted suicide policy](#), 25 February 2010

⁴⁷ [HC Deb 27 March 2012 cc1363-1440](#)

humane and popular policy could be changed only by Parliament. In conclusion, I welcome the DPP's policy and this debate. The policy is sensible, humane and provides clarity on how the law is applied in assisted suicide cases. The public strongly support that approach, which is why I believe the Government should consult on whether they want the clarity provided by the policy to be placed on a statutory footing. I have always known that in compelling circumstances I would assist a loved one to die. That is why I think it is so important that the DPP's policy should be placed in statute. I urge hon. Members to support this amendment and the motion.⁴⁸

In response, the then Solicitor General Edward Garnier said:

Guidelines or a policy statement are not required in every criminal case, but I invite the House to consider that such guidelines are best issued by prosecutors and for prosecutors, although available for public inspection and comment. Quite apart from the propriety of guidelines for prosecutors being a matter for prosecutors, there are some practical considerations to guidelines remaining on a non-statutory basis. Surely to place them in statute would be to attempt to confine the infinite. Policies and guidance are there to provide practical assistance to prosecutors on how particular categories of cases should be approached and the internal processes that should be followed. Therefore, there needs to be a certain amount of flexibility, not least because, as case law develops and public opinion and our collective moral view alter, the law changes and these guidelines and the policies will need to change in response, often quickly.⁴⁹

Dame Ruddock's amendment was negated without division.

The House of Lords considered the policy and some of the broader legal issues in March 2014, when Baroness Jay of Paddington tabled a question asking whether the Government "continued to be satisfied" with the DPP's guidelines. She took the view that the current law – including the DPP's guidelines – did not provide overall coherence on the issue, did not offer adequate legal protection, and did not do enough to prevent unnecessary suffering at the end of life.⁵⁰ She called for Parliament to legislate on the matter, rather than leaving the issue in the hands of the courts and lawyers.

Justice Minister Lord Faulks responded to the debate for the Government. He said that the DPP's policy did not change the law and could only act as guidance for prosecutors. He also confirmed that any change on the law in this area would be a matter for Parliament to determine as an issue of individual conscience.⁵¹

3.4 Clarification of the policy (October 2014)

Following the decision from the Supreme Court in the Nicklinson and Lamb case, the Director of Public Prosecutions, Amanda Saunders clarified the DPP policy on assisted suicide. She said that in the section relating to the likelihood of prosecutions of health professionals, this

⁴⁸ [HC Deb 27 March 2012 c1374](#)

⁴⁹ [HC Deb 27 March 2012 c1377](#)

⁵⁰ [HL Deb 5 March 2014 c1410](#)

⁵¹ [HL Deb 5 March 2014 c1429](#)

refers to those with a specific and professional duty of care to the individual:

During earlier proceedings in the Court of Appeal, the then Lord Chief Justice interpreted this guidance to mean that if a person operating in one of the prescribed professions had cared for a victim to the extent that they were in a position of authority, and may have been able to use that authority to exercise undue influence over the victim, then this may be considered as a factor tending in favour of prosecution. In his view it was not to be interpreted as meaning that professionals brought in to help from outside the family circle should be more likely to be prosecuted simply because of their professions.

Therefore the DPP has confirmed that the words "and the victim was in his or her care" will be highlighted to prosecutors. The following footnote will also be added: "For the avoidance of doubt the words 'and the victim was in his or her care' qualify all of the preceding parts of this paragraph. This factor does not apply merely because someone was acting in a [professional] capacity described within it: it applies only where there was, in addition, a relationship of care between the suspect and the victims such that it will be necessary to consider whether the suspect may have exerted some influence on the victim."

Director of Public Prosecutions, Alison Saunders, said: "I am grateful to the Supreme Court for the careful and detailed analysis of this issue. I am happy to further clarify the factor in favour of prosecution where the suspect is a healthcare professional."⁵²

The Guardian reported in April 2015 that the High Court had granted permission for a Judicial Review into the DPP's clarification of the policy on assisted suicide.⁵³ Disability rights campaigners had applied to the court, claiming that the clarification had liberalised the policy and that it had been unconstitutional. It was reported that a spokesperson from the CPS said that the clarification was made as a direct result of the Supreme Court judgement and did not amend the law in any way.

⁵² CPS, [Director of Public Prosecutions responds to Supreme Court on assisted suicide policy](#), 16 October 2014

⁵³ The Guardian, [Campaigners win right to challenge assisted dying prosecution policy](#), 28 April 2015

4. Previous attempts to change the law

4.1 The Assisted Dying for the Terminally Ill Bill [HL]

In 2004, Lord Joffe introduced the [Assisted Dying for the Terminally Ill Bill \[HL\]](#), which aimed “to enable a competent adult who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and to make provision for a person suffering from such a condition to receive pain relief medication”.⁵⁴ It was referred to a [select committee](#) under the chairmanship of Lord Mackay of Clashfern.

The take note debate was on 10 October 2005.⁵⁵ The Bill lapsed at the end of the 2004/05 session, but was re-introduced on 9 November 2005.⁵⁶ The Second Reading debate was on 12 May 2006;⁵⁷ however, on division the Lords voted by 148 to 100 against second reading. Writing in the *Times*, Lord Joffe commented that the last thing the opponents of assisted dying seem to want is a debate,

... shown by their conduct at the last hearing of my Bill when they broke a longstanding tradition in the Lords of never opposing a Private Member's Bill at second reading. They succeeding in summarily bringing the debate to an end before a detailed examination of its provisions could even take place.⁵⁸

4.2 The Coroners and Justice Bill 2008-09

During the passage of the *Coroners and Justice Bill* (now the *Coroners and Justice Act 2009*), two amendments that sought to amend the law on assisted suicide were tabled. Neither was successful.

Patricia Hewitt tabled an amendment for the Bill's report stage in the Commons. The amendment would have added the following provision to the 1961 Act:

“2ZA Acts not capable of encouraging or assisting

An act by D is not to be treated as capable of encouraging or assisting the suicide or attempted suicide of another person (“T”) if the act is done solely or principally for the purpose of enabling or assisting T to travel to a country or territory in which assisted dying is lawful.”

The amendment was not called. A number of members expressed dissatisfaction that the programme motion had made it virtually certain that the amendment would not be reached, commenting that assisted

⁵⁴ This Bill followed a similar one (the [Patient \(Assisted Dying\) Bill](#)) introduced by Lord Joffe in 2003, which had its second reading in June 2003 but did not proceed any further ([HL Deb 6 June 2003 cc1585-1690](#)).

⁵⁵ [HL Deb 10 October 2005 c12-32, 45-150](#)

⁵⁶ [HL Deb 9 November 2005 c619](#)

⁵⁷ [HL Deb 12 May 2006 c1184-1296](#)

⁵⁸ “[Debbie Purdy deserves a less terrible choice](#)”, 30 October 2008, *The Times* [subscription only]

suicide was a topical and urgent matter that required parliamentary debate.⁵⁹

During the Bill's committee stage in the Lords, Lord Falconer of Thoroton proposed an amendment that would have provided:

"Acts not capable of encouraging or assisting suicide

(1) An act by an individual ("D") is not to be treated as capable of encouraging or assisting the suicide or attempted suicide of another adult ("T") if—

(a) the act is done solely or principally for the purpose of enabling or assisting T to travel to a country or territory in which assisted dying is lawful;

(b) prior to the act, two registered medical practitioners, independent of each other, have certified that they are of the opinion in good faith that T is terminally ill and has the capacity to make the declaration under subsection (2); and

(c) prior to the act, T has made a declaration under subsection (2).

(2) A declaration by T is made under this subsection if the declaration—

(a) is made freely in writing and is signed by T (or is otherwise recorded and authenticated if T is incapable of signing it),

(b) states that T—

(i) has read or been informed of the contents of the certificates under subsection (1)(b), and

(ii) has decided to travel to a country or territory falling within subsection (1)(a) for the purpose of obtaining assistance in dying, and

(c) is witnessed by an independent witness chosen by T.

(3) "Independent witness" means a person who is not—

(a) likely to obtain any benefit from the death of T; or

(b) a close relative or friend of T; or

(c) involved in caring for T.

(4) D is not to be treated as having done an act capable of encouraging or assisting the suicide or attempted suicide of T by virtue of being with T when, in a country or territory falling within subsection (1)(a), T takes steps (including steps taken with the assistance of D) to commit suicide by lawful means."

