

A FINAL PLEA FOR “DEATH WITH DIGNITY”: A PROPOSAL FOR THE MODIFICATION AND APPROVAL OF THE ASSISTED DYING FOR THE TERMINALLY ILL BILL IN THE UNITED KINGDOM

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ABSTRACT

Increasing respect for personal autonomy in health-related decision-making, major alterations in the assisted suicide laws of other European countries (especially Switzerland and the Netherlands), and the rising popularity of Swiss suicide clinics have introduced the need for the British legislature to reevaluate the United Kingdom’s stance on assisted suicide and to adjust medical practices to contemporary social needs. The introduction and obstruction of a bill in the House of Lords for the legalization of physician-assisted suicide for terminally ill individuals has provoked opposition from the British medical community and serious concern on behalf of members of the government regarding the future of the nation’s end-of-life law. In contrast, general public opinion appears to grow in favor the bill’s passage.

The Swiss and Dutch legal regimes provide settings against which the potential change in British medical law can be compared. This Note proposes the implementation of further alterations of the bill to ease concerns about a “slippery slope” and encourages the bill’s approval in the House of Lords in a future parliamentary session.

I. INTRODUCTION

The British government faces an ongoing controversy over its end-of-life law, which now reaches beyond its nation’s borders. Proponents for change in the country’s assisted suicide law assert that the rising trend toward autonomous health care decisions,¹ the example of liberalized neighboring nations,² and the growth of the

¹ Hazel M. Biggs, *The Assisted Dying for the Terminally Ill Bill 2004: Will English Law Soon Allow Patients the Choice to Die?*, 12 EUR. J. HEALTH L. 43, 44-47 (2005).

² Georg Bosshard, Susanne Fischer & Walter Bär, *Open Regulation and Practice in Assisted Dying: How Switzerland Compares with the Netherlands and Oregon*, 132 SWISS

suicide clinic phenomenon³ necessitate the introduction of legalized, physician-assisted suicide to respect the wishes of terminally ill patients who desire to end their unbearable pain in a dignified and peaceful manner. The criminal penalty in the United Kingdom for assisting an individual to end his or her life through suicide remains one of the most severe in Europe.⁴ While the Suicide Act 1961 made suicide permissible, a provision of the act simultaneously created a new statutory offense defined as “aid[ing], abet[ting], counsel[ing] or procur[ing]” the act of suicide by another, to which a punishment of up to fourteen years imprisonment was attached.⁵ Although the British Parliament has held steadfast to this harsh criminal penalty, members of the House of Lords have voiced their determination to overcome this long-standing barrier. This Note encourages the initiation of a major change within Great Britain through the House of Lords’ approval of proposed legislation known as the Assisted Dying for the Terminally Ill Bill.⁶ The second version of the bill brought before the House of Lords⁷ authorizes the establishment of assisted suicide as a legally viable option for an individual suffering from the physical pain and loss of personal autonomy associated with a debilitating terminal illness.⁸ Although rejected by the British Parliament for the second time in May 2006 and delayed for six months, there is no foreseeable end to its controversy.

The bill was not a revolutionary proposition bound to startle and offend, but rather the inevitable result of tensions among the medical community, legislators, and the general public that have

MED. WKLY. 527, 527 (2002) (explaining the legalization of assisted suicide in both Switzerland and the Netherlands).

³ Antonio Ligi, *Suicide Tourism a Grisly Problem for the Swiss*, N.Z. HERALD, Aug. 12, 2006, available at http://www.nzherald.co.nz/section/story.cfm?c_id=2&objectid=10395906.

⁴ Biggs, *supra* note 1, at 45.

⁵ Suicide Act 1961, 1961, 9 & 10 Eliz. 2, c. 60 (Eng.).

⁶ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

⁷ The first bill was brought before the House of Lords in 2004, but time ran out before the House could further deliberate on it. Assisted Dying for the Terminally Ill Bill, 2004, H.L. Bill [17] (Gr. Brit.). The main difference between the 2004 and 2005 versions and the likely reason for the 2004 bill’s failure is that the 2004 bill preceded the extensive research done in connection with the bill, which provided the House of Lords with more of a background against which they could accurately assess its proposal. The 2004 bill also lacked certain safeguards that the 2005 bill contains. The possibility of success for the bill in a future parliamentary session likely increases with the number of safeguards included in the bill.

⁸ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

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accumulated over time. National polls have indicated notable changes in public opinion. One such opinion poll administered in 1976 reported that 69% of Britons were in favor of legislation to allow assisted dying, while the same opinion poll administered in 2004 reported that 82% of Britons were in favor.⁹ According to Lord Joel Joffe, the bill's author, the debate surrounding the bill should be primarily characterized as a balancing of two competing and conflicting interests, namely the potential social injuries that result from allowing assisted suicide with the personal and individual right to request assistance to die.¹⁰ The bill addresses this conflict by including an extensive list of safeguards and a highly regulated decision-making process to prevent the creation of a slippery slope.¹¹ Its provisions do not compel assisted suicide but only create the option;¹² the bill's ultimate goal is to empower those individuals of sound mind who feel that ending their lives is in their own best interest.

The goal of this Note is to encourage acceptance of the legalization of assisted suicide in Great Britain by evaluating the need for change from the perspectives of legislators, physicians, and the British people. It also proposes changes to the current version of the bill to improve the likelihood that the bill will be approved upon further review. The liberalized assisted suicide laws and stable medical practices of nearby Switzerland and the Netherlands provide an important context for assessing the likely success of this legal change in Great Britain, particularly because they form the background against which Lord Joffe reviewed his own bill.

⁹ M.A. Branthwaite, *Taking the Final Step: Changing the Law on Euthanasia and Physician Assisted Suicide*, 331 BRIT. MED. J. 681, 682 (2005). These surveys have been remarked as too basic due to the "form of simple Yes/No questions posed without an exploration of the surrounding context—for example, the availability and effectiveness of palliative care," but the increase in the proportion of positive respondents is a significant indication of a change in public opinion. SELECT COMMITTEE ON THE ASSISTED DYING FOR THE TERMINALLY ILL BILL, VOL. I: REPORT, 2005, H.L. 86-I, at 6, available at <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86i.pdf> [hereinafter SELECT COMMITTEE REPORT].

