Law and Practice Following the Lord Falconer Bill: Should England and Wales Reform the Law on Assisted Dying?

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FOREWORD

At the time of writing the United Kingdom remains a full member of both the European Union and the European Convention on Human Rights (through the Council of Europe). Therefore, any discussion or potential impact on domestic legislation surrounding Brexit—the United Kingdom's possible exit from the European Union—or its withdrawal from the Convention, is not included for reasons of legal certainty.

I. Introduction

THE EUROPEAN ASSOCIATION for Palliative Care defines assisted suicide as one person 'intentionally helping [another] person to commit suicide by providing drugs for self-administration'.[1] The difference from euthanasia is that a 'doctor intentionally kills another person with the administration of drugs'. In both circumstances, the patient's 'voluntary and competent request' is required; the patient must have the requisite capacity to make such a decision,

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[1] Lars Materstvedt et al., 'Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force' (2003) Palliative Med. 97, 98.

if law permits it.[2]

This paper shall concentrate on the existing law in England and Wales as per the Suicide Act (SA) 1961[3] and prominent case law. I shall then proceed to critically analysing the current practice, taking into account the related Director of Public Prosecutions (DPP) Guidelines of 2010[4] that explain the circumstances where the DPP is 'more' or 'less likely' to prosecute a person for assisting the suicide of another.[5] This paper shall argue that the law, in contrast to present day practice, not only presents a problem that needs to be amended, but also creates uncertainty and confusion both for medical practitioners and patients' relatives.

This paper shall focus on the Supreme Court case of *R (Nicklinson) v DPP* to underline the existing clash between Art. 2 ('right to life' in support of the patient's interests) and Art. 8 ('respect of private and family life')[6] of the European Convention on Human Rights (ECHR), in defence of the rights of the relative assisting the patient's suicide.[7] Until 2014 in England and Wales the burden of this problematic area in law fell on Courts rather than Parliament. *Nicklinson* reiterates that the onus is on Parliament, if it so wishes, to change the present law as regards assisted suicide. This paper shall demonstrate that courts from other jurisdictions, as exemplified by the most recent case of *Carter v Canada (Attorney-General)* in the Supreme Court of Canada,[8] can act above Parliament. I shall then concentrate on Westminster's most recent failed call to amend the law, the Assisted Dying Bill 2014,[9] and its potential dangers. I then conclude that the law (including the 2010 DPP Guidelines) on this controversial matter must be amended due to the uncertainty caused. However, due to flawed caveats present in the rejected Falconer Bill, the draft Bill should be re-examined in order to reach safeguards as envisaged by MPs.

Although this paper ultimately supports the legalisation of assisted suicide based on the principle of a person's own autonomy, such support requires the most prudent protection of all those affected by such a change in the law. This especially applies to the vulnerable.

2 ibid.
3 The 1961 Act applies only to England and Wales.
4 As amended in 2014.
5 DPP, Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide (2010), hereafter referred to as the 2010 DPP Guidelines.
6 Article 8 of the European Convention on Human Rights provides a right to respect for one›s 'private and family life, his home and his correspondence'.
7 *R (Nicklinson & Anor) v Ministry of Justice; R (AM) v DPP* [2014] UKSC 38 (conjoined).
8 [2015] SCC 5 (Canada).
9 Hereafter referred to as the Lord Falconer Bill.

II. Ethics: Do We Have a Right to Die?

Today, one Briton every two weeks travels to Dignitas[10] in Switzerland to die.[11] In *Nicklinson*, it was argued, though unsuccessfully, that Art. 2 ECHR and the 'right to life' should naturally and automatically confer a 'right to die' as well to patients who have voluntarily chosen to die. Herring emphasises that supporters of legalisation of assisted suicide claim that 'there is nothing more horrific than a slow, pain-filled, undignified death' and that these terminally ill patients have a right to autonomy: to be able to choose on their own accord how and when they want to die, as these are matters of personal choice.[12] The principle of autonomy to that extent is dominated by the view that people should 'have control over their own bodies' and all decisions on how a person wants to live must be respected.[13] Legally, per Justice Cardozo, autonomy is defined as 'every human being of adult years and sound mind [that] has a right to determine what shall be done with his own body'.[14] Supporters of the quality of life argument claim that a good life is defined by the 'experiences of the person and their interaction with others'. If this, due to illness, can no longer be experienced by the patient, then 'life has lost its goodness'.[15]Consequently, supporters argue that if the individual patient believes that his life does not carry any more value, their decision to die should be upheld.[16] This opinion agrees with those who oppose a paternalistic approach in medical practice, since under the notion of modern paternalism a government or, in this case, the law, prohibits people from taking certain decisions or actions for their own good, as considered by society.[17]

On the other hand, the Hippocratic Oath[18] states that 'to please no one will I prescribe a deadly drug nor give advice which may cause his death'; the Oath could be claimed to cover both practices of assisted suicide and euthanasia equally.[19] The NGO Dignity in Dying—an organisation which supports the decriminalisation of assisted suicide—challenges this claim and supports that the Hippocratic Oath is

[10] A clinic assisting the suicide of competent patients.
[11] Dignity in Dying, *Assisted Dying: Setting the Record Straight* (November 2014) 3.
[12] Jonathan Herring, *Medical Law and Ethics* (4th edn, OUP 2012) 509.
[13] ibid 513.
[14] *Schloendorff v New York Hospital* (1914) 105 NE 92 (USA).
[15] Jamie Hale, 'We are told we are a burden. Legalising assisted suicide would further devalue our lives' (17 July 2017, The Guardian, London).
[16] Herring (2012) 512.
[17] ibid 198–99.
[18] Hippocratic Oath: One of the oldest binding documents in history, the Oath written by Hippocrates is still held sacred by physicians: to treat the ill to the best of one›s ability.
[19] Kenyon Mason and Graeme Laurie (eds), *Mason and McCall Smith's Law and Medical Ethics* (9th edn, OUP 2013) 741.

nowadays 'generally considered incompatible with contemporary medicine'[20] and has been replaced by a new Physicians' Oath, as prescribed in the 1948 Declaration of Geneva.[21] Nevertheless, the 1994 House of Lords Select Committee stressed that although assisting dying (including euthanasia) may be seen as appropriate in some circumstances, prohibition of intentional killing 'is the cornerstone of the law' and 'individual cases cannot…establish…a policy that would have such serious and widespread repercussions' on society.[22] Most importantly, the Committee challenged the principle of autonomy mentioned earlier, as it claims that the 'death of a person affects the lives of others' since in these cases 'the interests of the individual [patient] cannot be separated from the interest of society as a whole'.[23] As Herring puts it, 'dying is not an individual matter' due to its impact on patients' relatives and the society.[24]

The principle of sanctity of life remains one of the biggest arguments for opponents of assisted dying and euthanasia. The principle considers that no person should be intentionally killed, as each person should be highly valued even if she or he is voluntarily requesting to die. The core of this principle stems from the suggestion that if a society loses this norm, inevitably it then 'becomes necessary to value some lives as less than others'.[25] In societies that value religion more, such as Italy (predominantly Christian Catholic), Greece and Cyprus (predominantly Christian Orthodox) for example, it is considered a blessing,[26] even in severe terminal illnesses, for the patient to stay alive for as long as possible. God, and only God, decides on the length of the patient's life and the relatives will take care of the patient no matter what.[27] One could argue nevertheless that the above paradigm of three smaller societies is affected by religious views, as all three countries mentioned are considered to belong in the most religious states in the European Union.[28]

It is indeed a fact that theologists and all prominent religious faiths in the

[20] Dignity in Dying (2014) 7.

[21] As revised in 2006. The Declaration of Geneva 1948 is one of the World Medical Association's (WMA) oldest policies adopted by the 2nd General Assembly in Geneva in 1947. It builds on the principles of the Hippocratic Oath, and is now known as its modern version. It also remains one of the most consistent documents of the WMA. With only very few and careful revisions over many decades, it safeguards the ethical principles of the medical profession.

[22] House of Lords Select Committee on Medical Ethics, *Report of the House of Lords Select Committee on Medical Ethics* (HL 21–1, 1994) [237]; cited in Sheila McLean, *Assisted Dying: Reflections on the Need for Law Reform* (1st edn, Routledge 2007) 10.

[23] ibid [237]–[238].

[24] Herring (2012) 514.

[25] ibid 517.

[26] "The Will of God'.'