Introducing the amendment, Lord Falconer said:

The reason that I proposed this amendment, along with my noble friend Lady Jay of Paddington and the noble Lords, Lord Low and Lord Lester of Herne Hill, is that it is absolutely plain that the law is being marginalised. The law is not being applied by the Director of Public Prosecutions because it plainly no longer fits the current situation. The result of the law not being applied is that we have the horror of people going earlier to clinics abroad, without their loved ones being there on the day that they die. Equally, the law provides no protection or safeguard against abusive people, or for

⁵⁹ [HC Deb 23 March 2009 cc52-61](#)

those under a mistaken impression of what illness they have. The only current safeguard is the fear of prosecution. That is not removed because the declaration must be made freely.⁶⁰

Baroness Campbell, a leading campaigner for disabled people's rights who herself has the degenerative condition spinal muscular atrophy, spoke strongly against the amendment:

...if these amendments were to succeed, despair would be endorsed as a reasonable expectation for which early state-sanctioned death is an effective remedy. Is this really the message that we wish to give disabled and terminally ill people? Is this really the future that we wish to offer those who become terminally ill? Those of us who know what it is to live with a terminal condition are fearful that the tide has already turned against us. If I should ever seek death - there have been times when my progressive condition challenges me - I want a guarantee that you are there supporting my continued life and its value. The last thing that I want is for you to give up on me, especially when I need you most. I urge your Lordships to reassure us by rejecting this amendment.⁶¹

On a free vote, the amendment was defeated by 194 votes to 141.⁶²

⁶⁰ [HL Deb 7 July 2009 c598](#)

⁶¹ [HL Deb 7 July 2009 c614](#)

⁶² [HL Deb 7 July 2009 c634](#)

5. The Assisted Dying Bill

The [Assisted Dying Bill \[HL\]](#) is a Private Member's Bill first introduced by Lord Falconer in May 2013. It did not proceed beyond First Reading in the 2013-14 session, but was reintroduced by Lord Falconer in the 2014-15 session, where it reached Committee Stage consideration.

The Bill has been reintroduced by Lord Falconer in this Parliament in June 2015. The Labour MP, Rob Marris, after coming first in the Private Member's Bill ballot this Parliament has introduced the *Assisted Dying (No 2) Bill* in the House of Commons. This is scheduled for its Second Reading on 11 September 2015.

This section will provide an overview of the current *Assisted Dying (No 2) Bill* for consideration at Second Reading in the House of Commons. It will also include a brief discussion of the *Assisted Dying Bill 2014* and its progress through the House of Lords, and responses to these Bills.

5.1 The Assisted Dying (No 2) Bill 2015

This section will provide an overview of the contents of the [Assisted Dying \(No 2\) Bill 2015](#).

The [Assisted Dying \(No 2\) Bill](#)⁶³ is similar to the previous Bill introduced by Lord Falconer in the House of Lords in 2013 and 2014. This briefing highlights where the Bill differs (following amendments added during consideration of the Bill in the House of Lords in the last Parliament, or otherwise).

[Explanatory notes](#) to accompany the Bill have been produced and made available online by Mr Marris.⁶⁴

The Bill aims to enable competent adults who are terminally ill to be allowed assistance with ending their life if they request it.

Clause 1 would allow a terminally ill person to request assistance with ending their life. A judge of the High Court (Family Division) must confirm that they are satisfied that the person has a voluntary, settled and informed wish to end his/her life. The person must have made this declaration and have capacity to do so. Clause 12 states that capacity should be construed in accordance with the *Mental Capacity Act 2005*. To be eligible, the person must be resident in England or Wales, aged 18 or over and have a diagnosis of a terminal illness.

The requirement for a judge of the High Court (family division) to decide that a person has a voluntary, clear and settled wish was added as an amendment to the Assisted Dying Bill 2014 at Committee Stage in November 2014 (see below for further information).

Clause 2 provides a definition of terminal illness. The person must have been diagnosed by a registered medical practitioner as having a progressive terminal illness and be reasonably expected to die within six months.

⁶³ [The Assisted Dying \(No 2\) Bill 2015](#)

⁶⁴ Assisted Dying Bill 2015, [Explanatory Notes \[accessed 2 September 2015\]](#)

Clause 3 outlines how an application to the High Court will be made, and in what circumstances:

- The person must have made and signed a declaration that they have a voluntary, settled and informed wish to end their life. They must sign the form in the presence of a witness.
- The declaration must be countersigned by two doctors, the “attending doctor” whom has been requested to assist with ending the person’s life, and another suitably qualified registered medical practitioner ‘the independent doctor’. Both doctors will sign to say that, following separate examination of the person and their medical records that they are satisfied and agree that:
 - The person is terminally ill;
 - They have the capacity to make the decision to end their own life; and
 - They have a clear, settled intention to end their life and this has been reached voluntarily.
- The attending doctor (but not the independent doctor) may, but need not be the doctor who diagnosed the person with the terminal illness or has provided treatment to the person.
- The doctors must be satisfied that the person has been fully informed of all the palliative care options available to them.
- If either doctor has concerns about the person’s capacity to make this decision they must refer the person for assessment by an appropriate specialist (a psychiatrist) and take account of this specialist’s opinion in relation to their assessment of the person.
- The declaration will take effect following an order from the High Court.
- The person who makes this declaration can revoke it at any time, and this need not be in writing.

A requirement for the doctor to refer a person to a psychiatrist if they have concerns regarding their capacity was not within the Assisted Dying Bill 2014. It was the subject of a proposed amendment to that Bill at Committee Stage but was not moved (more information provided below).

Clause 4 outlines the assistance that may be given in ending the person’s life. Following a person making a valid declaration, the attending doctor may prescribe medicines for that person to enable them to end their own life. The medicines will only be delivered after a ‘cooling off’ period of at least 14 days and may only be delivered by the attending doctor or another doctor or nurse authorised by the attending doctor at the person’s request ‘the assisting health professional’. The ‘cooling off’ period may be reduced to 6 days where both the attending doctor and the independent doctor agree that the person is reasonably expected to die within one month of the day on which the declaration is made.

The assisting health professional delivering the medicine would check that the person did not want to revoke their request and remain with the person until the medicine had been self-administered and the person had died or has decided not to take the medicine. The assisting

health professional may prepare the medicine for self-administration, prepare a device (such as a syringe driver) which will enable the person to self-administer the medicine, or assist the person to ingest or otherwise self-administer the medicine. However, subsection 6 clarifies that the Bill does not allow the health professional to administer the medicine to the person with the intention of causing that person's death- it does not permit voluntary euthanasia.

The Secretary of State may make regulations under Clause 4 to specify the medicines to be prescribed, the form and manner of the prescription and the conditions under which the medicines should be stored, transported, used and destroyed.

Subsection 8 states that the regulations shall provide that the health professional must only deliver the medicine immediately prior to its use, and that if the person decides not to take the medicine that it must be immediately removed from the person and returned to the pharmacy as soon as possible.

Clause 5 provides that health professionals may refrain, on the grounds of conscientious objection from assisting a person to die.

Clause 6 provides that a person who assists someone to die under the Bill will not commit an offence. It amends the *Suicide Act 1961* to clarify that a person assisting dying under the provisions of the Bill is not committing an offence under that legislation.

Clause 7 outlines that a coroner may, but is not obliged to hold an inquest into an assisted death. It also amends the Births and Deaths Registration Act 1953 to provide regulation making powers for the Secretary of State to determine how assisted deaths should be recorded on death certificates. Regulation-making powers would also allow the Secretary of State to require that the Registrar-General produce an annual statistical analysis of deaths that have occurred under the provisions of the Assisted Dying Act.

Any report prepared by the Registrar-General would have to be laid before Parliament.

Clause 8 enables the Secretary of State to issue codes of practice, following consultation, relating to activities under the Bill. These may be on subjects including:

- the assessment of whether a person has a clear and settled wish to end their life and has capacity to make this decision;
- the effects of psychological illness such as depression on a person's decision-making;
- the information made available on treatments and end of life care options, and the consequences of deciding to end their own life;
- The counselling and guidance that should be made available; and
- The arrangements for both delivery of the medication, and the assistance that can be given to a person to ingest or self-administer the medication.

The codes of practice would come into force through a statutory instrument laid before Parliament and subject to the positive resolution procedure.

Clause 9 states that the Chief Medical Officers will monitor the operation of the Act, including compliance with provisions within it. They will submit an annual report to the relevant national authority on the operation of the Act.

Clause 10 creates a number of offences under the Bill:

- Making/knowingly using a false declaration under the Bill;
- wilfully concealing or destroying a declaration made under Section 3 of the Bill;
- knowingly or recklessly providing a false medical/professional opinion.