¹⁰ Lord Joel Joffe, Letter to the Editor, *The Proposed Assisted Dying Bill in the UK*, 20 PALLIATIVE MED. 47, 47 (2006); see also Part III of this Note (explaining fears, such as abuse of vulnerable and elderly patients and the undermining of the medical profession, and describing the rise in respect for autonomous decision-making).

¹¹ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.); see also Joffe, *supra* note 10.

¹² Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.); see also Joffe, *supra* note 10.

Part II.A of this Note provides the history of Great Britain's end-of-life law and the state of its medical treatment methods in order to assess the desirability and potential consequences of implementing a change. Part II.B discusses assisted suicide laws in both Switzerland and the Netherlands and their influence on the British controversy. Swiss suicide organizations have sprouted since the legalization of assisted suicide, the most controversial of which offers assisted suicide services to individuals not only within the country's borders but throughout Europe, having drawn at least 54 British individuals to its clinics.¹³ One side of the ongoing debate in Great Britain believes that this growing number must be heeded as a signal that British law must conform to the changing needs of these strong-minded people in order to assure them a safe and manageable way of ending their lives. This section next focuses on the Netherlands, which is the most liberal of all the European countries in terms of its end-of-life practices.¹⁴ Assessing the country's cultural circumstances and legal changes allows one to better comprehend the spectrum of end-of-life decision-making and, in turn, more ably to scrutinize the potential successes and downfalls inherent in a system permitting physician-assisted suicide.

Part III analyzes the most current Assisted Dying for the Terminally Ill Bill and assesses criticisms of the bill, which include slippery slope arguments, fears about damage to the state of palliative care and the medical profession, and other concerns.

In conclusion, this analysis demonstrates the urgency to amend the time-worn Suicide Act 1961¹⁵ in view of the current state of affairs in Great Britain and the changing face of international end-of-life law.

¹³ *Depressed 'Could Get Help to Die,'* BBC NEWS, Sept. 20, 2006, <http://news.bbc.co.uk/1/hi/health/5364000/5364400.stm>.

¹⁴ Mason L. Allen, Note, *Crossing the Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia*, 31 *BROOK. J. INT'L L.* 535, 535-575 (2006).

¹⁵ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.) (amending Section 2 of the Suicide Act 1961 by inserting a subsection which states that "Subsection (1) does not apply where a person assists another person to die, or where a person helps another person to assist a third person to die, or where a person is present when another person ends his own life or attempts to do so, in accordance with sections 1 and 8 of the Assisted Dying for the Terminally Ill Act 2005."); see Suicide Act 1961, 1961, 9 & 10 Eliz. 2, c. 60 (Eng.).

II. BACKGROUND

A. *British Law*

The Suicide Act 1961 simultaneously eliminated suicide as a crime in Great Britain and made to “aid, abet, counsel or procure such an act by another”¹⁶ a statutory offense with a possible penalty of up to fourteen years imprisonment.¹⁷ Many exceptions and exclusions to the Suicide Act 1961 have been born as a result of British medical procedure, creating uncertainty in an area that should otherwise be unambiguous. These procedures include terminal sedation and refusal of treatment despite certain death (the purpose of which is difficult to distinguish from that of assisted suicide). Terminal sedation is frequently referred to under the “double effect”¹⁸ doctrine, in which reasonable measures to reduce the pain experienced by a terminally ill patient may be legally taken even in the event that they accelerate death in the process.¹⁹ *Airedale NHS Trust v. Bland* discusses refusal of treatment, in the context that physicians “responsible for [a patient’s] care must give effect to his wishes, even though they do not consider it to be in his best interests to do so”²⁰

One of the most widely publicized cases was *Pretty v. United Kingdom*, in which a woman with motor neurone disease challenged assisted suicide law by requesting that her husband not be

¹⁶ *Id.*

¹⁷ *Id.* Assisted suicide is commonly defined (and is so defined in Great Britain) as “any action taken to encourage or help somebody to kill oneself. It may consist of providing a lethal substance or any other means to the person planning to commit suicide. The final gesture (e.g. taking and swallowing the pills) must be made freely by the person committing suicide.” Olivier Guillod & Aline Schmidt, *Assisted Suicide Under Swiss Law*, 12 EUR. J. HEALTH L. 25, 26 (2005).

¹⁸ The double effect doctrine is described in *Cruzan v. Director, Missouri Dep’t of Health*, where the Court made the distinction between allowing a patient to die and making him die. The case shows that in some cases, where death is imminent, a patient’s autonomy interest may outweigh the state interest in preserving life. 497 U.S. 261, 273 (1990). For an overview of the double effect doctrine, see Alison McIntyre, *Doctrine of Double Effect*, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., 2006), available at <http://plato.stanford.edu/entries/double-effect/>.

¹⁹ In *R. v. Adams*, the jury received the instruction that “[i]f the first purpose of medicine, the restoration of health, can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life.” [1957] CRIM. L. REV. 365.

²⁰ [1993] AC 789, 864 (Civ.).

subject to prosecution for assisting in her death.²¹ She knew that her disease would ultimately paralyze her, rendering her physically unable to end her life on her own or communicate with her family.²² The House of Lords explained that they could not interpret Section 2 of the Suicide Act 1961 to mean that there is a right to die or a right to gain assistance in dying.²³ Rather, it relied on a ruling by the European Convention on Human Rights, which “enunciated the principle of the sanctity of human life and provided that no individual shall be deprived of life by means of intentional human intervention, [and] did not imply the right of an individual to choose whether to live or die.”²⁴ The case continued for two years until the European Court of Human Rights heard it in 2002.²⁵ Ms. Pretty was ultimately denied relief and later died of suffocation, as she had dreaded.²⁶

