Royal College of Nursing

RCN Policy Unit

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Assisted Suicide

An overview of the debate

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1. Introduction

Assisted suicide is the process by which an individual is provided with the means and the assistance (e.g. drugs or equipment) to commit suicide by another person or persons.[1]

The issue of assisted suicide generates debate on a variety of levels – ethical, moral, religious, spiritual, political, professional and legal. By definition, it is an issue that affects the nursing workforce, both as individuals and as health professionals. There have been several attempts to change the law and legalise assisted suicide in the UK, with the most recent draft legislation (proposed by Lord Joffe) being defeated in the House of Lords in 2006.

The RCN is aware that there is a clear distinction between *end of life* decisions that are taken as part of palliative care and the concept of *ending life* which is a feature of assisted suicide. Health professionals can withhold or withdraw life prolonging treatment if the patient refuses it or if it is considered that the patient will not benefit from it. They may anticipate that death will result but this recognition is fundamentally different to using medical skills actively to assist suicide.

This briefing is designed to provide an impartial and balanced overview of the debate on assisted suicide to help inform a UK wide consultation with RCN members. Whilst legal and parliamentary issues vary across the four countries, many of the issues of debate are consistent across the UK. As such, this paper sets out the current different legal positions across the UK; it highlights potential changes to the existing laws; and it outlines the main arguments surrounding this important, but often contentious, issue. The briefing is not intended to cover in detail all the issues related to assisted suicide and for more information members should refer to the further reading items listed at the end of this briefing.

2. The current legal position in the UK

What does the law say on assisted suicide across the four UK countries?

Assisted suicide is illegal in England and Wales under the 1961 Suicide Act which makes it unlawful to *"aid, abet, counsel or procure the suicide of another".* In Northern Ireland, similar provisions about suicide are contained in Section 13 of the Criminal Justice Act (Northern Ireland) 1966. In Scotland, while there is no specific statute relating to suicide, it is the case that assisting, or attempting to assist, a suicide is likely to constitute a criminal offence.

In practice, current laws across the UK have been subject to wide interpretation and application. This has been demonstrated most clearly in

[1]The term 'assisted suicide' needs to be distinguished from 'euthanasia', which means the taking of direct action by a doctor to end a patient's life. The term 'assisted dying' is often used to encompass either or both 'assisted suicide' and 'euthanasia'. In 'physician assisted suicide' a doctor prescribes a lethal drug but it is either administered by the patient or by a third party, such as a nurse or a relative (Machin, V, *Churchill's Medicolegal Pocketbook*, 2003).

recent high-profile cases in England and Wales. For example, the Crown Prosecution Service (CPS) has not prosecuted anyone who has accompanied any of the 100 UK citizens who have gone abroad to end their lives at facilities run by the Swiss assisted suicide organisation Dignitas, although the police have investigated many of these cases.

Moreover, in December 2008, the new Director of Public Prosecutions (DPP) for England and Wales, Keir Starmer QC, said that no action would be taken against the parents and a family friend of the 23-year-old rugby player Daniel James, who was paralysed in a training ground accident, for assisting his death at the Zurich Dignitas facility. He stated that, although there was sufficient evidence to prosecute Mark and Julie James under the Suicide Act 1961, he felt that a prosecution would not be in the public interest. It should be emphasised that prosecutions are decided on the merits of each case, and it is for the prosecuting authorities to apply the law (i.e. Suicide Act 1961) as set down by the UK Parliament. To date nobody has been prosecuted for assisting someone with suicide. However it cannot be ruled out that legal action will be taken against an individual in the future.[2]

Are laws in the UK likely to be changed?

Previous attempts to change the law in England and Wales have failed. For example, the bill brought by the Labour peer Lord Joffe in 2006 was defeated in the House of Lords by 148 votes to 100.