The clause clarifies that these new offences would have no effect on the existing offence of assisted suicide under the Suicide Act 1961. Anyone assisting death outside of the provisions of the Bill would be open to prosecution under the Suicide Act.

The penalties for these new offences are outlined under this clause. A person guilty of an offence under clause 10 is liable, on summary conviction to imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum (or both). On conviction on indictment, the person is liable to imprisonment not exceeding 5 years or a fine (or both).

Clause 11 states that any regulations made by the Secretary of State under the Bill will be made by statutory instrument. Any statutory Instrument made under the Bill, is subject to annulment by a resolution of either House of Parliament.

Clause 12 provides the meanings of terms used within the Bill.

Clause 13 provides that the Bill will extend to England and Wales only. It states that only parts of certain clauses of the Bill that relate to the making of regulations and issuing codes of practice and clauses 11, 12 and 13 will come into force on the day the Bill is passed. The other provisions within the Bill will come into force two years after it receives Royal Assent.

The clause contains a sunset provision. This states that the Bill may be repealed by a resolution of each House of Parliament and with no need for further primary legislation, after the Bill had been in force for ten years. This power will only exist for 12 months beginning on the day that the Bill has been in force for ten years.

5.2 Background

The content of the *Assisted Dying Bill* was shaped by the findings of the [Commission on Assisted Dying](#), which was chaired by Lord Falconer. The Commission was established following a tender from two private individuals, Terry Pratchett and Bernard Lewis (both advocates of assisted dying), with support provided by think-tank Demos.

The Commission published its final report in January 2012.⁶⁵ It described the current legal status of assisted suicide as “inadequate and incoherent” and proposed that Parliament should consider developing a new legal framework. This conclusion was supported by all of the Commissioners other than the Reverend Canon Dr James Woodward, who considered that greater ethical, moral and social consensus needed to be generated on this issue before legal change should be considered.

5.3 Consideration of the *Assisted Dying Bill 2014*

Second Reading

The Bill’s Second Reading debate took place on 18 July 2014.⁶⁶ Opinion on the Bill was evenly split. To give one example in support of the Bill, Lord Falconer said:

Some say that the courts should be involved as an additional safeguard before an assisted death occurs. We should constructively consider that issue in Committee. Others say that the change in the law will place pressure to take that option on those who are dying. I disagree. The numbers will be small—that is the experience in Oregon. The safeguards make clear the exceptional nature of the course. Some say that the current law should just be allowed to continue. They are wrong. Without intending to be, and despite the very best efforts of those who seek to enforce it, the current law provides the option of an assisted death to those rich enough to go abroad; for the rest, it provides despair and often a lonely, cruel death—and no adequate safeguards.⁶⁷

To give one example in opposition to it, Baroness Campbell of Surbiton said:

First, I must declare a very important interest. This Bill is about me. I did not ask for it and I do not want it but it is about me nevertheless. Before anyone disputes this, imagine that it is already law and that I ask for assistance to die. Do your Lordships think that I would be refused? No; you can be sure that there would be doctors and lawyers willing to support my right to die. Sadly, many would put their energies into that rather than improving my situation or helping me to change my mind. The Bill offers no comfort to me. It frightens me because, in periods of greatest difficulty, I know that I might be tempted to use it. It only adds to the burdens and challenges which life holds for me.⁶⁸

For the Government, Justice Minister Lord Faulks said:

...the Government believe that any change in the law in this emotive area is an issue of individual conscience. In our view, it is rightly a matter for Parliament to decide rather than government policy. Taking a neutral position on an issue of conscience, though, is not the same as doing nothing. The Government must of course be concerned with the fitness for purpose of any legislation that may reach the statute book. That is not to suggest

⁶⁵ The Commission on Assisted Dying, [“The current legal status of assisted dying is inadequate and incoherent...”](#), 2012

⁶⁶ [HL Deb 18 July 2014 c775](#)

⁶⁷ [HL Deb 18 July 2014 c777](#)

⁶⁸ [HL Deb 18 July 2014 c809](#)

that the Government will seek to block the Bill at a later stage if the consensus of this House is that it should proceed; rather, we should seek to correct any drafting deficiencies and to ensure that the law would operate in the way that Parliament intended.⁶⁹

There was general consensus among those who spoke in the debate – whether for or against the Bill – that Parliament needed to properly address the issue following the Supreme Court’s judgment in Nicklinson, and that the Bill should proceed to Committee for detailed consideration. The Bill was therefore given its Second Reading without division.

Committee Stage

There were two days of Committee Stage consideration of the Bill in the House of Lords. This section will not provide a detailed account of the whole debate but will outline some of the proposed amendments.

The role of a high court judge

Amendment 1 was tabled by Lord Pannick, with Baroness Neuberger, Baroness Mallalieu and Baroness Shackleton of Belgravia. It required that the person who wished to have assistance to end their life must satisfy a judge of the Family division of the High court that they have made a voluntary, clear settled and informed decision to end their own life. This amendment passed and was added to the Bill.

Lord Pannick provided a [summary of the intention of the amendment](#), and the Courts current role in deciding similar issues:

These amendments would require that the person concerned must satisfy a judge of the Family Division of the High Court that they have made a voluntary, clear, settled and informed wish to end their life. Judges of the Family Division already decide the most profound questions of life and death. Can doctors separate two Siamese twins, knowing that one will die but that the operation is necessary to save the life of the other? Should the life support system be turned off for Tony Bland, a victim of the Hillsborough disaster who was in a persistent vegetative state? Judges already decide these questions of life and death—and, tragically, there are many of them—in a principled manner but also with great compassion, and, where necessary, they decide them speedily.

In the Nicklinson case, decided in our Supreme Court in June—I declare an interest because I represented the organisation Dignity in Dying—some of the judges suggested that a judicial safeguard for assisted dying would be appropriate and would provide greater protection for the vulnerable than they have under the present law. The noble and learned Lord, Lord Neuberger, the President of the Supreme Court, said at paragraph 108 of his judgment, that less protection for the vulnerable is provided by the current system of a lawyer from the DPP’s office inquiring after the event into the motives of the person who provided the assistance, and whether the individual concerned was voluntarily ending their life, than under a new law that would require a judge to be,

⁶⁹ [HL Deb 18 July 2014 c919](#)

“satisfied in advance that someone has a voluntary, clear, settled and informed wish to die and for his or her suicide then to be organised in an open and professional way”.

Lord Carlile of Berriew tabled amendment 2 on the same subject.⁷⁰ He said that there should be a court-based approach to decision-making. He highlighted the recent decision by the Supreme Court in the Nicklinson case and said that that it had been identified that there may be cases in which the Suicide Act 1961 is incompatible with the European Convention on Human Rights. Under this amendment to the Bill, a court might allow some cases of assisted suicide where “*it was shown beyond reasonable doubt that there was a breach of the relevant articles of the European Convention.*”⁷¹

There were a number of Peers who contributed to the debate on these amendments.

Lord Falconer said that he thought it should be the doctor’s decision in these cases but he accepted the proposals made, that there needs to be some degree of oversight and the amendment proposed by Lord Pannick was the right one.⁷²

Lord Faulks confirmed that the Government would remain neutral in the consideration of this Bill, but said that the Family division of the High Court is accustomed to dealing with such sensitive life and death decisions and would be well placed to take on the role envisaged in the amendment.⁷³

Amendment one was added to the Bill following a decision on a show of voices.⁷⁴ Amendment 4 which provided further detail on the role of the High Court was also agreed to and added to the Bill.⁷⁵

Assessment of Capacity

There were a number of amendments on the assessment of capacity. None of these were moved during Committee Stage.

Baroness Murphy spoke to Amendments 54 and 59 during Committee Stage consideration of the Bill.⁷⁶ These would add a provision that the person should be referred to a specialist if there is any doubt in the minds of the two doctors about their capacity to make the decision about ending their life. She highlighted that this safeguard is part of the legislation in Oregon on assisted dying.