A more recent case, from the United Kingdom High Court, is *Re Z; Local Authority v. Z*, which involved a woman who, like Ms. Pretty, suffered from an incurable disease that would ultimately destroy her motor function.²⁷ After first attempting her own suicide, she later expressed interest in assisted suicide to her husband and family.²⁸ While disagreeable at first, her husband and family came to support her desire and the woman arranged to go to Switzerland to follow through with her decision.²⁹ However, since she needed the assistance of her husband to do so and he informed the local authorities about the plan, the husband was barred by an injunction, on the basis of potential criminal liability under the Suicide Act 1961, from assisting his wife in her suicide by removing

²¹ *Pretty v. United Kingdom*, 41 Eur. Ct. H.R. 155 (2002). Individuals diagnosed with motor neurone disease do not necessarily have palliative care as an available remedy. One fervent speaker revealed during a House of Commons debate that “[h]alf of all patients diagnosed with motor neurone disease die within 14 months of diagnosis, yet a survey carried out in 2005 found that only 39 percent of such patients were referred to specialist palliative care services. Is it any wonder that people take fright when diagnosed with MND?” 441 PARL. DEB., H.C. (6th ser.) (2006) 1443.

²² *Pretty*, 41 Eur. Ct. H.R. 155, ¶14.

²³ *Id.*; see Suicide Act 1961, 9 & 10 Eliz. 2, c. 60 (Eng.); see also *United Kingdom: The Physician-Patient Relationship*, in INTERNATIONAL ENCYCLOPAEDIA FOR MEDICAL LAW 204 (Herman Nys, ed. 2002) (discussing *Pretty v. UK*).

²⁴ SELECT COMMITTEE REPORT, *supra* note 9, at 25; see *Pretty*, 41 Eur. Ct. H.R. 155.

²⁵ *Pretty*, 41 Eur. Ct. H.R. 155.

²⁶ GAIL TULLOCH, EUTHANASIA—CHOICE AND DEATH 90 (2005).

²⁷ *Re Z; Local Authority v. Z*, [2004] EWHC (Fam) 212, 2004 All E.R. (D) 71 (Eng.).

²⁸ *Id.*

²⁹ *Id.*

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her to Switzerland.³⁰ The Court determined that the woman had legal decision-making capacity and had made the decision solely on her own behalf.³¹ Although the Court found that the local authorities had the power to further enforce the injunction, it lifted the injunction and allowed Mrs. Z to proceed with her plan.³² The Court explained that the primary duty of the local authorities was to determine Mrs. Z's decisional capacity, and the Court could not interfere with her right to autonomy and self-determination, especially if it were to do so largely because of her disability.³³

Lord Joffe first introduced the Patient (Assisted Dying) Bill as a Private Members Bill in 2003.³⁴ The bill was representative of the increasing attention paid to the importance of personal autonomy.³⁵ It was changed following an intense Parliamentary debate and reintroduced as the Assisted Dying for the Terminally Ill Bill in 2004, modeled on the effective Oregon assisted suicide law.³⁶ It

³⁰ *Id.*; see Suicide Act 1961, 1961, 9 & 10 Eliz. 2, c. 60 (Eng.).

³¹ *Re Z*, [2004] EWHC (Fam) 212, 2004 All ER (D) 71 (Eng.) (“[I]n the context of a person of full capacity, whilst the right to life is engaged, it does not assume primacy (at the hands of another especially) over rights of autonomy and self-determination.”)

³² *Id.*

³³ *Id.*

³⁴ Biggs, *supra* note 1, at 43 (Private Members Bills “have traditionally been the vehicle for controversial socially reforming legislation where party political support is difficult to muster despite growing public encouragement hence it is significant that it takes this form.”).

³⁵ SELECT COMMITTEE REPORT, *supra* note 9, at 20-29 (in the chapter titled “Underlying Ethical Principles”); see also Branthwaite, *supra* note 9, at 681.

³⁶ Clare Dyer, *UK House of Lords Rejects Physician Assisted Suicide*, 332 BRIT. MED. J. 1169, 1169 (2006). The Death with Dignity Act, which allowed for a physician to assist in a person's death through prescribing lethal drugs, passed in Oregon in November 1994 with a vote of 51% to 49%. Roger S. Magnusson, *Book Review—Dying Right: The Death with Dignity Movement*, 11 MED. L. REV. 408 (2003) (reviewing DANIEL HILLYARD & JOHN DOMBRINK, *DYING RIGHT: THE DEATH WITH DIGNITY MOVEMENT* (2001)). The Oregon statute places the following requirements on the patient and the primary physician. The patient must: [1] be capable (able to make and communicate decisions about his/her health care); [2] have a terminal disease (incurable and irreversible disease that is expected to lead to death within six months); and [3] have made one written and two oral requests to die to his/her primary physician. The primary physician, on the other hand, is required to: [1] confirm the above conditions together with a consultant; [2] refer the patient for counseling if either he or the consultant believes that the patient's judgment is impaired by depression or some other psychiatric or psychological disorder; and [3] inform the patient of all feasible alternatives, such as comfort care, hospice care, and pain-control options. OR. REV. STAT. § 127.800 – 127.890; 127.895; 127.897 (1994) (numerals added); see *infra* Appendix (showing the characteristics shared by both the Oregon and British models). Certain factors that may have contributed to the successful passage of the Death with Dignity Act include the “pre-existing legal framework (which already included provisions for living wills and advance directives), the presence of a detailed protocol seeking to secure

was presented to the House of Lords but did not advance further.³⁷ The Select Committee on the Assisted Dying for the Terminally Ill Bill was then formed for the purpose of scrutinizing the issues and determining whether proceeding with the bill was the best course of action.³⁸