The Diane Pretty case resulted in increased public attention on the issue of assisted suicide. Diane Pretty had been diagnosed with Motor Neurone Disease in November 1999. The disease progressed rapidly so that by the time she began legal action in 2001, she was confined to a wheelchair, had no movement in her limbs and was being tube-fed. She asked that her husband could be permitted to help end her life, to assist in her suicide, without fear of prosecution. The case highlighted the significant ethical and legal dilemmas in balancing the rights of an individual to self-determination with the rights of others, particularly other vulnerable people whom the law must aim to protect. Following rejection of her request, Diane Pretty took her case, firstly to the Divisional Court for Judicial Review, then appealed to the House of Lords, and finally to the European Court of Human Rights (ECHR), all in an effort to overturn the decision of the DPP.

In its judgment in Pretty, the ECHR said that "the [UK] law which criminalised assisted suicide was designed to safeguard life by protecting the weak and vulnerable, and especially those not in a condition to take informed decisions, against acts intended to end life or to assist in ending life. The blanket nature of the ban on assisted suicide was not disproportionate, as there was flexibility, in that consent was needed from the DPP to bring a prosecution and a maximum sentence was provided, allowing lesser penalties to be imposed as appropriate."[3]

[2] Note that as a result of the Suicide Act 1961 a person who commits suicide (him or herself) will not be deemed to have committed an offence.
[3] Pretty v United Kingdom, ECHR, Application No 2346/02, 29 April 2002.

In October 2008, Debbie Purdy, who has multiple sclerosis, lost a High Court case in which she asked the Director of Public Prosecutions to provide guidance on the circumstances in which her husband could face prosecution for assisted suicide. Two judges rejected her bid, which was intended to protect her husband from prosecution, saying it was a matter for parliament and not the courts. Ms Purdy was, however, given leave to take her case to the Court of Appeal and a judgment is expected early in 2009.

In December 2008 the Prime Minister, Gordon Brown, said that he did not back a change in the law for England and Wales to legalise assisted suicide. However, during 2009 there may potentially be a further attempt by a private members bill to draft legislation proposing a new legal framework for assisted suicide.

In the Queen's Speech at the end of 2008 the Westminster Government announced that it would introduce the Coroners and Justice Bill for England and Wales. This Bill contains proposals to modernise the law on assisted suicide so it explicitly applies to internet use as well as to literature, published material, or anything that encourages or assists a person to commit suicide. It is believed that attempts will be made to use this as an opportunity to amend the 1961 Suicide Act.

Previous bills for England and Wales have envisaged a number of safeguards. For example, a patient must be determined as being terminally ill, as capable of making a choice to end his or her life and to be 'suffering unbearably'. A waiting period of 15 days would also be required between two requests for assistance. Physicians would be required to assess applicants to ensure they met all the criteria; and they would also be permitted to opt out of the process by exercising a conscientious objection.

In Scotland, Margo MacDonald, an Independent Member of the Scottish Parliament (MSP), is currently consulting on proposals to permit a capable patient to request a physician assist them in ending their life under certain circumstances. This is the second time that an MSP has attempted to pass new laws in Scotland on this issue in the last four years. The first attempt was not successful, but did generate a great deal of impassioned debate.

Margo MacDonald's proposals for Scotland include the safeguards seen in previous bills for England and Wales. However, a patient would not necessarily have to be terminally ill. He or she might also be suffering from a degenerative disease, or have been unexpectedly incapacitated or simply find their life intolerable in order to request assistance in ending their life. Her consultation document asks whether 16 is an appropriate minimum age for a patient to be considered 'capable'.

Because of the way the Scottish Parliament works, there is no guarantee that these particular proposals will turn into draft legislation, be debated in the

Scottish Parliament or become law in Scotland. That will depend on the level of support for the Bill received from other MSPs.

End of life/palliative care

If further public debate about the management of terminal conditions is to be taken forward, an urgent and continuing matter of concern remains the availability of good quality palliative care for patients who need it. There have been significant developments and improvements to end of life care over recent years, for example the 'Preferred Priorities for Care Tool'. Mental capacity laws make it clear that individuals must be involved as far as possible in decision-making processes about their care unless it can be proved that they lack the requisite mental capacity. The National Council for Palliative Care published in 2008 updated guidance on the Mental Capacity Act for England and Wales providing advice and support for practitioners engaging with those who lack requisite mental capacity.