Amendment 54 adds a provision in the Bill that a patient should be referred to a specialist if there is any doubt in the minds of the attending consulting physicians on the patient’s capacity. That safeguard is in the Oregon legislation and is worthy of being put in this Bill. It could easily be put into the code of practice also, and that is where those of us who originally were concerned about the Bill had in mind for that provision to go. However, if people would feel more reassured that it should be in the Bill, I would

⁷⁰ HL Deb 7 November 2014 c1854

⁷¹ HL Deb 7 November 2014 c1856

⁷² HL Deb 7 November 2014 c1882

⁷³ HL Deb 7 November 2014 c1880

⁷⁴ HL Deb 7 November 2014 c1885

⁷⁵ HL Deb 7 November 2014 c1906

⁷⁶ HL Deb 7 November 2014 c1916

support that. We must get away from the notion that doctors somehow do not understand capacity or use it. They do so every day of the week—not always perfectly but sufficiently to this end. We cannot expect that people should have a sort of supercapacity over and above what is generally accepted by the courts.⁷⁷

Other amendments to strengthen the assessment of capacity were also tabled at Committee Stage. Baroness Hollins tabled amendments 71 and 151 on this issue. She said that the Assisted Dying Bill as it stood failed to provide a strong enough assurance that the person requesting assistance with dying has mental capacity. She proposed that the attending doctor should be satisfied that the person requesting assistance has *“a level of capacity commensurate with this life or death decision.”*⁷⁸ If they are satisfied, they should then refer the person for confirmation of this decision by a specialist. Baroness Hollins explained why she felt the strengthened assessment was needed in all cases:

Some may ask why I have not chosen to follow Oregon’s model of requiring referral for a specialist opinion only in cases of doubt, as proposed by my noble friend Lady Murphy and others. The question might be asked that if the attending doctor has a concern about a potential mental disorder, surely he would ask for an assessment, would he not? If he thought there was a serious mental disorder, surely he would seek to use the Mental Health Act, would he not? But research has demonstrated that many doctors are poor at recognising depression and lack knowledge on how to assess for its presence in terminally ill patients.⁷⁹

Baroness Butler-Sloss and Viscount Colville of Culross tabled amendments 66 and 84 on capacity.⁸⁰ These amendments, required that the attending doctor should be satisfied that the person had capacity and is not suffering from any condition (including but not limited to depression) which might be impairing their judgement. If the doctor is not satisfied, the person should be referred to a psychiatrist for a specialist assessment. Baroness Butler-Sloss explained that the amendments also required that both the attending doctor and the specialist have appropriate training in identifying issues with capacity:

The second point, which is covered by proposed new subsection (6), is on appropriate training. Every doctor—and obviously the psychiatrist, if it ever gets to a psychiatrist—will have that training. However, as I understand it—of course, I am not a doctor—there are modules for training doctors in various other aspects which are not their particular expertise. I suspect that we are talking here largely about general practitioners, who will be the attending doctor, and the independent or second doctor. It would be very important for each of those doctors to have adequate information, at least at a primary stage, to understand what pointers they should be looking for when they are judging the capacity of a patient who is asking that doctor to assist them to die. I do not think the requirement for at least some training

⁷⁷ HL Deb 7 November 2014 c1917

⁷⁸ HL Deb 7 November 2014 c1919

⁷⁹ HL Deb 7 November 2014 c1919

⁸⁰ HL Deb 7 November 2014 c 1911

before they make that decision is to be found anywhere else in these amendments.⁸¹

Lord Falconer responded to the amendments. He said that he was not inclined to say that there should be a psychiatric assessment in each case but that the amendment tabled by Baroness Murphy was probably the right approach.⁸²

Assisted dying or assisted suicide

Amendment 12B, tabled by Baroness O'Neill of Bengarve, Lord Gold, Lord Brennan and Baroness Williams of Crosby sought to change the wording of clause 2 of the Bill to refer to assisted suicide. This was one of a number of amendments that aimed to alter the wording of the Bill in this way.

Baroness O'Neill of Bengarve said that this was a clarificatory amendment and that the Bill's provisions were about assisted suicide:

It would be helpful to us all to focus on what the Bill is actually about, which is assisting suicide. As a number of noble Lords said at Second Reading, the legislation that is intended to be changed by this Bill is the Suicide Act 1961. It is intended to alter the provisions by which people aid and abet another person's suicide. It should be very clear in the text of the Bill that that is what it is for. We all believe in truth in advertising. I suggest that we want clarity in legislation and the same sort of truthfulness.⁸³

There was extensive debate on this amendment, with a number of different views expressed.

Baroness Campbell of Surbiton was in favour of the amendment, she said that disabled people and terminally ill people were frightened that the Bill, as currently named puts them at risk:

By avoiding the term "assisted suicide", the Bill circumvents the framework of measures in place to review, monitor and prevent other forms of suicide. It seeks to exclude deaths under the Bill from the general requirement for a coroner's inquest to be conducted where suicide is considered a possible cause of death. It contains a provision for publication of annual statistics of "assisted deaths" separate from the established arrangements for collecting and publishing statistics on deaths by suicide. It provides for a death under the Bill to be recorded by the registrar as an "assisted death". [...]

We all, in this House and outside, understand the word "suicide". It centres on the individual. The act of suicide is the responsibility of the person who commits it, and no other. It is impossible to commit suicide without first consenting to do so. The same does not apply to the word "dying".

Assisted dying is practised in Belgium, the Netherlands and elsewhere. Whatever the initial intentions were, decisions to end life in those places are now not taken only by the individual. It is not an autonomous act. The slippery slope is oiled by the vague euphemism of "assisted dying". Disabled and terminally people are rightly frightened that the Bill, as currently named, puts them at risk. The purpose of the amendment is to provide some

⁸¹ HL Deb 7 November 2014 c1912

⁸² HL Deb 7 November 2014 c1916

⁸³ HL Deb 16 January 2015 c1004

safeguards through the use of plain language. “Assisted suicide” makes it clear that only the individual may instigate and control the process leading to an early, state-sanctioned death. I urge noble Lords to support this argument⁸⁴

Lord Low of Dalston said that the Bill should stay as it currently stood, and that the amendment was conferring the stigma associated with suicide on to the Bill:

We need to recognise that the amendments are not really about clarity but about conferring on the Bill the stigma which traditionally attaches to suicide. The use of the term suicide breaches the Samaritans’ guidance on language, which states that:

“Inappropriate or careless use of language can perpetuate stigma or sensationalise a death”.

The term suicide is inappropriate when discussing the rational choice of a mentally competent terminally ill patient who is seeking a peaceful and dignified death. The American Psychological Association has stated that:

“It is important to remember that the reasoning on which a terminally ill person [whose judgments are not impaired by mental disorders] bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide”.

The amendments add nothing to what the debate should be about and distract us from discussing the mechanics of the process, which I think we should get on with.

The Bill would legalise the provision of assistance to a dying competent adult to control the time and manner of their death when that death is imminent and unavoidable. It would not legalise assistance with suicide for those who are not terminally ill, and I think that we should leave the Bill as it stands.⁸⁵

Lord Falconer responded to the amendment. He said he had used the phrase assisted dying for three reasons. The first was that it was accurate and corresponded with the long title of the Bill, “*to enable competent adults who are terminally ill to be provided at their request with specified assistance to end their own life.*” The second was that to call the Bill the assisted suicide bill would give the wrong impression—that assistance could be given in any type of suicide. The third reason was that those people helping others as regards suicide dislike the word suicide due to stigma and shame—“*there is a moral opprobrium attached to it.*”⁸⁶

Amendment 12B was put to a division and was disagreed (Contents 107, Not-Contents 180).⁸⁷

The medical practitioners

Lord Carlile of Berriew, Lord Darzi and Lord Harries of Pentregarth tabled amendment 13 which sought to change the requirements for the doctors under the Bill. This would introduce a requirement in Clause

⁸⁴ HL Deb 16 January 2015 1009

⁸⁵ HL Deb 16 January 2015 c1014

⁸⁶ HL Deb 16 January 2015 1024

⁸⁷ HL Deb 16 January 2015 c1025

two of the Bill for two registered medical practitioners to make the diagnosis of terminal illness and the prognosis of life expectancy of six months or less. The person should have been registered for medical care for at least 6 months with one of the medical practitioners and one should have diagnosed the terminal illness and treated the person in relation to the illness.