The majority of the Lords praised Chairman of the Select Committee Lord Mackay for his thorough report, published in April 2004, that presented the ethical principles and practical issues surrounding the bill, as well as studies on public opinion and comparisons of the legislation to that of other regions where assisted suicide had already been legalized, including Switzerland, the Netherlands, Belgium, and the state of Oregon.³⁹ It also made suggestions for future legislation.⁴⁰ The report focused on five points. First, it revealed that “the demand for assisted suicide or voluntary euthanasia is particularly strong among determined individuals whose suffering derives more from the fact of their terminal illness than from its symptoms and who are unlikely to be deflected from their wish to end their lives by more or better palliative care.”⁴¹ While some may view this as an unacceptable reason to request assisted suicide, one must keep in mind that suffering is not only physical but strongly emotional as well. Some patients are so overcome with dread about their anticipated demise that they cannot be sufficiently consoled by palliative care. Who is to decide which state is more painful than terminally ill patients themselves? Second, the bill must be clear in distinguishing assisted suicide from euthanasia, as statistics reveal that assisted suicide is more prevalent in jurisdictions where euthanasia is lawful. Third, the directions a doctor must follow in arranging an assisted suicide after a patient is eligible for the procedure must be more precisely defined. Fourth, the terms “terminal illness,” “mental incompetence” and “unbearable suffering” must be more thoroughly defined.⁴²

‘voluntariness’ within the initiative itself, and crucially, the limitation of the initiative to physician-assisted suicide (excluding voluntary euthanasia).” Magnusson, *supra*.

³⁷ 681 PARL. DEB., H.L. (5th ser.) (2006) 1183. Because any member of the House of Lords can verbally object upon the reading of the title of a bill and consequently adjourn its second reading, only uncontroversial bills pass through without debate. HOUSE OF COMMONS INFORMATION OFFICE, FACT SHEET: PRIVATE MEMBERS’ BILLS PROCEDURE 4 (2006), available at <http://www.parliament.uk/documents/upload/102.pdf>.

³⁸ Biggs, *supra* note 1, at 43-44.

³⁹ See SELECT COMMITTEE REPORT, *supra* note 9, at 2-7.

⁴⁰ SELECT COMMITTEE REPORT, *supra* note 9, at 7.

⁴¹ Joffe, *supra* note 10.

⁴² Branthwaite, *supra* note 9, at 683.

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The report also recommended changing the phrase “unbearable suffering” to “unrelievable suffering,”⁴³ making clear that the pain cannot be mitigated. And fifth, the report suggested that patients actually experience palliative care rather than merely being informed of the possibility as an option.⁴⁴

An extensive debate in October 2005 in the House of Lords followed the report’s publication.⁴⁵ The primary concerns expressed by members of the House of Lords included lack of protection of vulnerable parties, harm to the quality of palliative care, and potential undermining and obstruction of the medical profession.⁴⁶ Lord Joffe responded to the Select Committee’s concerns by making the relevant changes to the bill, but rejected the recommendations that the patient experience palliative care and that “unbearable suffering” be changed to “unrelievable suffering.”⁴⁷ In spite of (perhaps surprising) acclaim from the House of Lords for the report, the newly altered bill was rejected in November 2005.⁴⁸ Lord Joffe was persistent in his efforts and read the bill for the second time in the House of Lords in May 2006, but it was rejected for yet a second time by a margin of 148 votes to 100.⁴⁹ A number of particular adjustments were made during the time between the rejection of the 2004 version of the Assisted Dying for the Terminally Ill Bill and the introduction of the 2005 version, many of which accommodated concerns expressed by the House of Lords in the October 2005 debate.⁵⁰

The current bill’s stated purpose is to “[e]nable an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request; and for connected purposes.”⁵¹ More specifically, in order to make a valid assisted suicide request, a pa-

⁴³ Branthwaite, *supra* note 9, at 683.

⁴⁴ Branthwaite, *supra* note 9, at 683.

⁴⁵ 674 PARL. DEB., H.L. (5th ser.) (2005) 46.

⁴⁶ *Id.*

⁴⁷ 681 PARL. DEB., H.L. (5th ser.) (2006) 1187. Allowing this change in language would limit assisted suicide to only those whose pain could not be alleviated by palliative care. Yet, some might argue that terminal sedation could always be employed, despite that it would essentially strip a patient of any control over his own body.

⁴⁸ *Id.* at 1183.

⁴⁹ Will Woodward, *Lords Vote to Block Assisted Suicide Bill for Terminally Ill: Peers Delay Second Reading for Six Months; Sponsor Pledges to Reintroduce Measure*, GUARDIAN (London), May 13, 2006, at 11.

⁵⁰ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

⁵¹ *Id.*

tient is required to have mental decision-making capacity and must be suffering unbearably due to a terminal illness from which she is certain to die within six months.⁵² This time restriction is more limiting than it may seem, as cancer is one of the few illnesses of which physicians are able to make reasonable prognoses.⁵³ The bill contains an amendment to the Suicide Act 1961 and authorizes assisted dying only with the aid of a physician.⁵⁴

The current bill better defines the proposed law's permissions and prohibitions, includes extensive safeguards for vulnerable patients, and emphasizes the continuation of quality palliative care and protection for the medical community and others wary of related legal responsibilities.⁵⁵ Lord Joffe intends that the bill firmly eradicate fears about involuntary euthanasia of unconsenting patients through more than twenty safeguards.⁵⁶ Self-administration of the lethal drug is essential to protect doctors from criminal liability.⁵⁷ Only if a patient is physically unable to administer the drug herself, estimated to be a rare circumstance,⁵⁸ will assistance be provided.⁵⁹ The 2005 version of the bill included a new provision on determination of lack of capacity for further assurance that physicians would only grant a request for assisted suicide after a finding that the patient was of sound mind.⁶⁰ It includes more safe-

⁵² *Id.*

⁵³ Irene J. Higginson, *Conclusions from the Meeting*, 94 J. ROYAL SOC'Y OF MED. 496, 496-97 (2001). In Britain, "only about 5% of patients entering hospice or palliative care services have a diagnosis other than cancer." *Id.* In January 2006, Jim Dobbin sought permission in the House of Commons to present a bill to provide palliative care to a broader number of terminally ill people, disclosing that the National Council for Palliative Care "estimates that, while 95 per cent of patients using hospice or palliative care have cancer, 300,000 people with other terminal diseases are excluded. It is a fact that cancer patients have access to the most and the best palliative care." 441 PARL. DEB., H.C. (6th ser.) (2006) 1443.