End of life care services support people approaching the end of their life to live as well as possible until they die and are often delivered by a large number and wide variety of generalist staff such as doctors and nurses, allied health professionals and social workers as well as by specialist practitioners (doctors and nurses) dealing with the most difficult cases both in hospitals and in the community. Specialist palliative care is delivered by health and social care staff with specific training in the management of pain and other symptoms and the provision of psychological, social and spiritual support.[4]

There has also been recent recognition of the need to improve access and provision of quality palliative care and end-of-life care in Scotland. An August 2008 review by Audit Scotland concluded that "good quality palliative care [was] not available to everyone who needs it", particularly those with conditions other than cancer, and that improvements were needed in terms of assessments, referral, support for patients and families, workforce development, and future planning.

The Audit Scotland report was followed up in September 2008 by the release of *Living and Dying Well,* the Scottish Government's action plan to improve the quality and delivery of palliative care and end-of-life services. The action plan is primarily aimed at NHS Boards and covers five key areas – assessment and review of needs; planning and delivery of care; communication and co-ordination; education, training and workforce development; and implementation. However, a proposal has now been put forward to place NHS Boards in Scotland under a statutory obligation "to provide high quality care to everyone on the basis of need", and to set up reporting arrangements so that the "quality of care provided can be monitored". The proposal has been introduced by Roseanna Cunningham, an

[4] The Mental Capacity Act (for England) was introduced in 2005 and the Adults with Incapacity (Scotland) Act was introduced in 2000. For further details members should refer to the links provided in the Further Recommended Reading section at the end of this briefing.

MSP for the Scottish National Party, and is also being consulted on within the same timeframe as Margo McDonald's Bill on assisted dying.

3. Arguments in favour of assisted suicide

a) Some countries allow assisted suicide

Those in favour point to the legality of assisted suicide in other countries. For example:

- In Switzerland patients must be seen by doctors and lawyers before being allowed assistance with suicide. Euthanasia is illegal in Switzerland;
- Luxembourg's parliament approved a law on euthanasia in February 2008 which allows a person who is suffering unbearably from an illness to request it;
- The Netherlands introduced euthanasia legislation in 2002, under which terminally ill patients may be eligible for voluntary euthanasia or assisted suicide. There are about 3,500 deaths a year. The practice is regulated and it is estimated that doctors - the only people allowed to perform euthanasia - turn down two-thirds of requests;
- Belgium legalised voluntary euthanasia in 2002. Patients there must consciously make the demand and be under "constant and unbearable physical or psychological pain" resulting from an accident or incurable illness;
- In the United States, Oregon was the first state to allow lethal prescriptions. Doctors can prescribe lethal drugs to help patients commit suicide, but cannot administer them.[5]

b) The right to die should be a fundamental freedom for each person

There are those who argue that, if a person judges that their life is not worth living, they have the right as sentient, autonomous human beings to act on that judgment, with assistance from others if they need it. Article 8 of the European Convention on Human Rights, for example, encompasses the right to make decisions about one's own body, and some would argue that the option of assisted dying for mentally competent, terminally ill individuals at the end of their lives should not be prevented by the state. However the European Court of Human Rights has not, to date, been prepared to find a violation of Article 8 where the state determines that there are limits to how far an individual may inflict injury and harm on him/herself.

Those advancing arguments based on human rights believe that, if people have both a human and general legal right to life and self determination, they should

[5] Washington State has recently followed suit and legalised physician assisted suicide.

also have the right to make their own choices including the choice to die with assistance.

c) Better to be realistic and regulate

Supporters of assisted suicide argue that is better to regulate it in the UK than force people into a position where they have to travel abroad, or they have to ask relatives or loved ones for help which places them in a precarious legal position and creates an unenviable ethical dilemma.

In addition, while it is illegal to assist a suicide, it is no longer a crime to commit suicide. Laws should therefore be reformed to ensure that people who wish to take their own lives – which they are legally entitled to do – but are, for whatever reason, unable to do so, can seek assistance to commit suicide.

d) Clinical consistency

Some commentators calling for a change in the law on assisted suicide point to differences and variations that exist within current clinical practice. For example, in certain circumstances some clinicians are legally entitled to withdraw and withhold life prolonging treatment; they can issue *do not attempt resuscitation* orders; and they can also provide medication to relieve pain that may have the unintended effect of hastening death.