[27] "True compassion leads to sharing another's pain; it does not kill the person whose suffering we cannot bear" Pope John Paul II, Evangelium Vitae (1995)

[28] European Commission, *Discrimination in the EU in 2012* (Special EuroBarometer 393, 2012) 49;

world (with some exceptions) oppose intentional killing in the form of either assisted suicide or euthanasia. The Church of England, for example, supports that 'life should be respected' and 'treatment should never be to make the patient die'.[29] Interestingly, the Church highlights that by changing the law to allow assisted suicide, persons 'who are ill or dying would feel a burden to others' and inevitably, the 'right to die would become a duty to die'.[30] Montgomery makes another significant argument, that surrounding the 'peculiarly British obsession' of secularism found in bioethics committees in this country.[31] The author rightfully underlines that the tendency in public ethics committees has led to secularism in the 'reductionist sense of religion' rather than to more pluralism, essentially arguing that religious views (or religion in general) have been left out of this committees and are not heard in the public debate.[32] This in the United Kingdom has arisen from a domination of 'imported individualism' from North America that has subsequently eroded the 'sense of common good' that is dominant in mainland Europe.[33] The effect, unfortunately, is to 'impoverish public debate on bioethical issues' in this jurisdiction.[34] Although some of the blame is attributed to religious representatives, Montgomery gives the example of the case of *Pretty*, discussed below, whereby the secularist restriction made 'it difficult to voice traditional Christian formulations of the issues' concerning assisted suicide.[35]

III. The Current Status of Assisted Suicide in England and Wales

A. The Law

As per s.2(1) of the Suicide Act (SA) 1961[36] a person who 'aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide'

cf. the United Kingdom is considered to be one of the least religious nations within the EU.

29 House of Lords Select Committee on Assisted Dying for the Terminally Ill Bill, Minutes of Evidence, *Letter from the Church of England House of Bishops and the Catholic Bishops' Conference of England and Wales* (HL 86–II, 2004) [11].

30 ibid [22].

31 Jonathan Montgomery, 'Public Ethics and Faith' (2014) Theology 342, 343.

32 ibid.

33 ibid 345.

34 ibid 347.

35 ibid 345.

36 As amended by s.59 Coroners and Justice Act 2009 to clarify the language used on assisted suicide; "The Law Commission…identified confusion about the scope of the law on assisted suicide…[s.59 CJA]…does not substantively change the law, but it does simplify and modernise the language of s.2 SA 1961 to increase public understanding…that the provision applies as much to actions on the internet as to actions off-line" HC Deb 1st March 2012, vol 487 col 35 (Lord Chancellor); cited in *Nicklinson* [2012] EWHC 2381 [33].

shall be liable for a term of imprisonment of up to fourteen years. Therefore, under this offence a physician would be potentially liable for administering the patient fatal drugs that caused or attempted to cause his suicide. In addition, this offence would include any other person who may have 'aided, abetted, counselled or procured' the patient in his effort to attempt suicide, for example a spouse. A person may also be liable for encouraging another to commit suicide, irrespective to whether the patient did actually attempt suicide or not.

In addition, following earlier *Re J (A Minor) (Wardship: Medical Treatment)*,[37] it was mentioned that death cannot be the main objective of medical treatment and that it would be 'unsafe to permit any erosion in the principle of the absolute sanctity of human life'.[38] It is vital to note that following *Airedale NHS Trust v Bland*,[39] if the patient's treatment is not promoting[40] his best interests, albeit a rare occurrence, an omission assisted by a professional physician such as discontinuing life support equipment, is permitted by law. The explanation given here by the Court per Butler-Sloss LJ was that removing life support treatment from the patient would not amount to murder, but would conversely constitute an omission since he would have been placed 'in the position he would have been in before the nasogastric tube was inserted'. Here, albeit speculative, I could argue that a strong motive behind the decision was public policy and to what extent long-term patients on life support cause a financial burden to the NHS.

S. 2(4) SA 1961 states that any prosecution for assisted suicide requires the consent of the DPP. It is clear that especially for family members acting out of compassion for their severely ill relatives who have expressed their decision to die, the Act causes uncertainty especially when taking into account that it was drafted more than five decades ago. Such uncertainty is illustrated by the fact that spouses who accompany their partners to other countries such as Switzerland return to the United Kingdom in fear of prosecution for aiding suicide.[41] In one of the circumstances involving a trip to Dignitas, the parents of a terminally ill man were initially arrested for suspicion of assisting suicide although eventually not prosecuted, for they were able to prove their 'relentless plead with him to change his mind' by having booked a return ticket to the UK for their son as well.[42]

[37] [1991] 3 WLR 592.

[38] [1991] Fam 33 (CA), 51 (Lord Justice Balcombe).

[39] [1993] AC 789 (HL).

[40] Emphasis added.

[41] Philippa Roxby, 'Assisted Suicide: 10 Years of Dying at Dignitas' *BBC News* (London, 21 October 2012) [6].

[42] Richard Edwards, 'Assisted Suicide: Parents of Daniel James Will Not Face Charges' *The Guardian* (London, 9 December 2008) [4]–[5].

B. The Impact of Convention Rights

R v DPP ex parte Pretty was the first modern case to address the issue of uncertainty with the existing law as per the 1961 Act and to that extent challenge the prohibition on assisted suicide.[43] It is a significant case as it challenges the 1961 Act in light of the ECHR. The claimant, who suffered from motor neurone disease, claimed that she could receive assistance from her husband in order to assist her suicide. In order to achieve this she sought a statement by the DPP that her husband would not be prosecuted in doing so. This was rejected. The appellant claimed that the SA 1961 was incompatible[44] to the ECHR due to the fact that Art. 2 should offer her the right to die and through the DPP's earlier refusal, she was subject to 'inhuman or degrading treatment' under Art. 3 of the Convention. Pretty also alleged that the United Kingdom's blanket ban on all methods of assisted suicide was disproportionate in accordance to Art. 8 and the right to a private and family life.[45] Finally, deploying *Thlimmenos v Greece*,[46] the appellant alleged that her rights under Art. 14 were violated as she had been discriminated upon due to her disability.[47]

The Court refused her claims for a number of reasons. Violations of Art. 2 and Art. 3 could not be justified as under Art. 2(2) ECHR there is a positive obligation on the state to protect life, as concluded in *Osman v United Kingdom*.[48] Due to this positive obligation, it could not be said that Pretty was subjected to inhuman or degrading treatment because the negative obligation under Art. 3 (that one shall be subjected to inhuman or degrading treatment) complements the positive obligation to actively protect citizens' lives under Art. 2(2).[49] As regards the appellant's Art.8 'private life' claim, this could not be justified due to the provision of Art. 8(2), which provides for 'no interference of a public authority with the exercise of this right' unless it is 'in accordance with the law and necessary in a democratic society', and is in the interests of 'the protection of health' or the 'protection of the rights and freedoms of others'.[50] Under the doctrine of proportionality the latter outweighed the former. Lastly, her claim for discrimination under Art. 14 was considered by Lord Bingham to be a 'misconception' as the 1961 Act deals specifically with prohibiting assisted suicide and does not refer to disabilities.[51] Pretty then took the

43 [2002] 1 AC 800 (HL).
44 As incorporated by the Human Rights Act 1998, ss.3 and 4.
45 *Pretty* 801.
46 (2000) 31 EHRR 411.
47 *Pretty* 805.
48 (1998) 29 EHRR 245.
49 *Pretty* 806–807.
50 ibid 822.
51 ibid 825.

case to the European Court of Human Rights (ECtHR) where, in a unanimous verdict, no violations were found.[52]

C. *Purdy*: A Struggle to Clarify the Law

Debbie Purdy had been diagnosed with multiple sclerosis. As with *Pretty*, she concluded that her husband would be able to travel with her to Switzerland to assist her during her last moments. Her legal challenge under this case involved the claim that the DPP had failed to provide clear guidance on when one would be prosecuting for assisting suicide. Lord Pannick QC for Purdy, contended that s. 2(1) SA 1961 breached her right to respect of private life under Art. 8(1) of the Convention. In addition, as mentioned earlier, such an interference is permitted under Art. 8(2) if it is in 'accordance with the law'.[53] Counsel rightfully argued that this interference was unlawfully imposed due to the 'absence of an offence-specific policy' issued by the DPP, making the interference not in accordance with the law.[54] Purdy sought to also challenge whether assisting a patient to commit suicide was permitted if this occurred in a jurisdiction other than England, such as Switzerland and the Netherlands, where assisted suicide or euthanasia have been decriminalised. S. 3(3) SA 1961 states that 'this Act shall extend to England and Wales only'.[55]