⁵⁴ Suicide Act 1961, 1961, 9 & 10 Eliz. 2, c. 60 (Eng.); Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

⁵⁵ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.). The greatest difference between the two bills is the increase in the revised bill's safeguards, particularly with regard to physician involvement. *Compare* Assisted Dying for the Terminally Ill Bill, 2004, H.L. Bill [17] (Gr. Brit.), *and* Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

⁵⁶ 681 PARL. DEB., H.L. (5th ser.) (2006) 1186.

⁵⁷ *Id.* at 1183.

⁵⁸ *Id.* at 1188. It is estimated that approximately 5 percent of patients will be physically incapable of swallowing the drug; in this circumstance, the drug may be added to the patient's feeding tube. *Id.* at 1188-1189.

⁵⁹ *Id.* at 1188.

⁶⁰ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

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guards for physicians involved with dying patients, such as the option for attending physicians to work with a member of a health care team and permitting a consulting physician to carry out the patient's request.⁶¹

The medical community has been largely unyielding to legal change in the current end-of-life care system due to reservations about the potential abuse of vulnerable patients and fears about neglect of palliative care and medical research.⁶² All the while, opinions among medical professionals have also become more diverse.⁶³ While most physicians are content with the current legal landscape, a portion report feeling inhibited in their ability to provide patient care.⁶⁴ British physician organizations have expressed ambivalence about a change in the law, stating their vehement opposition toward some points and tolerant neutrality toward others. In a survey taken of British medical practitioners of the Royal College of Physicians, 73% of the physicians were not in favor of a change in the law, and those involved in palliative care were most opposed.⁶⁵ A survey of 1,202 general practitioners (GPs) in Wales demonstrated that the opinions of GPs against assisted suicide have become more rigid since an earlier survey in 1994, as currently only one in five GPs would agree to prescribe lethal medication, and only one in eight GPs would administer the medication themselves.⁶⁶ The British Medical Association (BMA), which is the United Kingdom's largest voluntary professional organization for doctors, was a long-time opponent of doctor-assisted suicide,

⁶¹ *Id.* Lord Joffe also stated at the meeting of the House of Lords in May 2006 that he wished to narrow Section 1(a)(ii) of the bill by removing "or appropriate" after "impossible" and that he intended to add a provision explicitly proscribing acts of active euthanasia. He also emphasized Clause 14(2)(d) of the act, which would allow the Secretary of State to set out a code of practice that would instruct doctors in prescribing, dispensing and controlling the medication, as well as the steps of self-administration. *Id.*

⁶² I.G. Finlay et al., *The House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill: Implications for Specialist Palliative Care*, 19 *PALLIATIVE MED.* 44 – 53 (2005).

⁶³ At an annual representatives meeting in 2005, the British Medical Association acknowledged diverse opinions among British doctors with regard to assisted dying. *BRITISH MEDICAL ASSOCIATION, END OF LIFE DECISIONS: VIEWS OF THE BMA 3* (July 2006).

⁶⁴ Clive Seale, *National Survey of End-of-Life Decisions Made by UK Medical Practitioners*, 20 *PALLIATIVE MED.* 3, 8 (2006).

⁶⁵ James Chapman, *Three Out of Four Doctors Are Against the Euthanasia Bill*, *DAILY MAIL* (London), May 10, 2006, at 2.

⁶⁶ *GP Views Harden Over Assisted Dying*, *PULSE*, June 1, 2006, at 3.

but assumed a neutral position on the matter in 2005.⁶⁷ The organization overturned this position, however, in June 2006, when delegates to the annual conference of the British Medical Association voted against the legalization of doctor-assisted suicide and voluntary euthanasia.⁶⁸ Public opinion seems to be in direct contrast to these physicians' opinions, as a YouGov survey conducted by the Dignity in Dying group in 2006 found that 76% of people supported assisted dying under the condition that safeguards were utilized.⁶⁹

A possible explanation for the physician organizations' changes in stance may be a combination of unwarranted fears and misinterpretation of the likely consequences of the law itself.⁷⁰ One of these fears is the potential for abuse of vulnerable patients, such as disabled individuals, and the likelihood that older patients will feel obliged to die to prevent undue emotional or financial burden on their families.⁷¹ Another fear is that palliative medicine would be neglected and medical research would be stunted because assisted suicide will become too much of a trouble-free substitute for treatment.⁷² Advocates of physician-assisted suicide blame religious group interference for the escalation of these concerns.⁷³ Surveys also strongly suggest that most of the public would trust their doctors to the same degree, or even a higher degree, if assisted suicide were legalized.⁷⁴ A social attitudes survey taken in 1996 showed that 82% of the British public was in favor of assisted

⁶⁷ Jane Merrick, *Doctors' Revolt Over Assisted Suicide Law*, DAILY MAIL (London), June 24, 2006, at 53.

⁶⁸ *Doctors in Britain Give Thumbs-Down to Euthanasia*, AGENCE FRANCE PRESSE, June 29, 2006.

⁶⁹ Rosa Prince, *Killed Off: Lords Block Law for Assisted Suicide Should We Get the Right to Have Ourselves Killed?*, MIRROR (London), May 13, 2006, at 23.

⁷⁰ See *infra* Part III (Subsection titled *Misinterpretation of the Bill*).

⁷¹ R.J.D. George, I.G. Finlay & David Jeffrey, *Legalised Euthanasia Will Violate the Rights of Vulnerable Patients*, 331 *Brit. Med. J.* 684, 684 (2005); Shawn Pogatchnik, *British Doctors Vote to Oppose Assisted Suicide, Overturn Policy of Neutrality*, ASSOCIATED PRESS (Belfast), June 30, 2006.

⁷² One Lord is cited as exclaiming, "Why waste money on care for the terminally ill?" 681 *PARL. DEB., H.L.* (5th ser.) (2006) 1225.

⁷³ "Advocates of medically assisted suicide accused religious pressure groups of exerting undue influence over the [BMA] vote." Pogatchnik, *supra* note 71.