As such, the proponents of this particular argument state that UK laws must be amended in a way that ensures clinical consistency by giving patients the same rights over their life as clinicians and by protecting clinicians who are willing to assist suicides when requested to do so.

4. Arguments against assisted suicide

a) Clinical ethics and the doctor/nurse-patient relationship

Deliberately ending a patient's life, even at his or her request, is by many considered as contrary to clinical and nursing ethics.[6] It is argued that acting with the primary intention to hasten a patient's death would be difficult to reconcile with the medical ethical principles of beneficence and non-maleficence.[7]

A competent patient must always have the right to follow or refuse medical advice, even to their detriment. The Nursing and Midwifery Council (NMC) stated in its evidence to the Select Committee on Lord Joffe's Assisted Dying for the Terminally Ill Bill that: "The NMC Code … states that nurses must protect and support the health of individual patients and clients. The Code also clearly dictates that nurses must respect the rights of the individual and the patient/client's role in planning their own care. Nurses are advocates for

[6] Note the Nursing and Midwifery Council's (NMC) Code: Standards of conduct, performance and ethics for nurses and midwives (2008), http://www.nmc-uk.org/aArticle.aspx?ArticleID=3056.

[7] See evidence given on Lord Joffe's 2004 Assisted Dying for the Terminally Ill Bill, House of Lords Report HL 86-I (Session 2004-05, Paragraph 108).

the patient/client and have a legal, moral and professional duty of care recognising the patient/client's right to individual choice at all times."[8]

However a core element of nursing practice is that, health professionals must never have the right, or option, to suggest a course of action that would cause harm to their patients. This is especially true when the physical, mental and emotional state of a patient makes them vulnerable to making an unconsidered decision about assisted suicide.

Furthermore, patients trust their doctors and nurses on the basis that the treatments and advice they receive will always be those considered to be in their best interests. Agreement by a doctor or nurse to take forward a request for assisted suicide could carry with it a subtle message that such a course of action is regarded as the right thing for the patient to do in his or her clinical circumstances.

b) Better palliative care

Improved palliative care would negate the need and the demand for assisted suicide. Those who put forward this argument believe that the focus should be on meeting the palliative care needs of dying people in order to ensure the provision of appropriate pain control, dignity and comfort, rather than clinically assisting suicide.

They argue that much more attention needs to be given to the provision of high quality end of life care, available to all who need it, including the accurate assessment and treatment of pain and the provision of appropriate psychological care.

c) Value and sanctity of human life

Spanning the ethical, the religious and the spiritual there is an argument which states that assisted suicide should be always outlawed because of the sanctity of human life.

All human beings are worthy of dignity and respect and should be cared for throughout their lives. People nearing the end of their lives need to know that society in general, and healthcare professionals in particular, are committed to their well-being, even if this does involve expenditure of time and money. In other words, it is morally wrong for society to pass legislation that is grounded in the belief that some people are better off dead. Assisted suicide would therefore undermine all the fundamental principles underpinning the sanctity of life.

This argument also states that the right to decide what happens to your life must be balanced against the responsibilities and the rights of others. No person chooses assisted suicide in isolation - friends, relatives, doctors,

[8] Memorandum by the NMC to the Select Committee on Lord Joffe's Assisted Dying for the Terminally Ill Bill (2004), http://www.parliament.the-stationery-office.com/pa/ld200405/ldselect/ldasdy/86/5020343.htm.

nurses and society are affected by the wider ramifications of the process. Consequently, a person's request to die is neither straightforward nor uncomplicated.

d) Potential coercion of vulnerable members of society and broadening of application

Opponents of any change in current UK laws argue that the legalisation of assisted suicide would make vulnerable people – the sick, elderly, depressed and disabled – feel under pressure, whether real or imagined, to request early death. They might come to believe that they have become a care, financial or emotional burden to their family or others, and might also potentially be suffering from transient despair or depression, such that a risk arises that they will feel pressured into a decision they would not have made under different circumstances.