The Lords unanimously agreed that Purdy rightfully challenged her decision for assisted suicide through Art. 8(1). The Law Lords opinion can be reflected through Lord Brown's judgment. His Lordship rhetorically questioned whether on some occasions assisting one's suicide could be 'commended rather than condemned'. He continued by adding that it would be possible, in certain situations, to 'regard the conduct of the aider and abettor as altruistic rather than criminal'.[56] The Court also concluded that interference of Art. 8(1) could be justified under Art. 8(2),[57] only if in accordance with the law. Lord Hope recognised that the then current practice remained unclear. He noted that the law is clear as regards someone's action of assisting another person's suicide. Nevertheless, His Lordship underlined that the 'practice that will be followed in cases where compassionate assistance' is requested from a spouse as in *Purdy*, 'is far less clear'.[58] To that extent it was ruled that the DPP should issue a Code that will 'provide sufficient guidance to Crown Prosecutors and to the public, as to how decisions' to prosecute a person

[52] *Pretty v United Kingdom* [2002] ECHR 423.
[53] *R (Purdy) v DPP* [2009] UKHL 45 [28].
[54] ibid [29]
[55] ibid [11]
[56] ibid [83]
[57] Thus overruling earlier *Pretty* on the question of Art.8.
[58] *Purdy* [27].

assisting suicide should be taken and if these are in the sphere of public interest or not.[59]

Lord Hope finally addressed the challenge to the jurisdictional spectrum of the 1961 Act and whether it would be an offence to travel with someone abroad to assist their suicide. The terminology cited by Lord Hope to analyse the construction of s. 2(1) SA 1961, was first drawn by Glanville Williams.[60] Under the terminatory theory, 'jurisdiction to try the offence is established in the country in which it was completed'.[61] Conversely, under William's initiatory theory, 'jurisdiction is established in the country where the offence had commenced'.[62] In the judgment, Lord Hope was the only Law Lord to address the issue of jurisdiction directly and concluded that the application of s. 2(1) cannot be avoided by 'arranging for the final act of suicide to be performed on the high seas…or in Scotland'.[63]

IV. The Practice

A. 2010 DPP Guidelines

Purdy required the DPP to issue Guidelines that would make the practice of prosecution for assisting suicide, for both patients and others assisting them, clearer. The Guidelines were relaxed in 2014 as regards to prosecution of physicians. One view against the reform contended that the revised Guidelines made 'society think [the disabled] are in the way', with the best option for the vulnerable being death.[64] Following *R (Nikki Kenward) v DPP*,[65] a challenge of judicial review by a pro-life disability campaigner, the Guidelines were amended in 2014 to negate the change of policy that previously said medical practitioners engaged in assisting suicide were less likely to be prosecuted.[66]

To begin, the Guidelines state expressly that *Purdy* 'did not change the law' and that only Parliament can do so.[67] The Guidelines divide into two sets of categories the factors in favour and against prosecution for a person assisting another's suicide. Some examples of prosecution being 'more likely' to be required are when

[59] ibid [54].
[60] Glanville Williams, 'Venue and the Ambit of the Criminal Law' (1965) LQR 518, 519.
[61] *Purdy* [20].
[62] ibid.
[63] ibid [18], [24].
[64] Emma Glanfield, 'Disability Campaigners to Challenge Country's Top Prosecutor' *Daily Mail* (London, 28 April 2015) [13].
[65] Unreported (28 April 2015).
[66] Owen Bowcott, 'Campaigners Win Right to Challenge Assisted Dying Prosecution Policy' *The Guardian* (London, 28 April 2015) .
[67] DPP Guidelines 2010 [5].

the victim is under 18, when they do not have capacity to reach an 'informed decision' and when the suspect 'stood to gain in some way' from the death of the victim.[68] On the other hand, it is 'less likely' for one to be prosecuted for assisting suicide if the victim had reached a 'voluntary, clear, settled and informed decision', the suspect was 'wholly motivated by compassion' and when the actions of the suspect were of 'only minor encouragement'.[69] The latter three 'less likely' factors seem relatively clear, however there are other factors that cause uncertainty. For example, one is less likely to be prosecuted if the actions of the suspect could be 'characterised as reluctant encouragement or assistance' towards the victim's wish to die.[70] The Guidelines state that the evidence to support the above mentioned factors must be 'sufficiently close in time to the assistance [to suicide]'.[71] One could question how a suspect would be expected to find evidence proving that their encouragement towards the victim was merely 'reluctant' rather than 'complete', or even challenge what 'reluctant encouragement' actually means. The Guidelines create more uncertainty to the present law and practice as they underline that the public interest factors mentioned are 'not exhaustive and each case must be considered on its own facts'.[72]

B. A Change in the Law?

Herring argues that until September 2011, 44 cases had been referred to the Crown Prosecution Service (CPS) for suspects assisting suicide, however none were prosecuted, as they were 'not motivated by a desire to gain'.[73] This could strongly indicate that the Guidelines, in practice, legalised what was already a criminal offence through s. 2(1) SA 1961. Nevertheless, this is not exactly true because between April 2009 and April 2015 there had been 110 recorded cases referred to the CPS for assisted suicide. Of these, 95 were withdrawn possibly due to policy considerations. There are currently 8 ongoing cases, 1 case that was successfully prosecuted in 2013 and 6 cases that were referred onwards for other serious crimes.[74] The CPS indicates that it is still active in following the law and initiating prosecution for alleged assisted suicide, however one would argue that s. 2(1) SA 1961 is still in place, making—at least under the strict application of the law—assisted suicide a criminal offence for all circumstances, without exceptions.

[68] ibid [43].
[69] ibid [45].
[70] ibid [45(5)].
[71] ibid [46].
[72] ibid [47].
[73] Herring (2012) 489.
[74] CPS, 'Latest Assisted Suicide Figures' (24 April 2015) <www.cps.gov.uk/publications/prosecution/assisted_suicide.html> accessed 21 July 2015.

Of the 95 withdrawn cases mentioned, most of them involved relatives acting by compassion and without any direct gain following the victim's death. This mere statistic may indicate that the law, through the democratically passed 1961 Act, has covertly been replaced by current practice, through the 2010 DPP Guidelines.

It could be argued that the Guidelines offer a fresh flexibility to the ones requesting assisted suicide, as the practice of assisting suicide may in some cases be "excused" through the DPP's decision not to prosecute but at the same time keep the law as it is, at least on paper. Supporters of the Guidelines contend that they offer a 'reasonable balance between the competing views' as regards to assisted suicide. Also, the Guidelines seem to focus more on the victim's wishes, for example by referring to family relatives that have acted wholly by compassion.[75] It is also important to note that the Guidelines focus on whether or not to prosecute the person assisting, and not on the morality behind assisting suicide. Mullock argues that the Guidelines actually reversed the pre-Guidelines 'consistent lack of prosecutions' as there existed a 'long-standing motive-centred approach to the offence' on behalf of the CPS.[76]

C. The Case Against the DPP Guidelines

There is a strong argument against the maintenance of the 2010 DPP Guidelines, which is supported by this paper. It can be claimed that these Guidelines are 'dangerous'[77] for a number of reasons, the primary reason being the potential contravention to the doctrine of supremacy of Parliament and to that extent, the rule of law. Keown underlines that even if the Guidelines did not decriminalise the s.2(1) offence *de jure*, they have done so *de facto*.[78] Lord Falconer noted that 'the DPP…in practice…carv[ed] out an exception to the terms of s.2(1)'[79] and that the existing law is 'in a mess and no longer capable of being enforced'.[80] This opinion was reflected in the 2012 Report of the Falconer Commission, discussed later in detail, where it was said that the Guidelines had 'taken a whole identifiable category of case (the offenders under s.2) out of the ambit of the criminal justice process'.[81]

[75] Herring (2012) 489–490.

[76] Alexandra Mullock, 'Compromising on Assisted Suicide: is "Turning a Blind Eye" Ethical?' (2012) Clinical Ethics 17, 17; cited in Catherine O'Sullivan, 'Mens Rea, Motive and Assisted Suicide: Does the DPP's Policy Go Too Far?' (2015) Legal Studies 96, 104.

[77] ibid.

[78] John Keown, 'In Need of Assistance?' (2009) New.L.J. 1340, 1340.

[79] Charles Falconer, 'A right to die – and a right to clarity in the law' *The Times* (London, 31 July 2009).

[80] Owen Bowcott, 'Lord Falconer: Government Must Clean Up Assisted Dying Legal Mess' *The Guardian* (London, 1 June 2015).

[81] Commission on Assisted Dying, *The Current Legal Status of Assisted Dying is Inadequate and Incoherent* (2012) 285.