⁷⁴ COMPASSION IN DYING ALL PARTY PARLIAMENTARY GROUP, BRIEFING FOR THE DEBATE ON THE REPORT OF THE SELECT COMMITTEE ON THE ASSISTED DYING FOR THE TERMINALLY ILL BILL 7 (2005), available at [http://www.politics.co.uk/campaignsite/compassion-in-dying-all-party-parliamentary-group-\\$366359\\$2.htm](http://www.politics.co.uk/campaignsite/compassion-in-dying-all-party-parliamentary-group-$366359$2.htm) [hereinafter COMPASSION IN DYING BRIEFING].

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dying in the situations described in the proposed bill, and, most interestingly, disabled people were more agreeable toward the bill's proposal than people who were not disabled.⁷⁵

In contrast to the confusion surrounding the medical community's position on the matter, general public support for the bill has remained stable. Public opinion polls spanning the past twenty-five years have demonstrated that public support for assisted dying has always been above 70%.⁷⁶ A January 2007 study in which forty-one terminally ill patients were interviewed revealed that most of the patients supported the legal change in Britain, and those who opposed it appeared to have based their decision on their misunderstanding that involuntary euthanasia would be permitted.⁷⁷ The Select Committee has previously reported that, although polling results cannot be deemed completely accurate, "the apparent groundswell in public agreement with the concept of euthanasia cannot be dismissed."⁷⁸

B. *The Swiss and Dutch End-of-Life Legal Regimes*

As Lord Joffe has said, "As there is no available experience of assisted dying in the UK, it is natural to turn to the experience of other countries with similar health provision and similar standards of living which have actually implemented similar legislation."⁷⁹ The legal regimes of both Switzerland and the Netherlands offer insight into the effectiveness of certain legal systems, or aspects of those legal systems, over others. Additionally, proposed legislation in these countries is relevant because critics of the Assisted Dying for the Terminally Ill Bill utilize these extremely liberal legal propositions to enhance their "slippery slope" arguments.

Switzerland is known for its extremely liberal end-of-life law.⁸⁰ A patient need not receive a second medical opinion, as required

⁷⁵ *Id.* at 9.

⁷⁶ 681 PARL. DEB., H.L. (5th ser.) (2006) 1185.

⁷⁷ *Shortcuts from BMJPG Journals: Dying Patients Wish to Control Their Lives*, 334 BRIT. MED. J. 68, Jan. 13, 2007. The results of this study are a sound example of the weight that misinterpretation and misunderstanding have in preventing the successful implementation of legal change.

⁷⁸ COMPASSION IN DYING BRIEFING, *supra* note 74, at 5.

⁷⁹ Memorandum from Lord Joffe on Patient (Assisted Dying) Bill to Select Committee on Liaison (Oct. 22, 2003).

⁸⁰ Bosshard et al., *supra* note 2, at 527. The Netherlands, Belgium and Oregon have legalized assisted suicide, as well. *Id.*; *Belgium Legalises Euthanasia*, BBC NEWS, May 16, 2002, available at <http://news.bbc.co.uk/2/hi/europe/1992018.stm>; see also Graeme Laurie,

in the Netherlands and the state of Oregon, nor be dying of a terminal illness to request assisted suicide.⁸¹ The subject of greatest controversy is Switzerland's Article 115, a law established in 1942 that criminalizes inciting and assisting someone to commit suicide.⁸² It reads, "[a] person who, for selfish reasons, incites someone to commit suicide or who assists that person in doing so will, if the suicide was carried out or attempted, be sentenced to a term of imprisonment (*Zuchthaus*) of up to 5 years or a term of imprisonment (*Gefängnis*)."⁸³ The four required elements are: "[1] a suicide was committed or attempted; [2] a third party encouraged or helped in the suicide; [3] the third party acted on selfish grounds; [4] the third party acted deliberately (intent)."⁸⁴ However, some restrictions do apply. Article 114 of the Swiss penal law states that killing a person at his or her request "for decent reasons, especially compassion," is still an illegal act.⁸⁵ While its language may seem contradictory, Article 114 is viewed as punishing direct active euthanasia, which may be defined as follows:

Direct active euthanasia is commonly defined as the deliberate killing of another person in order to shorten his or her suffering. For instance, a doctor or any third party deliberately injects a lethal substance into the veins of the suffering person, thus directly causing his or her death. The death-causing act is not made by the suffering person but by the mercy-killer.⁸⁶

Like the Assisted Dying for the Terminally Ill Bill, Article 115 is claimed to permit assisted suicide only if the person has the mental capacity to appreciate the "meaning and importance of his or her act."⁸⁷

Editorial, *Physician Assisted Suicide in Europe: Some Lessons and Trends*, 12 *EUR. J. HEALTH L.* 5, 5 (2005) (including discussion about Belgian assisted suicide law).

⁸¹ See *infra* Appendix; see also Bosshard et al., *supra* note 2, at 527.

⁸² Guillod & Schmidt, *supra* note 17, at 29.

⁸³ *Criminal Law and Assisted Suicide in Switzerland: Hearing with the Select Committee on the Assisted Dying for the Terminally Ill Bill*, H.L., 3 (2005) [hereinafter *Switzerland Hearing*] (statements of Prof. Dr. Christian Schwerzenegger & Sarah Summers). "Zuchthaus" means a maximum of five years imprisonment, while "Gefängnis" means a minimum punishment of three days of imprisonment. *Id.* at 3 n.5 (2005).

⁸⁴ Guillod & Schmidt, *supra* note 17, at 29 (numerals added).

⁸⁵ *Switzerland Hearing*, *supra* note 83, at 3; Guillod & Schmidt, *supra* note 17, at 26.

⁸⁶ Guillod & Schmidt, *supra* note 17, at 26.