Lord Carlile said that this would ensure that decisions on terminal illness and prognosis would be strengthened:

My view, and that of the noble Lords who have also signed this amendment, and, I hope, of many others, is that nobody should go through the gateway of this Bill unless they have been seen by medical practitioners—I respectfully suggest to your Lordships that it should be no fewer than two—with at least one of them having had relevant care of that patient for at least six months, so that they have been able to build up a knowledge of that patient. It is difficult to imagine somebody with a terminal illness who has not had a relationship of six months with a doctor unless they have been involved in a trauma that has happened very recently.⁸⁸

There were a number of Members who spoke in both support and opposition to this amendment. Lord Cormack said that the amendment would add an important safeguard to the Bill and ensure that the doctor had real knowledge of the patient.⁸⁹ Lord Warner said that the amendment was impractical and failed to provide for the fact that often terminally ill people will move to be near relatives and may register with a new GP.⁹⁰

Lord Falconer responded to the amendment. He said that the Bill already required that a second doctor confirm that the person is terminally ill and has made a clear, settled and voluntary decision. He did not think it was right that a persons' right to access assistance under the Bill should be limited by how long you were registered with a doctor, or whether you had recently moved, the approach was unworkable and unfair. However, he said that the idea proposed by Lord Empey, and Lord Cormack that there may develop 'doctors for hire' in this field was something he wished to avoid as much as possible. Lord Falconer said that he would expect the medical bodies to produce guidance on this issue and that the Secretary of State could make regulations to ensure this did not happen.

Amendment 13 was put to a division and was disagreed (Contents:61, Not-contents:119)⁹¹

There were a number of other amendments tabled in this group on the medical practitioners but these were not moved.

Baroness Finlay of Llandaff tabled amendment 13A to amend amendment 13 so reference to registered practitioners in clause two would be changed to "*licenced medical practitioners, who are on the*

⁸⁸ HL Deb 16 January 2015 c1029

⁸⁹ HL Deb 16 January 2015 c1036

⁹⁰ HL Deb 16 January 2015 c1043

⁹¹ HL Deb 16 January 2015 c1069

*General practice or Specialist register.*⁹² She said that this ensured that appropriately trained doctors would make decisions of this gravity:

To be licensed to practise means that one has been revalidated after an annual appraisal, and may maintain one's clinical professional competencies. However, that is not enough for a matter of this gravity. One does not want decisions to be taken by doctors who perhaps are still in training, or not in a specialty but doing sessions in it, or whatever. The additional requirement should be that they have completed their training and therefore be on the general practice register or the specialist register, which would mean that they are recognised as having completed their specialist training and would be able to apply for a consultant post.⁹³

Baroness Finlay, with Lord Mackenzie of Culkein, Baroness Campbell of Surbiton and Lord Crisp also tabled amendments 19-23 which changed different elements of clause two of the Bill, including changing the prognosis for life expectancy for requesting assistance with ending life to six weeks rather than six months. Baroness Finlay said that the prognosis of terminally ill is "*highly unreliable*" over a range of six months:

A number of clinicians have tried to predict prognosis—for instance, whether to take the risk of a heart or lung transplant, and when to introduce palliative care in non-cancer services for the frail elderly. However, they have found that they just cannot determine time. Prognostication is reasonably accurate on the population level but, as the noble Lord, Lord Winston, has just illustrated, it is not accurate at an individual level at all. It is no better than tossing a coin. Indeed, different studies have shown that a prognostication expecting someone to live for more than a year is not too awfully wrong. Similarly, expecting somebody to die within a

month is more likely to be accurate than inaccurate. However, in the interval in between you honestly could toss a coin on it. It is for that reason that I suggested that, if the prognosis in the Bill really is to deal with those people who are distressed during their dying phase, the prognosis section should be shortened to six weeks.⁹⁴

Lord Faulkner responded that he accepted there are uncertainties from time to time about diagnosis, but he did not believe that a prognosis of six months to live was an impossible task for a doctor to decide on. He believed six months was the right length of time.⁹⁵

Legal aid

Lord Phillips of Sudbury tabled amendment 12A on the subject of legal aid.⁹⁶ This said that legal aid should be available to anyone making an application regarding assisted dying to the High Court. He said that the House should not legislate on this matter "*knowing that access to its provisions will be confined to the better off.*"⁹⁷

⁹² HL Deb 16 January 2015 c1031

⁹³ HL Deb 16 January 2015 c1031

⁹⁴ [HL Deb 16 January 2015 c1034](#)

⁹⁵ HL Deb 16 January 2015 c1063

⁹⁶ HL Deb 16 January 2015 c1001

⁹⁷ HL Deb 16 January 2015 c1001

The Minister of State, Lord Faulks responded to the amendment. He said that the scope of civil legal aid is set out in the Legal Aid, Sentencing and Punishment of offenders (LASPO) Act 2012 and he set out the position under this legislation:

It might help if I clarify that the scope of civil legal aid is set out in the LASPO Act 2012. It provides that civil legal services are to be made available subject to satisfying the means and merits and the matter or type of case being within the scope of the civil legal aid scheme. In order to bring a matter within the scope of the civil legal aid scheme, an amendment to Part 1 of Schedule 1 to LASPO would need to be made. The power to make such an amendment by way of affirmative secondary legislation is already set out in LASPO. It would therefore be unnecessary and not usual practice for separate provision to be made in other primary legislation to provide such a power.⁹⁸

The amendment was withdrawn.

5.4 Responses to the Bill

Reaction to both the most recent, and previous versions of the Assisted Dying Bill has been mixed. A number of opinions from stakeholders representing both sides of the debate are set out below.

The charity [Dignity in Dying](#), which supports a terminally ill person's choice for assisted dying, says that the Bill "would not lead to more deaths, rather it would lead to less suffering for those dying people who want the choice to control how and when they die".⁹⁹ It argues that the Bill would do the following if enacted:

- Result in fewer dying adults – and their families – facing unnecessary suffering at the end of their lives, subject to strict upfront safeguards, as assessed by two doctors.
- Bring clarity to an area of the law that is currently opaque and thereby provide safety and security for the terminally ill and for medical professionals.
- Neither legalise voluntary euthanasia, where a doctor directly administers life-ending medication nor act as a slippery slope to do so.
- Protects anyone who doesn't have a terminal illness, including elderly and disabled people, by not in any way affecting the law that makes it a criminal offence to assist ending their lives.
- Above all it will give dying adults peace of mind that the choice of assisted dying is available if their suffering becomes too great for them in their final months of life.¹⁰⁰

[Living and Dying Well](#), a public policy research organisation that was formed in 2010 to explore issues surrounding terminal illness and dying, has made a number of criticisms of the Bill. The group has published an analysis of the Assisted Dying (No 2) Bill 2015. This states that the significant changes proposed by the Bill should not be introduced

⁹⁸ HL Deb 16 January 2015 c1002

⁹⁹ Dignity in Dying website, [Rob Marris Assisted Dying Bill](#) [accessed 21 August 2015]

¹⁰⁰ Dignity in Dying website, [Rob Marris Assisted Dying Bill](#) [accessed 21 August 2015]

before there is evidence that the existing law is not fit for purpose and that the proposed legislation fails the public safety test:

What is being proposed is that doctors should be licensed to supply lethal drug to terminally ill people to enable them to end their own lives if they are thought to meet certain conditions. That would represent a major change both to the criminal law and to the fundamental 'do no harm' principle that underpins medical practice.

Before legislation of such gravity can be responsibly enacted, serious evidence is needed, first, that the law as it stands is not fit for purpose; and, second, that what would be put in its place would be better. On neither count has any convincing evidence been presented.

The law that we have is not perfect but it does what it is designed to do. It holds penalties in reserve to deter malicious assistance with suicide and it allows for discretion not to prosecute where that is appropriate. The law also reflects social attitudes to suicide - that, while people who attempt to end their lives should be treated with understanding and compassion, suicide itself is not something to be encouraged, much less assisted.

The legislative proposals that have been put forward fail the public safety test. Safeguards to protect vulnerable people are either non-existent or, where they exist, inadequate. They also seek to involve doctors in practices in which most of them are unwilling to participate and to involve the courts in a way which blurs responsibilities for decision-making and undermines accountability.¹⁰¹

A cross-party group of Members of the House of Lords, writing for Living and Dying Well, had described the *Assisted Dying Bill 2014* as a "blank cheque" given that it would leave detailed provisions on the assessment of mental capacity to secondary legislation.¹⁰²

In 2014, the leaders of the major faith communities in Britain issued a joint statement opposing the Assisted Dying Bill 2014, arguing that it would "only add to the pressures that many vulnerable, terminally ill people will feel, placing them at increased risk of distress and coercion at a time when they most require love and support".¹⁰³ The Archbishop of Canterbury described the system the Bill would introduce as a "sword of Damocles to hang over the head of every vulnerable, terminally ill person in the country".¹⁰⁴ The Church of England reiterated its opposition to a change in the law in July 2015 and urged churchgoers to contact their MPs about the Assisted Dying Bill. James Newcome, Bishop of Carlisle, the Church of England's lead bishop on healthcare said that the Bill would have a detrimental effect on individuals and society as a whole:

¹⁰¹ Living and Dying Well, [Should Parliament License Assistance with Suicide? An analysis of proposals currently before Parliament](#), 15 July 2015

¹⁰² Living and Dying Well, [The Assisted Dying Bill \(HL Bill 6\): A Critique](#), 15 July 2014 and Baroness Berridge and others, [The Assisted Dying Bill \(HL Bill 6\): A Critique](#), July 2014

¹⁰³ ["Assisted dying bill: faith leaders' statement"](#), *Telegraph*, 16 July 2014

¹⁰⁴ ["Helping people to die is not truly compassionate"](#), *Times*, 12 July 2014 [subscription only]

He said: "Our concern about this proposed legislation is rooted in our practical care for the most vulnerable in our society. In our communities and through healthcare chaplaincy, the Church of England cares daily for the elderly, the ill, the dying and their families.