Crucial is the dissenting opinion in *Nicklinson* of Lord Judge in the Court of Appeal. His Lordship highlighted that reform is necessary in the area of law surrounding assisted suicide had been 'subsumed into a method of law reform (if only by way of non-enforcement of the criminal law) which is outside the proper ambit of the DPP's responsibilities'.[82] He added that it will be 'inevitable' that the Guidelines 'at the very lowest, [will]…encourage a deep misunderstanding of the responsibilities and functions of the DPP'.[83] As laws are created for the public, public perception is also a crucial factor in defining how effective the criminal justice system is. Greasley states that 'it is not relevant… that clarification does not modify the offence (of assisted suicide) itself, so long as the public perception is that [it has been]'.[84] Put simply, the argument here is that even if the Guidelines did not modify the law under s. 2(1) *per se*, public perception to these is what counts. Indeed, as supported earlier, it seems that the public perception has been affected since 2010. The Solicitor-General in the House of Commons had underlined that 'there is a growing confusion…between the [DPP] Guidelines…and the substantive view that is set out in s. 2 SA 1961'.[85] Importantly, the Falconer Commission noticed that there was a 'broad public perception that assisted suicides that meet the criteria stipulated in the [Guidelines] are effectively decriminalised'.[86]

Once that has happened, I argue that there are two options available: either to repeal the law, or enforce it strictly, without middle or temporary solutions. This is exactly the situation with the lacuna created as regards s. 2(1) SA 1961, following the 2010 Guidelines. This argument is important because there is an obvious and potential infringement of parliamentary supremacy: a public body, the DPP, effectively amended the democratic parliamentary provision of s. 2(1) SA 1961. In *Purdy*, it was stated that the legislature and not judges are to 'make law'.[87] O'Sullivan supports that by exempting suspect relatives that had acted by compassion[88] to assist suicide from prosecution 'through the language of motive', the offence of assisted suicide has been 'dramatically curtailed by the [Guidelines]'.[89] As mentioned in *Nicklinson*, the judgment in *Purdy* could have potentially brought the DPP close to 'cross[ing] the line of constitutional propriety'.[90]

As rightfully claimed by O'Sullivan, if a 'legitimate expectation of non-

[82] *Nicklinson* (n 7) [169].
[83] ibid.
[84] Kate Greasley, '*Purdy* and the Case for Wilful Blindness' (2010) Oxford J Legal Stud. 301, 326.
[85] HC Deb 27 March 2012, vol 287 col 1380.
[86] Falconer Commission (2012) 299.
[87] *Purdy*, n 42, [26] (Lord Hope); [83] (Lord Brown); [106] (Lord Neuberger).
[88] Also referred to as 'Class 1 Helpers.'
[89] O'Sullivan (2015) 104.
[90] *Nicklinson* [145].

prosecution has been created, then this constitutes an effective[91] amendment of the offence',[92] and here the DPP Guidelines, surely, can be regarded as a legitimate expectation to potential offenders. She continues that this problem may be created when a person is prosecuted under s. 2(1), despite adhering to the Guidelines, choosing to argue 'abuse of process'.[93] Finnis agrees, noting that the 'legal (un) certainty' created by the Guidelines 'publicly carves out an exception to the blanket ban on assisted suicide'.[94] It should be reminded that the aim of publishing the 2010 Guidelines was to help a 'prospective assister and/or requester (of suicide)'[95] to foresee the 'consequences which [their] action may entail'.[96] The principal problem however is that the Guidelines 'cannot do what is asked of [them] because [they] create that which [they] seek to reduce (assisted suicides)'.[97] For that reason, by agreeing with O'Sullivan, this paper supports that *Purdy* did 'not provide clarity' but instead, 'created the very circumstances of uncertainty'.[98] These circumstances, if not acted upon immediately by Parliament, could inevitably bring the ultimate repeal of the s.2(1) offence 'by unconstitutional means'.[99]

V. Constitutionality

A. *Nicklinson*

It was expected that the decision in *Purdy* and the subsequent DPP Guidelines would lead to more 'experimentation' with the law by affected individuals. *Nicklinson*, a conjoined case in the Supreme Court, focused its claim mainly on *Purdy* and the development of the right to one's 'private life', and the Guidelines.

Tony Nicklinson had suffered a stroke that left him paralysed and in a permanent vegetative state (PVS). Following this, he could only move his mouth and eyes.[100] Mentally he remained unaffected. His wish was to die with the help of either a physician or his wife. During the first appeal, Nicklinson sought a declaration from the Court that the UK's general ban on assisted suicide under s. 2(1) SA 1961 is incompatible with his 'private life' under Art. 8 ECHR and his

[91] Emphasis added.
[92] O'Sullivan (2015) 105.
[93] ibid.
[94] John Finnis, 'Invoking the Principle of Legality Against the Rule of Law' (2010) NZ L.Rev. 601, 605.
[95] O'Sullivan (2015) 107.
[96] *Purdy* [41] (Lord Hope).
[97] O'Sullivan (2015) 106–07.
[98] ibid 107.
[99] ibid.
[100] *Nicklinson* [11].

'right to life' under Art. 2, as per the powers of s. 4 HRA 1998.[101] In the second appeal, the other appellant, Martin, challenged whether the 2010 DPP Guidelines had become present day law[102] while he also requested that the DPP Guidelines be clarified and modified in order to allow for non-family carers to assist a patient's suicide without being prosecuted.[103]

B. Compatibility with the European Convention

Nicklinson was a landmark case. The Court first addressed the issue of a 'blanket ban' on assisted suicide in England and consequently whether s. 2 SA 1961 falls within the United Kingdom's margin of appreciation under Art. 8 ECHR.[104] Here we recall that in *Pretty* any suggestion for an Art. 8 infringement on the applicant, was outright rejected by the Court. This stance was however overridden in *Purdy*.[105] Lord Neuberger, presiding the Court, stated that the 'blanket ban' concerned in *Hirst* was very different to the nature of the law on assisted suicide, which in any event is there to protect the vulnerable.[106] His Lordship emphasised that he does not consider that 'the Strasbourg jurisprudence suggests that a blanket ban on assisted dying is outside the margin of appreciation afforded to member states', adding that the current ban cannot be claimed to be a 'blanket ban' since under s. 2(4) exceptions can be made by the DPP as regards whom to prosecute.[107]

Lord Neuberger, citing *Pretty v United Kingdom* in the ECtHR,[108] stated that the position in Strasbourg is that it is 'a matter for each member state whether, and if so in what form, to provide exceptions to a general prohibition on assisted suicides'.[109] The applicants contented that the earlier *Koch v Germany* indicated that a blanket ban on assisted suicide is incompatible with Art. 8. This was rejected by His Lordship.[110] The judgment in *Koch* had importantly stated that 'a spouse or partner of… [a]…party wishing to die may claim that his…own rights under Art. 8 of the Convention are directly infringed as a result of denying a remedy to the

[101] ibid [18].
[102] ibid [36]–[42].
[103] DPP Guidelines 2010, *Factors Tending in Favour of Prosecution* [14]; whereby the suspect if acting as a 'professional carer (whether for payment or not)' is more likely to be prosecuted for assisting one's suicide.
[104] A constitutional 'leeway' offered by Strasbourg to national Courts to decide on some of their own domestic policies; discussed in *A, B, C v Ireland* [2010] ECHR 2032, a case concerning abortion in Ireland.
[105] *supra* (n 50)
[106] *Nicklinson* [62].
[107] ibid [63].
[108] *Pretty* (n 49).
[109] *Nicklinson* [64]; citing *Pretty* [74].
[110] App no 479/09 (ECtHR, 19 July 2012).

party wishing to die'.[111] His Lordship distinguished that the main issue in *Koch* was that the German courts refused to consider the applicant's issue at first sight, in form of an application for judicial review.[112] Both arguments were dismissed.

The Court next addressed the issue of whether it is 'constitutionally open' to United Kingdom courts to consider the issue of compatibility with Art. 8.[113] Emphasising that especially within cases that Strasbourg has 'deliberately declined to lay down an interpretation'[114] by awarding a wide margin of appreciation to member states, the Court 'has jurisdiction to consider whether a provision such as… [s.2]…is compatible…with Art. 8, because that is part of the Court's function as determined by Parliament' in the HRA 1998.[115] Lord Neuberger noted that under our constitutional settlement it is 'open to a domestic court to consider whether s.2 infringes Art. 8'.[116] On the question of whether it is 'institutionally appropriate'[117] for the Court to consider whether there is an incompatibility in the law, Lord Neuberger, although holding an opinion contrary to those of Lords Sumption and Hughes, urged that the Court could 'properly hold that s.2 infringed Art. 8' but a declaration of incompatibility would only be considered 'on its merits'.[118]

The judgment becomes more constitutionally complex when it reaches the question of whether the Court should grant a declaration of incompatibility in *Nicklinson*.[119] Lady Hale expressed the view that a judge of the High Court should be the one deciding on the issue,[120] after feeling satisfied that the person's wish to die was 'voluntary, clear, settled and informed'.[121] Lord Neuberger agrees with this suggestion stating that it would have been inappropriate to 'reach such a conclusion in these proceedings [since] neither the Secretary of State nor the courts below have had a proper opportunity to consider this…proposal'.[122] His Lordship concludes on the matter by underlining that there would have 'been too many uncertainties to justify our (the Court in *Nicklinson*) making a declaration of incompatibility'.[123]