⁸⁷ Guillod & Schmidt, *supra* note 17, at 30. The statute is codified as a criminal law, meaning that it does not imply a right to assisted suicide, which weakens the autonomy right argument. *Id.* at 31. The law also leaves uncertain the issue of whether an institution or health care facility has the responsibility of allowing assisted suicide on its premises. *Id.* However, as of January 1, 2006, at least one Swiss hospital has allowed patients who are

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Significantly, assisted suicide in Switzerland was not intended to be closely associated with the practice of medicine,⁸⁸ which may be logically linked to the popularity of suicide clinics. Major assisted suicide organizations EXIT, which has offered its services since 1990,⁸⁹ and Dignitas, which has offered its services since 1998,⁹⁰ avoid legal punishment by asserting their lack of selfish motive in aiding people to end their lives in what they claim to be a quick, painless and dignified manner.⁹¹ The Dignitas motto is “[I]ive with dignity, die with dignity,”⁹² promising that, after a person ingests the lethal drug, he or she will fall into a deep coma after five minutes and ultimately die after twenty or thirty minutes.⁹³ The clinics prepare lethal doses of barbiturates and provide them to individuals who must ingest the drugs themselves, unless they are physically unable to do so.⁹⁴

Dignitas founder Ludwig Minelli has urged changes in Switzerland’s assisted suicide law⁹⁵, arguing against the threat of a

too incapacitated to go home to receive assistance in their hospital beds from the suicide organization EXIT. Luke Harding, *Swiss Hospital the First to Allow Assisted Suicide: Medical Chiefs Decide After Two-Year Ethical Debate: Euthanasia Still Not Allowed at Lausanne Site*, GUARDIAN (London), Dec. 19, 2005, at 12. The legal and ethical director of the hospital explained, “The mission of our hospital is to cure patients, not help them die,” but admitted, “[w]e cannot deprive them of a right they would have at home, simply because they are in a hospital.” Colin Nickerson, *Suicide Groups Make Switzerland a Final Destination*, BOSTON GLOBE, Feb. 26, 2006, at A12.

⁸⁸ Guillod & Schmidt, *supra* note 17, at 29. Rather, the concept of assisted suicide was derived from romanticized ideas about loyalty, family honor, and unrequited love. *Id.*

⁸⁹ Bosshard et al., *supra* note 2, at 529.

⁹⁰ While the agencies must offer not-for-profit services, they are allowed to charge basic fees. Nickerson, *supra* note 87. Dignitas members pay 100 Swiss francs (80 U.S. dollars) to join and an annual fee of 50 francs. Ligi, *supra* note 3.

⁹¹ Guillod & Schmidt, *supra* note 17, at 25.

⁹² Sarah Boseley & Clare Dyer, *‘I Believe I Must End My Life While I Am Still Able’: Terminally-Ill UK Doctor Kills Herself at Swiss Clinic: Campaigners Urge Britain to Permit Assisted Suicide*, GUARDIAN (London), Jan. 25, 2006, at 8.

⁹³ *Suicide-Clinic Entrepreneur: Depressed? ‘We Never Say No’ Insists Mentally Ill Have Same Rights as Able-Minded to Choose How to Die*, WORLD NET DAILY, Apr. 16, 2006.

⁹⁴ See Bosshard et al., *supra* note 2, at 530.

⁹⁵ Dignitas is at the forefront of the controversy over possible changes in Swiss law. Minelli has been spotlighted for his particularly liberal viewpoints, having stated that assisted suicide should be available to people without terminal illnesses and people with chronic, untreatable depression. Jane Kirby, *Britons ‘Should Be Free to End Their Lives,’* PRESS ASSOCIATION, Sept. 20, 2006. His rationale is, “[i]f you accept the idea of personal autonomy, you can’t make conditions that only terminally ill people should have this right.” *Id.* He has been quoted as saying that his organization’s services offer “a marvelous possibility” for people who want to gain some control over the manner of their deaths. *Suicide Helper Claims He Is Saving Lives*, CHINA DAILY, July 5, 2006. Minelli has also gained entrance to the courts in a variety of cases involving mentally ill patients. A

“slippery slope.”⁹⁶ He claims that, in his experience, it is clear that many individuals wish merely to have the option of assisted suicide rather than actually to take advantage of it.⁹⁷ Only Dignitas extends its services to people beyond the country’s borders. This practice has led to concern in the Swiss government about the spread of “death tourism,”⁹⁸ in which individuals travel from countries where assisted suicide remains illegal to end their lives at the organization’s clinics.⁹⁹ The organization has assisted at least 493 people in ending their lives, with more than half of them coming from Germany and Great Britain.¹⁰⁰

Swiss assisted suicide law is liberal to the point that it “has no centralized notification system for assisted suicide” and “there is strong reliance on figures from the right-to-die organisations themselves.”¹⁰¹ The investigative authorities examine reported deaths

Dignitas member with manic depression requested that Ludwig Minelli aid him in his suicide without first meeting the medical requirements under law; he fought his case to the Swiss Supreme Court and won. Lewis Wolpert, *Depression Is Not a Good Reason to Die*, TELEGRAPH (London), Sept. 22, 2006, available at <http://www.telegraph.co.uk/health/main.jhtml?xml=/health/2006/09/22/hsuicide22.xml>; Michael Sung, *Swiss Court Extends Physician-Assisted Suicide to Incurable Mental Patients*, JURIST (Pittsburgh), Feb. 3, 2007, available at <http://jurist.law.pitt.edu/paperchase/2007/02/swiss-court-extends-physician-assisted.php>. The Court also heard a case of a patient with bipolar disorder requesting the same. Ben Russell & Maxine Frith, *Swiss Clinic Wants to Offer Assisted Suicide to the Mentally Ill*, INDEPENDENT (London), Sept. 21, 2006, at 27. It recently concluded that mentally ill people do have the right to assisted suicide. Hilary White, *Mentally Ill Have a Right to Assisted Suicide*, LIFESITENEWS, Feb. 2, 2007. Some critics view Minelli’s challenges in court as “proof at last of the falsehood of the claim that the push to legalize euthanasia is about caring for people in distress,” labeling the push for euthanasia and assisted suicide as symbolic of a movement for a “death on demand culture.” Hilary White, *Swiss Euthanasia Group Demands Assisted Suicide for the Depressed: Proves Euthanasia/Assisted Suicide Movement is Essentially a “Death in Demand Culture,”* LIFESITENEWS, Sept. 22, 2006.