"If this Bill is passed we will have crossed a line that will make the future very uncertain and dangerous for a significant proportion of the most vulnerable people, including the elderly and those living with disabilities.

"This is a key moment for all of us as we decide what sort of society we want to live in and what future we want for our children and grandchildren, one in which all are valued and cared for, or one in which some lives are viewed as not worth living.

"I ask those who are happy to do so, to contact their MPs, either by making an appointment to see them in person at their constituency surgery, or by letter, to make it clear that they oppose this Bill." ¹⁰⁵

However, two high-profile religious figures have indicated their support for the Bill. In 2014 Desmond Tutu said that he revered the sanctity of life, "but not at any cost".¹⁰⁶ Former Archbishop of Canterbury George Carey expressed support for the Assisted Dying Bill during its consideration in the Lords¹⁰⁷ and has recently confirmed this support for the *Assisted Dying (No 2) Bill 2015* in a short video:

Lord Carey, who has maintained a strongly conservative stance on questions such as gay marriage, stunned the Church of England last year by announcing that he had changed his mind on the issue of assisted dying.

He used a short video promoted by the campaign group Dignity in Dying to underline his support for the new bill.

"Some people have said on the issue of compassion that actually pain is a noble thing, to bear pain and to say that we are suffering with you is, in my view, a very poor argument indeed," he said.

"There is nothing noble about excruciating pain and I think we need as a nation to give people the right to decide their own fate.

"And in my view it is a profoundly Christian and moral thing to devise a law that enables people, if they so choose, to end their lives with dignity." ¹⁰⁸

A group of religious leaders, including Lord Carey, wrote a letter to the Telegraph in August 2015 expressing support for the Assisted Dying (No 2) Bill 2015. The letter stated that the authors support the Bill on religious grounds for those who are terminally ill, competent and would want the choice. It suggested that this was the view of the majority of people with faith.¹⁰⁹

¹⁰⁵ Church of England, [News Release, Churchgoers encouraged to contact MPs over assisted suicide Bill](#), 15 July 2015

¹⁰⁶ "[Desmond Tutu: a dignified death is our right – I am in favour of assisted dying](#)", *Observer*, 13 July 2014

¹⁰⁷ "[Lord Carey: why I've changed my mind on assisted dying](#)", *Daily Mail*, 12 July 2014

¹⁰⁸ The Telegraph, [Assisted dying would be 'profoundly Christian and moral' – former Archbishop of Canterbury](#), 12 August 2015

¹⁰⁹ The Telegraph, [Letters: Choosing to die](#), 15 August 2015

In July 2014, the *Guardian* reported that a group of 27 senior medical figures (writing in a personal capacity rather than a representative capacity) had written to every Member of the House of Lords calling on them to back Lord Falconer's Bill:

The letter has been organised by Sir Terence English, a former president of the Royal College of Surgeons, who is also a patron of Dignity in Dying. The signatories ask peers to recognise "that the narrow scope of the bill does not allow for assisted suicide when the patient is not terminally ill, as is practised in Switzerland, nor for voluntary euthanasia, as in Belgium and Switzerland, where a doctor administers the lethal medication".

(...)

Assisted dying would empower patients, the doctors write. "We hope that assisted dying or, as some would have it, physician-assisted suicide for the terminally ill, will become legal and thereby allow dying patients who meet the criteria to have this degree of control over the final days of their life. The alternative is for them to have to consider a number of unpalatable options, including help from friends or relatives or travelling abroad to die without the advice and support of a sympathetic physician." ¹¹⁰

In a letter published in the *Telegraph* in August 2015, a group of over eighty palliative care doctors express concerns about the Assisted Dying (No 2) Bill. The letter stated that changing the law would put vulnerable people under pressure to remove themselves as a burden on their families, and that assisted suicide runs counter to the doctor's duty of care to do no harm:

We believe such proposals devalue the most vulnerable in society. We regularly come across patients who feel a burden to their relatives and to society because of their health and social care needs. These patients fit the criteria being proposed for being supplied with lethal drugs to end their lives.

They are mentally competent and are not, at least on the surface, being coerced by others to end their lives. But they may be under pressure from within to remove themselves as a burden on their hard-pressed families.

We fear that if Parliament were to legalise assisted suicide for terminally ill people, such pressures would be given free rein. Most families are loving and caring, but some are not.

The case for changing the law is being constructed on the basis that assisted suicide is needed to relieve the suffering of dying.

Dying is not an easy matter for anyone, but the advances that have been made in recent years in pain relief and the alleviation of distress have transformed the way in which the process of dying can be managed. "Hospice at home" is not yet as widely available as we would like. But it is undeniable that the incidence of "bad deaths" is much smaller today than was once the case.

Assisting suicide runs counter to our duty of care, is contrary to the "do no harm" principle and conflicts with policies for suicide

¹¹⁰ ["Assisted dying: leading doctors call on Lords to back legalisation"](#), *Guardian*, 15 July 2014

prevention. As successive surveys and consultations show, the great majority of doctors are opposed to such legislation.¹¹¹

Not Dead Yet UK, a network of disabled people opposed to assisted dying, made the following comments on the 2015 Bill:

We are opposed to legalisation of assisted suicide. It will remove equality and choice from disabled people and further contribute to our oppression. If the Assisted Dying Bill is passed, some Disabled and terminally ill people's lives will be ended without their consent, through mistakes, subtle pressure and abuse. No safeguards have ever been enacted or proposed that can prevent this outcome – an outcome which can never be undone.

With two Assisted Dying bills currently before parliament, it is really important that Deaf and Disabled people and our organisations speak out loudly against the legalisation of assisted suicide and raise awareness of the threat this poses to disability equality.

Our message is that we want support to live not die. At a time when essential support is being taken away from us, when the challenges we face are exponentially growing as a direct result of adverse government policy, it is more dangerous than ever to introduce legislation which encourages suicide as a solution to the barriers Disabled people face.

We say: give Disabled people a right to independent living before a right to suicide.¹¹²

In July 2014, the British Medical Journal (BMJ) set out its support for the Assisted Dying Bill 2014 in an editorial entitled "*It's the right thing to do, and most people want it*".¹¹³

The ex-Director of Public Prosecutions, Kier Starmer MP (who was responsible for issuing the CPS guidelines on assisted suicide in 2010) said, in an interview for the Times newspaper, that there is a need for a change in the law on assisted suicide. He was reported as saying that the CPS guidelines do not deal with those people who wish to have medical assistance with ending their lives in this country and that he believed concerns over vulnerable people were overstated:

Crown Prosecution Service guidelines "simply don't deal with the problem of people wanting to end their lives in this country, medically assisted, rather than traipse off to Switzerland", he said. "The present guidelines have in-built limitations, which mean that there can be injustice in a number of cases."

One of the key problems was that doctors were not allowed to help, which meant that chronically ill people might have to rely upon friends or relatives to help them to die.

Since he issued draft guidelines in 2009, the CPS has received files on assisted suicides in 110 cases — 70 were not proceeded with by prosecutors and 25 were withdrawn by police. The others are still being considered or have been referred for prosecution. Only one, in 2013, was prosecuted. Assisted suicide is punishable by up to 14 years in jail.

¹¹¹ The Telegraph, Letters, [Pressure to end lives](#), 24 August 2015,

¹¹² Not Dead Yet, [News: Reclaiming Our Futures Alliance Statement](#), 30 August 2015

¹¹³ "[It's the right thing to do, and most people want it](#)", *British Medical Journal*, 2014, 349: g4349

“In my time as DPP, there was only one prosecution — of someone who provided petrol and a lighter to a vulnerable man said to have suicidal intent, who subsequently suffered severe burns as a result,” Sir Keir said.