As mentioned above, Martin had initially challenged that the 2010 Guidelines

[111] ibid [45].
[112] *Nicklinson* [65]; citing *Koch* [52], [71].
[113] ibid [62]–[66].
[114] ibid [72]; citing Lord Hoffman in *Re G (Adoption)* [2008] UKHL 38 [36].
[115] ibid [73].
[116] ibid [76].
[117] ibid [77]–[118].
[118] ibid [112].
[119] ibid [119]–[128].
[120] ibid [314]–[316].
[121] ibid [123] (Lord Neuberger).
[122] ibid [126].
[123] ibid [127].

infringed Art. 8 because they were unclear and required more qualification and foreseeability with regards to doctors and professional carers. The Court concluded that although the Guidelines do 'not enable the healthcare professional to foresee to a reasonable degree the consequences of providing assistance'[124] to patients wishing to die, at that stage there should not be an order against the DPP.[125] Lord Neuberger explained that by granting such an order, 'the contents of any order would either be very vague or…would risk doing that which the court should not do, namely usurping the function of the DPP, or even of Parliament'.[126] It was also noted that if the 2010 Guidelines do not appear to reflect what the DPP intends, it would seem inevitable that 'she [would] take appropriate steps to deal with the problem [of confusion]'.[127] Lord Sumption reviewing his dismissal of this claim concluded that 'whatever…said about the clarity or lack of it in the Director's published…[Guidelines], the fact is that prosecutions for encouraging or assisting suicides are rare'.[128]

C. *Nicklinson* and the Role of Parliament

One of the most crucial aspects of this judgment is the Court's insistence for Parliament to take action. In summary, out of the nine Justices of the Supreme Court, three, namely Their Lordships Neuberger, Mance and Wilson, declined to issue a declaration of incompatibility while Lord Kerr and Lady Hale would have done so. Nonetheless, the remaining four Justices, namely Their Lordships Clarke, Sumption, Reed and Hughes, concluded that the issue of assisted suicide should be directed to Parliament.

Lord Neuberger mentioned that it is 'for Parliament to decide how to respond to a declaration of incompatibility and in particular how to change the law' on assisted suicide.[129] Lord Kerr underlined that if 'a provision of an Act of Parliament is incompatible with an applicant's Convention right, this is matter of Parliament'[130] and then accepts that in such controversial areas of the law, Parliament 'might have the means to consider the issue more fully'.[131] Lady Hale makes an important argument maintaining that even if an Act of Parliament does not 'share [the Supreme Court's] view that the present law is incompatible',

[124] ibid [138] (Lord Neuberger); citing Lord Dyson and Elias LJ in the judgment of *Nicklinson* in the Court of Appeal [140].
[125] ibid [144].
[126] ibid [145].
[127] ibid [146].
[128] ibid [255(5)].
[129] ibid [127].
[130] ibid [363].
[131] ibid [347].

it should be respected because Parliament may 'consider an incompatible law preferable to any alternative' at the moment.[132] Her Ladyship concludes that 'we (the Court) have no jurisdiction to impose anything: that is a matter for Parliament alone'.[133] As rightfully stated by Lord Browne-Wilkinson in a different context, 'it is for Parliament…to repeal legislation'.[134] The appeals were dismissed.

D. Post-*Nicklinson* Position: Blurrier?

Mullock claims that the judgment in *Nicklinson* actually brought a positive outcome to those supporting a change in the law of assisted suicide.[135] She noted that following *Nicklinson*, we are in a 'position of balancing the cruelty of forcing some people to stay alive in a state of interminable suffering' against the potential risks that could impact the vulnerable, if assisted suicide became legal.[136] Lady Hale had mentioned that 'it would not be beyond the wit of a legal system to devise a process for identifying those…few people who should be allowed help to end their own lives'.[137] Mullock examines Lady Hale's suggestion of setting a High Court judge, to assess who would be permitted to die and mentions that a last moment amendment to the Assisted Dying Bill, discussed below, 'replac[ed] doctors with judges as gate-keepers' to permit assisted suicide.[138] The author supports this approach mentioning that evidence during legislative scrutiny of the Mental Capacity Act 2005 suggests that 'doctors…often make inadequate or inaccurate capacity assessments' for their patients.[139]

Lord Neuberger, following *Bland*,[140] had underlined that 'a doctor commits no offence when treating a patient in a way which hastens death, if the purpose of the treatment if to relieve pain and suffering'.[141] As per Jackson this position would be likened to a 'thou shalt not kill but needst not strive officiously to keep alive' approach.[142] This practice can be referred to as lawful end-of-life care given to patients. Mullock recognises however that an oxymoron is created if one takes into

[132] ibid [300].
[133] ibid [325].
[134] *R v Secretary of State for the Home Department, ex parte Fire Brigade* [1995] 2 AC 513, 552.
[135] Alexandra Mullock, 'The Supreme Court decision in *Nicklinson*: Human Rights, Criminal Wrongs and the Dilemma of Death' [2015] PN 18.
[136] ibid 22.
[137] *Nicklinson* [314].
[138] Mullock (2015) 22.
[139] ibid 23.
[140] [1991] 3 WLR 592
[141] *Nicklinson* [18].
[142] Adam Jackson, 'Further clarification of the law regarding mercy killing, euthanasia and assisted suicide' (2013) JCL 468, 471; citing Arthur Clough's satirical poem 'The Latest Decalogue.'

account the virtual certainty test in *Woollin*:[143] if an action was foreseen to bring about a virtually certain consequence, for example, death, the necessary mens rea element to kill can be construed automatically. This above clash in the criminal law is deployed in order to indicate that doctors and medical professionals can face confusion and in some occasions fear as to what actions they are allowed to take.[144]

In its most recent guidance published, the General Medical Council (GMC) urges doctors to 'limit any advice or information about suicide to an explanation that it is a criminal offence to encourage or assist a person to attempt suicide'.[145] The GMC guidance however adds that following assessment of the patient's symptoms and possible pain, doctors are placed under a duty to provide care which may include 'prescribing medicines or treatment to alleviate pain or other distressing symptoms'.[146] It is thus argued that in situations whereby patients express their wish to die, doctors 'must tread a careful line' between not assisting suicide but at the same time providing end-of-life care tailored towards such patients.[147] Mullock emphasises that this confusion needs to be clarified, offering the example of terminally ill patient Jean Davies,[148] who took the decision to starve to death but unfortunately required more than five weeks of suffering, without food and water, to finally rest in peace.[149] She concludes that many people 'approaching death will suffer needlessly because of the profound tension surrounding end-of-life care' and the muddled law on assisted suicide.[150]

E. Comparison: The Canadian Perspective

Recent *Carter v Canada (Attorney General)*,[151] although decided within the Canadian common law jurisdiction, followed a completely different approach to the one seen in *Nicklinson*. Since the 1990s, Canadian courts had received a number of cases that challenged the Canadian prohibition on assisted suicide. *Carter* involved five plaintiffs.[152] For the purpose of this discussion, however, I shall focus on three. Lee Carter and Hollis Johnson had assisted a family relative to travel to Dignitas to die and they were concerned with possible prosecution upon

[143] [1999] AC 82 (HL).
[144] Mullock (2015) 26.
[145] GMC, *When a Patient Seeks Advice or Information About Assistance to Die* (March 2013) [6(b)(i)].
[146] ibid [7].
[147] Mullock (2015) 27.
[148] Alexandra Topping, 'Right-to-die campaigner who starved herself said she had no alternative' *The Guardian* (London, 19 October 2014).
[149] Mullock (2015) 27.
[150] ibid 28.
[151] [2015] SCC 15.
[152] The government side shall be referred to as the 'Respondents.'

their return to Canada. Gloria Taylor, the third plaintiff, suffered from ALS and advocated for the availability of physician-assisted death upon reaching the stage where she could not commit suicide on her own due to her progressing disability.

According to s. 241 (at the time) of the Canadian Criminal Code concerning assisted suicide, a person who 'counsels a person to commit suicide, or aids and abets a person to commit suicide' is guilty of an 'indictable offence and liable to imprisonment' for a maximum term of fourteen years. Under s. 14 of the Criminal Code with regards to euthanasia, 'no person is entitled to consent to have death inflicted on him and such consent does not affect the criminal responsibility of any person by whom death may be inflected on the person by whom consent is given'.[153] The applicants challenged that the current prohibition in the law infringed Taylor's rights under s. 7 of the Canadian Charter of Rights and Freedoms (CCRF),[154] which guarantees a person's 'right to life, liberty and security'. A violation under s. 7 however would be permitted if found to be reasonable under s. 1 CCRF which refers to certain circumstances where Canada can limit one's rights under the Charter. In addition, it was contested that the current prohibition violated Taylor's right to 'equal treatment by and under the law', as per s. 15 CCRF, because she was disabled.