A further concern sometimes expressed is that the criteria for legalised assisted suicide could either be widened by subsequent legislation or become subject to elastic interpretation. Thus, a law made initially for the terminally ill might come to be applied, once the principle of assisted suicide had been established, to chronically ill patients or others who might be considered to be suffering in one way or another.

5. Issues in relation to nursing practice

Between 2004 and 2006 the RCN talked with its membership about the issue of voluntary euthanasia, including assisted suicide. One of the most high profile issues concerned the potential for lawful assisted suicide to compromise the nurse-patient relationship, leading to fear amongst vulnerable people at a time when they most need to feel supported by their clinical team.

RCN members also expressed their concerns about the inconsistency of provision of end of life and palliative care services. It was felt that the availability of first class services would alleviate the desire of patients to seek to end their lives and the possibility that they would require assistance to do so. However, no evidence was offered that indicated that the people travelling to the Zurich Dignitas facility were doing so because their end of life care and palliative care was poor or undignified.

Additional issues to consider include:

- What would be the extent of nursing involvement in any decision making/assessment for/about patients requesting assisted suicide?

- Could the use of advance decisions to refuse treatment under mental capacity legislation be considered as an effective alternative?

- What would be the extent of nursing involvement in the act of suicide itself (for example, assisting a doctor in preparing medication for intra-venous delivery or delivery via a nasogastric tube)?

- What early warning systems are needed to highlight areas where end of life care and palliative care services are poor and patients may be looking to assisted suicide as an end to unnecessary suffering?

- What if an assisted suicide procedure went wrong or a patient took longer to die than expected? What would a nurse's role and extent of responsibility/liability be?

- What would the impact of assisted suicide be on nurse prescribing?

- What about patients who are not terminally ill?

- What is the likely impact of introducing assisted suicide on palliative care services?

6. The RCN's position

In 2004 the RCN invited, via its website, Discussion Zone and fortnightly Bulletin publication, its members to comment on Lord Joffe's *Assisted Dying for the Terminally Ill Bill*. Several key groups including RCN Fellows, issue-related Forums and the Ethics Advisory Panel were invited to comment. RCN members were concerned with pain and symptom control and a lack of palliative care options for terminally ill patients.

A 2005 RCN Congress item on euthanasia produced an evenly balanced debate in terms of arguments in favour of and opposed to euthanasia. The issue was not put to a vote.

Members were actively encouraged to explore the issues and in response to this debate the RCN initiated actions aimed at informing members with regard to issues relating to assisted suicide. This included the production and dissemination of material aimed at clarifying terms such as 'voluntary euthanasia', 'assisted suicide', 'assisted dying' etc. while further exploring the complex ethical issues.

The RCN did not support Lord Joffe's Assisted Dying for the Terminally Ill Bill in Westminster.[9] The Bill was not limited to physician assisted suicide and implied a substantial role for the nursing profession in assisting death. However, the RCN was very concerned that this role was not clearly defined and that the Bill failed to provide sufficient safeguards as to make the proposed legislation workable. Furthermore, the Bill was intended to make physician-assisted suicide lawful but the RCN felt that it had not been sufficiently tightly drafted to exclude voluntary

[9] See the RCN Parliamentary Briefing on Assisted Dying for the Terminally Ill Bill (May 2006), and also the Memorandum by the RCN to the Select Committee on Lord Joffe's Assisted Dying for the Terminally Ill Bill (2004), http://www.parliament.the-stationery-office.co.uk/pa/ld200405/ldselect/ldasdy/86/41014p07.htm.

euthanasia being carried out by a doctor. For similar reasons, the RCN did not support the 2005 proposal for the private members' Bill on 'Death with Dignity' that was put before the Scottish Parliament.

The RCN now believes that it is timely to consult more widely and systematically with its membership on the broader debates around this important issue.