An analysis from the Dignity in Dying campaign group shows that 166 Britons went to Dignitas to take their lives in the six years to last December. Assisted suicide and euthanasia are illegal in every country in Europe apart from Belgium, Luxembourg, Switzerland and the Netherlands.

Sir Keir believes that the law does not “strike the right balance” between allowing those with a “voluntary, clear, settled and informed wish to die to be assisted by someone acting out of compassion” and protecting those who are vulnerable to being pressurised to take their lives.

Concerns over the vulnerable are overstated, he believes. “In almost none of the 80 or so cases I reviewed when DPP was this an issue.” Sir Keir asked: “Do we keep something there to protect the vulnerable and ignore the plight of those actively committing suicide or being assisted to attempt suicide, or move to a different position where there are strong safeguards?”¹¹⁴

¹¹⁴ The Times, [Laws must change to give people right to die, says Sir Keir Starmer](#), 29 August 2015

6. Stakeholders

There are many stakeholders on both sides of the debate, including campaign groups and medical bodies. Brief details of some of these organisations are set out below; this is not a comprehensive list of all bodies that have an expressed interest in or position on this issue.

6.1 Campaign groups

Dignity in Dying

[Dignity in Dying](#), formerly known as the Voluntary Euthanasia Society, campaigns for “greater choice and control at the end of life”. This would include giving mentally competent, terminally adults the choice of an assisted death within a strict legal framework. Further details of Dignity in Dying’s aims are set out on its website:

We believe that everyone has the right to a dignified death. This means:

- **Choice** over where we die, who is present and our treatment options.
- **Access** to expert information on our options, good quality end-of-life care, and support for loved ones and carers.
- **Control** over how we die, our symptoms and pain relief, and planning our own death.¹¹⁵

Dignity in Dying has an [ongoing campaign in support of the Assisted Dying Bill](#).¹¹⁶

Care Not Killing

[Care Not Killing](#) is an alliance of groups opposing euthanasia and assisted suicide formed in 2005. Its members include religious groups, disability rights groups and palliative care doctors. An overview of its aims is provided on its website:

1. promoting more and better palliative care;
2. ensuring that existing laws against euthanasia and assisted suicide are not weakened or repealed;
3. influencing the balance of public opinion against any further weakening of the law.¹¹⁷

A section of its website suggests ways in which members of the public can express their opposition to the *Assisted Dying Bill* (No 2)¹¹⁸

Not Dead Yet UK

[Not Dead Yet UK](#) was founded in 2006 by Jane Campbell, a campaigner and adviser for disability reforms who was made a life peer in 2007. It is a network of disabled people who oppose what the organisation

¹¹⁵ Dignity in Dying, [About us](#) [accessed 4 August 2015]

¹¹⁶ Dignity in Dying, [Rob Marris Assisted Dying Bill](#) [accessed 4 August 2015]

¹¹⁷ Care Not Killing website, [About Care Not Killing](#) [accessed 4 August 2015]

¹¹⁸ Care Not Killing website, [Marris Bill](#) [accessed 6 August 2015]

describes as “the legalised killing of disabled people”. Its website sets out its position on assisted suicide:

Disabled people have become aware of the dangers associated with the call for assisted suicide to be legalised. The idea that disabled people, including those who do not have long to live, are “better off dead” is not new. We believe individual disabled people’s suicidal cries for help come from a lack of proper practical, emotional and medical support needed to live dignified lives, rather than from the ‘suffering’ they experience as a result of a medical condition. Such loss of hope – which forces some to see death as their only option – is easily misinterpreted in a society that continues to see and treat disabled people as second class citizens. Individuals risk being easily exploited by the ‘right-to-die’ movement or, worse, by family, friends and health care professionals. Their attitude is not compassionate – it is prejudiced and disablist. We oppose policies that single out individuals for legalised killing based on their medical condition or prognosis. This includes helping people to die whether by killing them, or by withdrawal or withholding of treatment, in the name of compassion and mercy.¹¹⁹

6.2 Medical bodies

The British Medical Association

The [British Medical Association](#) (BMA), the trade union and professional association of doctors, formulates policies at its Annual Representative Meeting (ARM) where motions submitted by the BMA membership are debated. If approved, they become BMA policy.

The BMA policy on assisted dying was agreed in 2006:

The BMA:

- believes that the ongoing improvement in palliative care allows patients to die with dignity
- insists that physician-assisted suicide should not be made legal in the UK
- insists that voluntary euthanasia should not be made legal in the UK
- insists that non-voluntary euthanasia should not be made legal in the UK
- insists that if euthanasia were legalised there should be a clear demarcation between those doctors who would be involved in it and those who would not.¹²⁰

BMA guidance to doctors issued in 2010 states:

The BMA advises doctors to avoid all actions that might be interpreted as assisting, facilitating or encouraging a suicide attempt. This means that doctors should not:

- advise patients on what constitutes a fatal dose;
- advise patients on anti-emetics in relation to a planned overdose;

¹¹⁹ Not Dead Yet, [History](#) [accessed 6 August 2015]

¹²⁰ BMA, [What is current BMA policy on assisted dying?](#) [accessed 21 August 2015]

- suggest the option of suicide abroad;
- write medical reports specifically to facilitate assisted suicide abroad; nor
- facilitate any other aspects of planning a suicide.¹²¹

Royal College of Nursing

In July 2009 the [Royal College of Nursing](#) (RCN) moved to a “neutral” position on assisted suicide, having previously opposed it.¹²² The decision, voted on by the RCN Council, followed a three month consultation by the RCN with its members. Over 1,200 individual responses were received; 49 per cent. of individuals supported assisted suicide, although a substantial minority of 40 per cent. opposed it. The remaining submissions were either neutral on the issue (nine per cent.) or failed to record a position (one per cent.).

The decision provoked some controversy among nurses; some argued that the consultation process was inadequate and that 1,200 responses out of around 400,000 members was not a sufficient mandate for change.¹²³

In a letter to the *Times*, Dr Peter Carter, Chief Executive of the RCN, emphasised that its shift to a neutral position did not represent “implicit support” for assisted suicide, nor was it advising nurses to engage in dialogue with patients “on this contentious issue”.¹²⁴

In October 2011 the RCN issued guidance to nurses on how to respond to requests to hasten death.¹²⁵

Royal College of General Practitioners

The [Royal College of General Practitioners](#) (RCGP) held a consultation on its position on assisted dying in 2013.¹²⁶ On 21 February 2014 it announced that the majority of respondents had agreed with maintaining a position of opposition to a change in the law on assisted dying:

Although a minority of respondents put forward cases to shift the College’s collective position to ‘neutral’ or ‘in favour’ of a change in law on assisted dying, most respondents were against a change in the law for a range of reasons, including that a change in the legislation would:

- be detrimental to the doctor-patient relationship
- put the most vulnerable groups in society at risk

¹²¹ BMA, [Responding to patient requests relating to assisted suicide: guidance for doctors in England, Wales and Northern Ireland](#), July 2010, p2

¹²² RCN news release, [RCN moves to neutral position on assisted suicide](#), 24 July 2009

¹²³ See, for example, “[Nurses need to speak up against euthanasia](#)”, *Telegraph*, 29 July 2009, “[Christian nurses speak against assisted suicide](#)”, *Observer*, 26 July 2009

¹²⁴ “[Nurses, undertakers and duty to die](#)”, *Times*, 30 July 2009 [subscription only]

¹²⁵ Royal College of Nursing, [When someone asks for your assistance to die: RCN guidance on responding to a request to hasten death](#), October 2011. See also RCN press release, [RCN launches guidance for nurses on assisted suicide](#), 20 October 2011.

¹²⁶ RCGP, [Assisted Dying Consultation Analysis](#), January 2014

- be impossible to implement without eliminating the possibility that patients may be in some way coerced into the decision to die
- shift the focus away from investing in palliative care and treatments for terminal illnesses
- instigate a 'slippery slope' whereby it would only be a matter of time before assisted dying was extended to those who could not consent due to reasons of incapacity and the severely disabled.¹²⁷

Royal College of Physicians

In July 2014, the Council of the Royal College of Physicians (RCP) reaffirmed its position on assisted dying, that it did not believe a change in the law was necessary.¹²⁸

This policy was based on the findings of a survey of RCP members in 2006 in which 73.2% of respondents said they did not believe a change in the law was necessary.