More than two decades ago the Canadian Supreme Court in *Rodriguez v British Colombia (Attorney General)* upheld the prohibition on assisted suicide by a narrow majority.[155] The judgment in the Supreme Court addresses all issues outlined and initially refers to trial at first instance presided by Justice Smith.[156] Firstly, under the *Rodriguez* precedent, the respondents claimed that *stare decisis* was breached and that because of that principle the lower court at first instance was obliged to follow the ruling in the judgment of *Rodriguez* in the Supreme Court. The Supreme Court found that because in this case a 'new legal issue' was raised[157] and because evidence on 'controlling the risk of abuse associated with assisted suicide' was further developed,[158] Justice Smith had correctly reversed *Rodriguez*. On the matter, the Court mentioned that '*stare decisis* is not a straitjacket that condemns the law to stasis'.[159] Arvay et al disagree with the Court's approach, emphasising that the application of *stare decisis* in the 'Charter context must be tempered both because it is a common law doctrine' and because it deals with constitutional cases.[160]

Furthermore, the Court had to balance between competing values before

[153] Criminal Code, RSC 1985, c.46 (Canada).
[154] As enacted by the Constitution Act 1982 (Canada).
[155] [1993] 3 SCR 519 (Canada).
[156] [2012] BCSC 886 (Canada).
[157] *Carter* [44] (SC); the majority in *Rodriguez* had not addressed the right to life.
[158] ibid [45].
[159] ibid [44].
[160] Joseph Arvay, Sheila Tucker and Alison Latimer, '*Stare Decisis* and Constitutional Supremacy: Will our Charter past become an obstacle to our Charter future?' (2012) SCLR 61, 75.

taking a decision. On the one hand there was the autonomy and dignity of a 'competent adult who seeks death as a response' to suffering and on the other hand, sanctity of life and protection of the vulnerable.[161] The Court found that because 'predicted abuse…on vulnerable populations has not materialised' in other Western nations,[162] the current law prohibiting assisted suicide in Canada violated s. 7 CCRF and hence Taylor's right to life, liberty and security. It found that the prohibition was 'not in accordance with the principles of fundamental justice'[163] because the current law had the effect of 'forcing some individuals to take their own lives prematurely'.[164] It defined liberty as the right to 'make fundamental personal choices free from state interference' and on the issue concluded that the prohibition violated the 'protection of individual autonomy and dignity' of the applicant[165] and was thus not justified under s. 1.[166]

The Court found a violation of s. 15 CCRF on the guarantee of equality as it was highlighted that the prohibition 'imposed a disproportionate burden on persons with physical disabilities' as they only had available the option of 'starvation and dehydration in order to take their own lives'.[167] Most interestingly, the Court also found that the law was 'overbroad'—a test similar to the European proportionality test found under Art. 8 ECHR. Overbreadth exists when a law that takes away rights 'goes too far by denying the rights of some individuals in a way that bears no relation to the object'.[168] It followed that the object referred to was what the Parliament had intended the law (or the prohibition in this case) to address.[169] The Court then underlined that the Parliament's aim was to 'protect vulnerable persons from being induced to commit suicide at a moment of weakness'[170] and consequently argues that the present prohibition, at least in some cases, '[is] not connected to the objective of protecting vulnerable persons'.[171] The Court concluded that the prohibition under s. 14 and s. 241(b) of the Criminal Code unjustifiably infringed the rights of i) a competent adult person who ii) consents to the termination of his life and iii) has a 'grievous and irremediable medical condition' that causes iv) 'enduring suffering that is intolerable' and is requesting

[161] *Carter* [2].
[162] ibid [25].
[163] ibid [56].
[164] ibid [57].
[165] ibid [64]; citing *Blencoe v British Columbia (Human Rights Commission)* [2000] SCC 44 [54] (SC) (Canada).
[166] ibid [28].
[167] ibid [29].
[168] ibid [85].
[169] ibid.
[170] ibid [86].
[171] ibid; cf. The Respondents argued that it is 'difficult to conclusively identify the vulnerable' [87].

physician-assisted death.[172] Parliament has until mid-2016 to revise the legislation and bring it into line with the Court's judgment.

F. *Carter* Versus *Nicklinson*: So Different Yet So Similar?

The two jurisdictions, England and Canada, clearly hold a few subtle differences as regards their nearly identical judicial systems. In *Nicklinson* the Supreme Court of the United Kingdom retracted from granting a declaration of incompatibility under Art. 8 ECHR for constitutional reasons. It focused on the 2010 DPP Guidelines and whether or not to clarify them further, and diverted the matter to Parliament before ultimately dismissing the appeals. In *Carter*, the Canadian Supreme Court found that the general prohibition on assisted suicide and euthanasia infringed fundamental rights of the Charter of Rights, namely ss. 1, 7 and 15. The Canadian Court in essence repealed s. 241(b) and s. 14 of the Criminal Code—laws once democratically created by Parliament. Although the Canadian Court acknowledged that the 'provincial power over health [does not] exclude the power of the federal Parliament to legislate on physician-assisted dying', one could suggest that the Court has undermined the doctrine of parliamentary supremacy, at least following *Carter*.[173] Palmer emphasised that it is a constitutional principle that 'Parliament changes the law'.[174] Conversely, in *Nicklinson* the constitutional sovereignty of Parliament was respected leading up to the Falconer Bill 2015.

This paper supports that the above outcome indicates three core differences between the judgments in *Nicklinson* and *Carter* that could explain the current (as of 2016) opposing laws now found in the two jurisdictions. Firstly, I argue that in comparison to *Nicklinson* the judgment in *Carter* is more anthropocentric rather than sociocentric: it rather addresses the rights of the individual, which are potentially violated, than the society's wider interests. This is best illustrated in *Carter* in the discussion surrounding the overbreadth of the prohibition and s. 7 CCRF. Recalling that the Parliament's target when legislating was to protect the vulnerable, the Court stated that 'the question is not whether Parliament has chosen [a particular prohibition], but whether the chosen means infringe life, liberty or security of the person in a way that has no connection' with Parliament's intentions.[175] The Court interestingly then underlines that 'the focus is not on broad social impacts, but on

[172] ibid [147].
[173] ibid [53].
[174] Stephanie Palmer, 'Assisted suicide and Charter rights in Canada' (2015) CLJ 191, 194.
[175] *Carter* [85].

the impact of the…individual whose… [rights]' are trammelled.[176]

Secondly, in various instances within the judgment in *Carter*, the Court reflected that no evidence whatsoever has indicated that legalisation of assisted suicide could lead to manipulation of the vulnerable. Smith J, at first instance, concluded that evidence has shown that 'a properly administered regulatory regime is capable of protecting the vulnerable from abuse or error'.[177] She added that 'there was no evidence from permissive jurisdictions that people with disabilities are at heightened risk of accessing physician-assisted dying'.[178] On the other hand, although in *Nicklinson* Lord Kerr mentioned that in other countries that have legalised assisted suicide 'no evidence has emerged of the vulnerable…being oppressed', the Court's direction remained cautious on the issue of protection of the vulnerable population.[179] Per Lord Neuberger for example: 'there is a risk that [legalisation of] assisted suicide may be abused in the sense that… [vulnerable] people may be persuaded that they want to die or that they ought to want to die'.[180]

Thirdly, perhaps due to the United Kingdom's direct influence from the European Convention—to which Canada is not a party—we may notice that in *Nicklinson* the applicant's challenge to his 'right to life' under Art. 2(1) ECHR could not be justified to have been violated due to the positive obligation placed on the respondent state under Art. 2(2). Conversely, under s. 7 CCRF, the Court in *Carter* found that the Canadian prohibition not only infringed the applicant's 'right to life, liberty and security' but was also found to be 'overbroad' and thus of disproportionate coverage and effect.[181] In *Nicklinson*, as mentioned above, Lady Hale with the support of other Law Lords, suggested the possibility of lessening the United Kingdom's 'blanket ban' on assisted suicide in order to make it less disproportionate by having High Court judges set out the exceptions on cases of who and when a fully consenting terminally ill patient in pain could die. Nevertheless, in England this has remained a mere proposal.[182]

VI. Parliament's Call

A. The Lord Falconer Bill on Assisted Dying

Following the Court's direction in *Nicklinson* indicating that Parliament is the

[176] ibid.
[177] ibid [3].
[178] ibid [107].
[179] *Nicklinson* (n 7) [356].
[180] ibid [49]; citing Lord Steyn in *Pretty v DPP* [54].
[181] *Carter* [85]–[87].
[182] *Nicklinson* [314]–[316].

institution to legislate on the issue of whether to legalise assisted suicide, the Bill on Assisted Dying, prepared by Lord Falconer of Thoroton, was introduced to Parliament in 2014. The Bill had experienced more than 160 amendments to date.[183] Parliamentary debates at the time indicated a tendency in slim support of the proposed Bill, an approach very different from earlier historical efforts to change the law.[184] In late 2015 the Bill got rejected by Parliament, with 330 MPs voting against the law and 118 in favour. However, as the Bill may set precedent for future legislation, it is vital to analyse its key provisions.