7. What are the options?

Over recent years many national organisations have given detailed consideration to the issue of assisted suicide. The debate has often been challenging with a clear consensus sometimes being difficult to reach. Although the media have often listed the possible options for assisted suicide as being for, against and neutrality, these positions are rarely clear cut. There is sometimes concern that the position of an organisation can be misinterpreted within the debate, for example neutrality has in some cases been incorrectly referred to as an indication of support for assisted suicide. Health professionals are medical, not ethical/legal experts and some feel this decision is a matter for Parliament, the law makers and society as a whole. Instead they feel their role as trusted medical professionals is to advise on the clinical consequences of such a change in the law and focus on the appropriate protection and safeguards for patients.

If there was a change in the current legal position to allow assisted suicide careful consideration should be given as to who would be responsible for the practical consideration of assisting suicide. Not all health professionals would wish to be involved and the extension of a nurse's role to encompass a role in assisting a suicide would be a fundamental step (as well as impacting on the public perception of nursing). There is a question of how those requested to assist suicide will be required to cope with the impact on themselves. As care is increasingly delivered in multidisciplinary teams it would be imperative that clear lines of responsibility were established in such a scenario.

8. Conclusion

Like any section of the population nurses express a range of views on sensitive ethical issues. The notion of ending a human life is a profound and emotive concept, particularly for health professionals whose values and code of ethics are orientated to improving and maintaining health wherever possible.

However, the RCN believes that a consultation with members on this area is now appropriate in light of the wider public debate and the recent developments in relation to assisted suicide over the last few years (in particular the high profile suicides at the Zurich Dignitas facility). It is important that nurses understand the issues, both from an ethical and legal standpoint as well as from a patient's perspective.

The College would like to hear the views of as many members as possible on this important issue. During the consultation process views will be sought from RCN regional and country boards, branches, forums and individual members. In addition to this briefing a proforma response template has been made available on the RCN website with the purpose of assisting members to frame their responses (members are not, however, restricted in any way in the form in which they choose to respond to the issues in this briefing). Further details regarding the consultation process are available on the RCN website.

Further Reading

(Please note that the following references are provided for those members interested in researching the topic of assisted suicide in more detail. The inclusion of an article or reference here does not necessarily indicate that its content is endorsed for the purposes of this briefing.)

Chapman, S, *The Mental Capacity Act in practice Guidance for End of Life Care*, NCPC London (2008)

European Court of Human Rights, Strasbourg, *Case of Pretty v. The United Kingdom* (2002)

Purvis, J, *Dying With Dignity: a consultation paper* (2005)

Van der Maas PJ, van Delden JJM, Pijnenborg L, *Euthanasia and other medical decisions concerning the end of life* (1992)

Royal College of Physicians, *Written Evidence to the House of Lords select committee on the assisted dying for the terminally ill bill [HL]*

BMA Medical Ethics Department, *Euthanasia and Physician Assisted Suicide: Do the Moral Arguments Differ* (April 1998)

House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill [HL], *Report on the assisted dying for the terminally ill bill*

MacDonald, M, *The Proposed End of Life Choices (Scotland) Bill Consultation Document* (2008)

National Council for Palliative Care, *The Mental Capacity Act in Practice: Guidance for End of Life Care* (March 2008)

Scottish Parliament, *End of Life Choices consultation*

National Audit Office, *End of Life Care* (November 2008)

Emerton, A, *A Truly Awesome Responsibility* (2008)

Storey, L, *End of Life Care 2007 Vol 1 No 2*

Storey, L; Pemberton, C; Howard, A; O'Donnell, L, *Cancer Nursing Practice May 2003 Vol 2 No 4*

All Party Parliamentary Group on Dying Well, *The slippery slope is no fiction, says Lord Carlile* (2008)

Select Committee on Assisted Dying for the Terminally Ill Bill, *Memorandum by the Royal Collage of Paediatrics and Child Health* (2004)

Mental Capacity Act 2005

Adults with Incapacity (Scotland) Act 2000

The Scottish Government, *Living and Dying Well: A national action plan for palliative and end of life care in Scotland* (October 2008)

Audit Scotland, *Review of palliative care services in Scotland* (August 2008)

Finlay, I, *Report to Minister (Wales): Implementation of Palliative Care Report* (September 2008)