Following this, the RCP conducted a new survey of members to seek their views on the issue. In November 2014, the RCP announced that the survey showed that the majority of respondents still did not think a change in the law in this area was necessary. However the percentage holding this opinion had fallen since the 2006 survey to 62.5%:

Dr Andrew Goddard, RCP registrar and senior officer with responsibility for professional matters, said:

These results give us a basis for our position on assisted dying and for responding to proposed legislation, now and in the coming years. Whilst there is still a majority against a change in the law, we recognise there has been a shift in opinion over the past eight years, and will continue to engage with members and fellows on this issue.¹²⁹

¹²⁷ RCGP, [RCGP announces continued opposition to change in law on assisted dying](#), 21 February 2014

¹²⁸ RCP, [Statement from RCP Council on assisted dying](#), 16 July 2014

¹²⁹ RCP, [RCP reaffirms position against assisted dying](#), 27 November 2014

Appendix: the position in other selected jurisdictions

This appendix provides an overview of the legal position in Switzerland, Oregon and Scotland. Switzerland has been selected as it is home to the Dignitas clinic, which a number of Britons have used to end their lives. Oregon has been selected as Lord Falconer has used its legislation on assisted suicide as the basis for his *Assisted Dying Bill*. Scotland has been selected to provide a domestic comparison with the law in England and Wales.

Switzerland

In Switzerland, there is very little explicit legal regulation on assisted suicide. Under [Article 115 of the Swiss Criminal Code](#) assisted suicide is only a crime if done for selfish reasons:

Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.

In October 2009, the Swiss cabinet sent two proposals into the legislative process for consultation, one for tighter regulation of assisted suicide and the other for an outright ban:

The Swiss parliament is said to prefer the less drastic route, which would set down strict guidelines for assisted dying groups to follow. The new rules would include requiring patients to obtain two medical opinions proving their illness was incurable and probably fatal within months. These doctors must state that the dying person had the mental capacity to assert their wish to die, and prove they had held this wish for some time. The new proposal would also require assisted dying groups to provide better written records to stop organisations profiting from patients wanting to die – and to help in case of any subsequent investigation and prosecution.¹³⁰

However, the Federal Council ultimately decided against introducing any specific criminal provisions targeting assisted suicide.¹³¹

In May 2011 Zurich-based voters took part in a referendum on assisted suicide. A proposal to ban assisted suicide was rejected by 85 per cent., while a second proposal to limit assisted suicide to Zurich residents was rejected by 78 per cent.¹³²

In recent years some concern has been expressed that in Switzerland there is no legal requirement for a person to be suffering from a terminal illness in order to undergo assisted suicide. For example, in 2009 the Guardian reported that it had obtained a document from the

¹³⁰ "['Death tourism' leads Swiss to consider ban on assisted suicide](#)", Guardian, 28 October 2009

¹³¹ Swiss Federal Department of Justice and Police press release, [Assisted suicide: strengthening the right of self-determination](#), 29 June 2011

¹³² "[Switzerland: Zurich votes on 'suicide tourism' laws](#)", BBC News, 15 May 2011

Dignitas clinic showing that a number of Britons with non-terminal conditions had used it to commit suicide:

The document shows that while many had terminal illnesses such as cancer and motor neurone disease, others had non-fatal conditions which doctors say some people can live with for decades.

It covers the medical history of all but one of the 115 Britons who have died with Dignitas's help since the first did so in 2002. It identifies 22 conditions in all. Thirty-six of the 114 unnamed Britons had various forms of cancer, 27 had motor neurone disease and 17 had multiple sclerosis.

But two had Crohn's disease, an inflammatory bowel disease; two were tetraplegics; three had kidney disease, which can be usually treated by dialysis or a transplant; and one had rheumatoid arthritis – all conditions which doctors say are not terminal.

The details have prompted deep concern among senior doctors, calls for the NHS to provide much better end-of-life care and a renewed debate over demands for a new legal right of assisted death to render the growing British use of Dignitas unnecessary.¹³³

Oregon

The relevant legislation in Oregon is the *Death with Dignity Act*, which was enacted in October 1997.

Detailed information on the Act is available on the Oregon Health Authority's website: see [Public Health: Death with Dignity Act](#).

According to the Authority's website, the Act "...allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose". A list of frequently asked questions provides more detailed background: see [FAQs about the Death with Dignity Act](#).

The FAQs set out the criteria that an individual must fulfil in order to make use of the Act:

The law states that, in order to participate, a patient must be: 1) 18 years of age or older, 2) a resident of Oregon, 3) capable of making and communicating health care decisions for him/herself, and 4) diagnosed with a terminal illness that will lead to death within six (6) months. It is up to the attending physician to determine whether these criteria have been met.

The patient must be able to prove residency in Oregon at the time they approach a physician for a prescription (e.g. by producing an Oregon Driver Licence or voter registration, or a lease agreement or property ownership document), but there is no minimum residency requirement.

The FAQs explain that prescriptions of lethal medications under the Act can only be made by qualified physicians who are willing to do so:

Patients who meet certain criteria can request a prescription for lethal medication from a licensed Oregon physician. The physician must be a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) licensed to practice medicine by the Board of Medical

¹³³ "[Suicide clinic challenged over patients who could have lived 'for decades'](#)", *Guardian*, 22 June 2009

Examiners for the State of Oregon. The physician must also be willing to participate in the Act. Physicians are not required to provide prescriptions to patients and participation is voluntary. Additionally, some health care systems (for example, a Catholic hospital or the Veteran's Administration) have prohibitions against practicing the Act that physicians must abide by as terms of their employment.

They also set out the procedure for obtaining a prescription:

The patient must meet certain criteria to be able to request to participate in the Act. Then, the following steps must be fulfilled: 1) the patient must make two oral requests to the attending physician, separated by at least 15 days; 2) the patient must provide a written request to the attending physician, signed in the presence of two witnesses, at least one of whom is not related to the patient; 3) the attending physician and a consulting physician must confirm the patient's diagnosis and prognosis; 4) the attending physician and a consulting physician must determine whether the patient is capable of making and communicating health care decisions for him/herself; 5) if either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder (such as depression), the patient must be referred for a psychological examination; 6) the attending physician must inform the patient of feasible alternatives to the Act including comfort care, hospice care, and pain control; 7) the attending physician must request, but may not require, the patient to notify their next-of-kin of the prescription request. A patient can rescind a request at any time and in any manner. The attending physician will also offer the patient an opportunity to rescind his/her request at the end of the 15-day waiting period following the initial request to participate.

Physicians must report all prescriptions for lethal medications to the Oregon Health Authority, Vital Records. As of 1999, pharmacists must be informed of the prescribed medication's ultimate use.

The FAQs also stress that euthanasia is illegal in Oregon (and in every other US state): the patient, not the doctor, must administer any lethal medication prescribed under the Act.

Scotland

In Scotland there is no specific statutory offence of assisting suicide. However, those who do assist suicide could potentially find themselves liable for more general offences such as murder, culpable homicide, reckless endangerment, assault, breach of the peace, or various offences under the *Misuse of Drugs Act 1971*.¹³⁴

In January 2010, the *End of Life Assistance (Scotland) Bill* was introduced in the Scottish Parliament by Margo MacDonald MSP. The Bill sought to permit assistance to be given to persons who wish their lives to be ended, under certain conditions. Further details can be found in [Scottish Parliament Information Centre Briefing 10/51](#) (2 September

¹³⁴ [Scottish Parliament Information Centre Briefing 10/51](#), 2 September 2010, p10. This Briefing suggests that there is currently no reported case law on the application of the criminal law to cases of assisted suicide in Scotland.

2010). The Scottish Parliament disagreed to the general principles of the Bill on 1 December 2010 and the Bill therefore fell.¹³⁵

In January 2012 Ms MacDonald launched a fresh proposal for a Bill on assisted suicide. Her [Proposed Assisted Suicide \(Scotland\) Bill](#) was subject to consultation until 2012. The [Assisted Suicide \(Scotland\) Bill](#) was introduced in November 2013. Patrick Harvie MSP was appointed an additional Member in charge of the Bill and took the lead on the Bill following the death of Ms MacDonald in April 2014.

The Bill was considered by the Health and Sport Committee before the Stage One debate on 27 May 2015.¹³⁶ Following the debate,¹³⁷ a motion on the general principles of the Bill was put to a division. The result was a decision against the motion (For:36, Against:82).

¹³⁵ [SP OR 1 December 2010, cc31042-31087 and 31094-31096](#)

¹³⁶ The Scottish Parliament, [Assisted Suicide \(Scotland\) Bill](#)

¹³⁷ [SP OR 27 May 2015, c18](#)

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