The proposed Bill begins, under s.1(1), by stating that 'a person who is terminally ill may request and lawfully be provided with assistance to end his or her own life'. However, this would occur legally only where the person (the patient) who has a 'clear and settled intention to end' their life[185] is an adult[186] and has been living in England or Wales for no less than a year.[187] The proposed Bill will not apply to Scotland or Northern Ireland.[188] After satisfying the above conditions the patient will need to sign a declaration, as per s. 3. A person who is not a relative of the patient and not directly linked to their treatment shall sign the declaration as a witness.[189] The declaration shall then be countersigned by two medical practitioners;[190] the first is referred to as 'the attending doctor' and the second as 'the independent doctor'. The attending doctor may be the person who first diagnosed the terminally ill patient.[191] The independent doctor must 'not [be] a relative, partner or colleague in the same practice or clinical team of the attending doctor'.[192] Before signing the declaration, the two practitioners must ensure that the patient is terminally ill,[193] has the necessary capacity to take such a decision[194] and that the 'clear and settled' voluntary decision to die had not been reached by coercion or duress.[195] The two doctors would be expected to 'separately examine the person…each acting independently of the other'.[196] Lastly, the patient

[183] House of Lords, 'Amendments' (*Assisted Dying Bill*, 2015) <www.publications.parliament.uk/pa/bills/lbill/2014-2015/0006/amend/ml006-II-R.htm> accessed 16 August 2015.

[184] Rowena Mason, 'House of Lords debate evenly split over assisted dying' *The Guardian* (London, 18 July 2014).

[185] Lord Falconer Assisted Dying Bill, s.1(2)(a); 'capacity' as encompassed in MCA 2005.

[186] ibid s.1(2)(c)(i).

[187] s.1(2)(c)(ii).

[188] s.13(5).

[189] s.3(1).

[190] s.3(1)(b).

[191] s.3(2).

[192] s.3(b)(ii).

[193] s.3(3)(a).

[194] s.3(3)(b).

[195] s.3(3)(c).

[196] s.3(3).

must have been informed about all other alternatives such as palliative and hospice care.[197] The declaration could be revoked at any time and need not be in writing.[198]

As noted, the proposed Bill was only expected to cover patients who are terminally ill. The Bill explains that a terminally ill person is one who 'has been diagnosed by a registered medical practitioner as having an inevitably progressive condition which cannot be reversed by treatment'.[199] Most interestingly, the patient should reasonably be expected to die within six months or less so as to qualify under the purposes of this Bill.[200] In terms of the extent of assistance available to the prospective patient under the Bill, it is emphasised that any medicines prescribed should be delivered to the patient only by either the attending doctor,[201] another registered medical practitioner,[202] or a registered nurse.[203] The medicines should be delivered to the patient within fourteen days from the day their declaration came into force.[204] If however the two medical practitioners agree that the patient is expected to die within one month or less from the day their declaration came into force, then any medicines must be delivered to the patient within six days.[205]

S. 4(4) of the Bill proposes a number of methods for assisting the patient to self-administer the medicines, but underlines that 'the decision to self-administer the medicine and the final act of doing so must be taken by the person for whom the medicine has been prescribed'. S. 4(5) makes clear that the Bill 'does not authorise an assisting health professional to administer (himself) a medicine to another person (the patient) with the intention of causing that person's death' and in this way rightfully draws a distinction between assisted suicide and euthanasia. The Bill gives leeway to the Secretary of State to regulate in the future the form and manner medicines and prescriptions will take.[206]

If enacted, the Bill would repeal s. 2(1) Suicide Act 1961, if in accordance with the regulations of the Bill.[207] Under the Bill, the Chief Medical Officer shall inspect, monitor and submit annual reports as regards to compliance with the law.[208] Furthermore, a person shall be committing an offence if he 'makes or knowingly

[197] s.3(4).
[198] s.3(6).
[199] s.2(1)(a).
[200] s.2(a)(b).
[201] s.4(2)(a).
[202] s.4(2)(b)(i).
[203] s.4(2)(b)(ii).
[204] s.4(2)(d).
[205] s.4(3).
[206] s.4(7).
[207] s.6(2).
[208] s.9.

uses a false instrument which purports to be a declaration made under [s. 3]'.[209] This person, if proven that he had the 'intention of causing death to another person' is liable to 'imprisonment for life, a fine, or both'.[210]

B. Was the Falconer Bill Flawed?

This paper stands against previous and current forms of the proposed Falconer Bill which have not been rejected by Parliament. In this case, although it supports future legalisation of assisted suicide for the terminally ill, I believe that the proposed Bill does not place the prerequisite safeguards for the protection of the vulnerable. Although there are positive aspects to the proposal such as the option of contentious objection under s. 5, I contend that the regulations surrounding completion of the necessary declaration under s. 3, the ambiguous encapsulation of the new criminal offences under s. 10, and the problematic criteria for eligibility under s. 2 urgently need to be revisited and clarified. I also support that without these necessary legal safeguards analysed below, a 'slippery slope' argument is more likely.

Under s. 3 a valid declaration must be completed, first by the patient and then by two independent medical practitioners. This paper argues that this is an inadequate safeguard because the doctor who first diagnosed the patient may be one of the two doctors required to countersign the declaration, as the 'attending doctor'. Again, under a healthcare context, we may recall the mistakes that occurred under the Abortion Act 1967. The said Act, similarly to the Falconer Bill, requires for two medical practitioners acting in good faith to ascertain whether the patient interested to receive an abortion falls within the four broad defences that allow an abortion to take place under the law.[211] A few years ago a scandal was revealed whereby it was found that medical practitioners were pre-signing the necessary declarations for an abortion without even examining the patient.[212] The above instance is arguably of less gravity in comparison to legalising assisted suicide, nonetheless it may indicate that either two doctors are not sufficient in number to safeguard the law as envisaged by Parliament, or that correct monitoring and inspection was not taking place effectively.[213] As in the Falconer Bill under s. 9, s. 2(2) of the 1967 Act provides for the Chief Medical Officer to monitor its

[209] s.10(1)(a).

[210] s.10(3).

[211] Abortion Act 1967, s.1(1).

[212] David Burrowes, 'Doctors Must not be Above the Law on Abortion' *The Telegraph* (London, 12 May 2014).

[213] The issue of abortions is touched upon briefly in John Keown, 'Physician-Assisted Suicide: Some Reasons for Rejecting Lord Falconer's Bill' (2015) [13] <www.carenotkilling.org.uk/public/pdf/falconer-bill---john-keown.pdf> accessed 15 August 2015.

compliance with the profession. Keown, writing against the Bill, underlines that there is 'nothing to prevent a patient "shopping around" to find two compliant doctors'.[214]

Moreover, as per s. 3(1)(b)(i), the two doctors need to act 'independently of the other' and must not be relatives, colleagues or partners in the same practice. The Falconer Bill does not refer to any criminal consequences whatsoever in case the two doctors are found to have breached the above requirements for independent assessment. The Bill imposes positive obligations on doctors (for example that they must not be colleagues) but fails to touch on the potential criminal consequences should the obligations not be followed. The Bill, under s. 10, refers only to other more serious criminal offences such as 'wilfully conceal[ing] or destroy[ing] a declaration made under [s. 3]'.[215] These particular offences are directed to all persons and not to doctors solely. One would speculate, for example, as to the legal outcome (if any) of a declaration under s. 3 regarding a truly terminally ill patient, of acceptable capacity, and with a clear and settled wish to die, but with the two doctors having previously not acted independently or with even one of them pre-signing relevant necessary documents, as in the case of abortions.

We may assume that future Codes of Practice would be developed by the Secretary of State or bodies such as the GMC to address this issue, however bearing the seriousness of the medical issue in question, this paper argues that such circumstances should be addressed clearly in the Bill. Keown rightfully argues that the vague terms of s. 4(7) whereby the Secretary of State may publish relevant Codes '[cannot] secure effective control'.[216] Baroness Finlay agrees and emphasises that the Bill is 'asking Parliament to sign a blank cheque' since the decision to approve the Bill would have to be taken 'in complete ignorance of what the safeguarding regime is'.[217]

It is noteworthy that even in cases of serious criminal offences under the Bill such as when making or 'knowingly us[ing] a fake instrument which purports to be a declaration' with the intention of causing another person's death, sentencing guides remain elusive.[218] In such an event and per s. 10(3) the offender would be faced with 'imprisonment for life, or a fine, or both'. *Inter alia*, this provision aims to protect the vulnerable. However, assuming that under this offence, in essence, the offender is illegally assisting another person by 'aiding, abetting, counselling or procuring' his suicide, the sentencing guide expectation would be imprisonment

[214] ibid.
[215] Falconer Bill, s.10(1)(b).
[216] Keown (n 212) [19].
[217] Graeme Catto and Ilora Finlay, 'Assisted Death: a basic right or a threat to the principal purpose of medicine?' (2014) JR Coll Physicians Edin 134, 137.
[218] Falconer Bill, s.10(1)(a).

of fourteen years or less and certainly without the option of a mere fine, as per the Suicide Act 1961. This paper argues that the option of a fine may potentially cause a sentencing 'slippery slope' at least in cases of *bona fide* assistance to mercy killings that would not otherwise qualify under the proposed Bill—for example a situation whereby a suffering terminally ill patient is predicted to die in more than six months.

C. Six-Month Eligibility Clause and Commission Funding

Among others, a patient would qualify for assisted suicide only if they are 'reasonably expected to die within six months',[219] possibly with the intention of protecting the long-time disabled. This paper supports that the six-month limitation not only is very restrictive but also imposes undue pressure on prospective patients, their relatives and medical practitioners.

It is supported that prognoses of death for a short period of time such as the proposed six months can be problematic. The Royal College of General Practitioners had submitted that although 'reasonably accurate prognoses of death' are possible if within minutes, hours or days, the problem underlying the six-month limitation is that it is 'genuinely difficult for doctors' to estimate death especially when it 'stretches into months' since the 'scope for error can extend into years'.[220]

Moreover, the proposed eligibility limitation does not solve the matter of patients travelling to Switzerland; it neither reduces patient flow to Dignitas nor does it clarify the ambiguity of the law surrounding people who accompany them abroad. For example, a person accompanying a patient to Switzerland, with the patient projected to die in more than six months, could still theoretically be liable for an offence under s. 2 SA 1961 as their circumstances would not be 'in accordance with the Act (the Falconer Bill)'.[221]

The s. 2(1)(b) limitation does not even address the questions presented in *Pretty* and *Purdy* since the law and practice, especially following the 2010 DPP Guidelines, would still remain blurry. Most importantly, as emphasised by Lord Neuberger in *Nicklinson*, the six-month limitation does not tackle the wider problem as reflected by patients such as Nicklinson and Martin. If alive, both applicants would not be covered by the Bill they so much fought for, because they were expected to live for much longer than six months.[222] This paper thus supports that a six-month limitation would only cover a very slim proportion of those patients wishing to

[219] s.2(1)(b).

[220] HL Select Committee (n 27) *Memorandum by the Royal College of General Practitioners* [4].

[221] Falconer Bill, s.6(1).

[222] '[The Falconer Bill] would not assist the Applicants' *Nicklinson* [122].

have assisted suicide. I believe that the focus of Parliament should not so much concentrate on whether a terminally ill patient is predicted to die in six or twelve months, but on ensuring adequate and effective safeguards are put in place to protect the potentially vulnerable.

The Falconer Commission was privately funded by influential pro-legalisation individuals such as the late Terry Pratchett and Bernard Lewis, and the NGO Dignity in Dying.[223] Opponents of a change in the law, such as the disability charity Scope, raised concerns as to the transparency and independence of the Commission's Report that is exclusively funded by pro-euthanasia individuals and organisations.[224] Lord Falconer however emphasised that the Report 'evaluates all the evidence…on a fair basis'.[225] Maynard, Chair of Scope, stresses that the Commission's 'recommendations are paper-thin on [the] crucial point' of safeguards to vulnerable persons,[226] noting that disabled lives may be seen as 'a burden on society'.[227] This paper does not assert that due to the Commission's source of funding, that arising exclusively from pro-euthanasia supporters, any lack of independence is present. Nevertheless, I argue that one could point to presumed[228] structural bias due to the Bill's pro-legalisation proposals. Montgomery, albeit from a different theological viewpoint, rightfully argues that due to the funders' 'firm secular views', the stances of Christianity (and more generally of faith under the representation of religious organisations) have been absent from the Report's (and the Commission's) core considerations.[229] As this Bill deals with serious matters that could become law, and to avoid any claims of structural bias, this paper suggests that Parliament revisits the topic with a new, fast and cost-effective White Paper or Consultation that would be independently prepared.

VII. Conclusion

This paper has argued in favour of changing the law under s. 2(1) Suicide Act 1961 and legalising the practice of assisted suicide in England and Wales. This nonetheless must not be sought at any cost to society. It is believed that the judgment in *Purdy* produced a trail of legal instability, in both the short- and long-

[223] Commission on Assisted Dying (n 78) 9, 38.

[224] ibid *Transcript of Evidence from Alice Maynard Chair of Scope* [2].

[225] Rachel Williams, 'Assisted Dying Inquiry will be Fair' *The Guardian* (London, 30 November 2010).

[226] Alice Maynard, 'Response to the Commission on Assisted Dying' (*Scope*, 10 January 2012) [8] <www.blog.scope.org.uk/2012/01/10/scope-chair-alice-maynard-responds-to-the-commission-on-assisted-dying/> accessed 16 August 2015.

[227] ibid [14].

[228] Emphasis added.

[229] Montgomery (n 29) 347.

run, whereby the DPP was requested to produce policy Guidelines to clarify the practice surrounding prosecutions for assisting suicides. To date, the 2010 DPP Guidelines have clashed with the law under the 1961 Act. In criminal law, an accused requires, *inter alia*, two elements to be convicted of an offence: breaking the law and being prosecuted for it. I therefore support that at least *de facto*, the Guidelines have somewhat changed the criminal offence of assisting suicide especially for situations involving close relatives and assistance directed by genuine compassion and no gain.

The judgment in *Nicklinson* has been constitutionally proper in diverting the matter ultimately to Parliament, although discussions around incompatibility of the law with the European Convention had been thorough. Noteworthy is also any possible effect the withdrawal of the United Kingdom from the ECHR may have on current and future euthanasia law. The contrast of *Nicklinson* with the Canadian case of *Carter* reflected the willingness of the Justices in the Canadian Supreme Court to amend the law themselves, as they saw fit. This paper supports the democratic imperative and would expect Parliament and only Parliament, to change the law on assisted suicide.

However much this paper welcomes Parliament's efforts to debate on an appropriate change of the law on assisted suicide, it cannot support the most recent Lord Falconer Bill on Assisted Dying which has now possibly set a trail for any future legislation on the matter. It has been indicated from its birth that the Commission on Assisted Dying had been funded by private pro-euthanasia individuals such as Pratchett.[230] I do not claim that the Commission and its subsequent Report have not been transparent or independent, nonetheless I do recognise the possibility of one claiming presumed structural bias towards the Report. For that reason, this paper has proposed that Parliament re-examine this serious piece of legislation by the means of a new, more pluralist (which includes religious views), fast and cost-effective White Paper or Consultation.

Although some, as in *Carter*, have made the claim that legalising assisted suicide does not produce evidence of a potential negative impact on the vulnerable, some would support that the risk to those who are vulnerable is real. Our line of argument follows that assisted suicide should be legalised only when proper and adequate safeguards have been put in place by Parliament, in order to protect the vulnerable. This paper supports that under the Falconer Bill these safeguards had not been identified appropriately, especially when considering s. 4(7) which may invite the Secretary of State to publish crucial Codes of Practice. Neither has protection been sought under the Bill by avoiding to refer to criminal consequences

[230] BBC News, 'Assisted dying inquiry backed by Terry Pratchett starts' (30 November 2010) <http://www.bbc.co.uk/news/uk-11875323>

in cases whereby doctors are found pre-signing declarations, or where they have not acted independently.

Moreover, I believe that the six-month limitation under the rejected Bill reduced terminally ill patients' eligibility to a great extent. Consequently, a vicious circle would be created whereby the road to Dignitas would still be open to prospective patients. But the ambiguity of the law, as well as fear of prosecution for assisting the suicide of a person who has been given a prognosis of more than six months to die, would also still remain. Finally, this paper supports that the only way forward is to ensure a future assisted dying Bill extends the six-month limitation to cover a wider scope of terminally ill patients, to guarantee proper safeguards for the vulnerable are put in place and to repeal the relevant section of the 1961 Act.