⁹⁶ Kirby, *supra* note 95.

⁹⁷ Kirby, *supra* note 95. It is likely that Britons would also take comfort in the fact that the choice of assisted suicide exists, rather than opt for it immediately upon its legalization.

⁹⁸ See Hilary White, *Switzerland Refuses to Alter Assisted Suicide Law to Nix Death Tourism*, LIFESITENEWS, June 2, 2006, available at <http://www.lifesite.net/ldn/2006/jun/06060210.html>.

⁹⁹ *Id.* In addition to its Zurich clinic, Dignitas has formed clinics in Germany. Annette Tuffs, *Assisted Suicide Organisation Opens Branch in Germany*, 331 BRIT. MED. J. 984, Oct. 19, 2005.

¹⁰⁰ Nickerson, *supra* note 87. Yet, several suicides with which the clinic has assisted have been the subject of legal investigations, leading Minelli to begin videotaping the deaths of patients to prove that they administered the medications themselves. EXIT has displayed comparatively more precaution, as a spokesman for the organization noted that it does not take clients from abroad “because the distance makes it difficult to assess their judgment and motivation.” *Id.*

¹⁰¹ Bosshard et al., *supra* note 2, at 531.

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from unnatural causes in the same way as unassisted suicides.¹⁰² The number of assisted suicides in Switzerland has averaged from 300 to 350 per year, but suicide tourism has caused this number to rise.¹⁰³ This circumstance has alarmed politicians; Beatrice Wertli of the Swiss Christian democrats, for example, has said, “We feel the organisations are too pushy in helping people to commit suicide.”¹⁰⁴ She was likely referring to the widely published grandiose expressions uttered by the Dignitas organization’s Ludwig Minelli, including “[w]e never say no”¹⁰⁵ and his describing assisted suicide as a “marvelous possibility.”¹⁰⁶ Yet, despite fervent political debate on implementing more restrictive laws on assisted suicide, the Swiss government has rejected proposals for change.¹⁰⁷

The Netherlands’ end-of-life law may be characterized as one of strict regulation and careful review, but also as the most radical.¹⁰⁸ The attention directed to the subject can be seen from the country’s continuous revisions of its formal procedure for review-

¹⁰² Bosshard et al., *supra* note 2, at 531. This practice is distinct from that of the Netherlands, where an “elaborate control system involving a special review committee” seems to provide more safeguards against abuse of patients. *Id.*

¹⁰³ Noelle Knox, *An Agonizing Debate About Euthanasia; European Nations Torn Not Only Over Whether to Legalize Assisted Suicide, but Also Over Where to Set Boundaries*, USA TODAY, Nov. 23, 2005, at A15. Given the lenient reporting procedures in Switzerland, an exact number cannot be determined.

¹⁰⁴ *Dignitas: Swiss Suicide Helpers*, BBC NEWS, Jan. 24, 2006, available at <http://news.bbc.co.uk/2/hi/health/4643196.stm>.

¹⁰⁵ *Suicide-Clinic Entrepreneur: Depressed?*, *supra*, note 93.

¹⁰⁶ *Suicide Helper Claims He is Saving Lives*, *supra* note 95.

¹⁰⁷ Dorle Vallender and Alexander Baumann brought two motions to the National Council regarding “suicide tourism” that were denied. The Vallender motion proposed that suicide tourism and the assisted suicide of mentally incompetent victims be legally regulated. It requested that the regulation state that:

(1) [o]nly people who are residents of Switzerland should be allowed to ask for assisted suicide within the country; (2) [o]rganisations [sic] providing suicide assistance should be registered and licensed, in order to prevent abuses; (3) [t]wo physicians should separately certify the victim’s persistent desire to die and his or her mental capacity; (4) [a]dvertising for organizations offering assisted suicide should be prohibited. The Baumann motion proposed to cancel the expression ‘selfish motive’ in the present text of article 115 of the Penal Code and, therefore, asked for a total criminalization of assisted suicide.

Guilloid & Schmidt, *supra* note 17, at 34; *see also* White, *supra* note 98 (discussing the Swiss Cabinet’s statement that it sees no need to tighten restrictions on assisted suicide).

¹⁰⁸ “In 2001, the proportion of assisted deaths (as reported to the authorities) in all deaths was almost ten times higher in the Netherlands (1.5% of all deaths) than in Oregon (<0.1% of all deaths) or Switzerland (0.2% of all deaths).” Bosshard et al., *supra* note 2, at 527. It also has been suggested that the cultural atmosphere in the Netherlands is distinct from that of Great Britain and likely contributes to the country’s very liberal end-of-life law. Three key characteristics of Dutch society include its liberal nature, long-term rela-

ing cases of euthanasia¹⁰⁹ and physician assisted suicide,¹¹⁰ which have both been legal since 1991.¹¹¹ This system of review is meant to encourage accurate reporting of cases and fulfillment of the requirements involved in prudent practice.¹¹²

The requirements for prudent practice in euthanasia and physician assisted suicide are both substantive and procedural. The substantive requirements are: “[t]he patient’s request must be voluntary and well considered; [t]he patient’s condition must be unbearable and hopeless;¹¹³ [n]o acceptable alternatives for treatment are available; [and] [t]he method is medically and technically appropriate.”¹¹⁴ The procedural requirements are that a second doctor be consulted before going forward and that the case be reported as an unnatural death.¹¹⁵ The most recent procedure, revised in April 2002, requires that a review committee still evaluate all reported cases, but the Assembly of Prosecutors General only reviews cases that do not meet the requirements for prudent practice.¹¹⁶

One difficulty with the Dutch system is the underlying tension between the physician’s duty to preserve life and his or her duty to alleviate suffering and respect the patient’s wishes.¹¹⁷ The “Termination of Life on Request and Assisted Suicide (Review Procedures) Act,”¹¹⁸ which was enacted in April 2002, specifically

tionships with doctors (which likely influences patients’ willingness to trust them), and free nursing home care. TULLOCH, *supra* note 26, at 109.

¹⁰⁹ Euthanasia is defined by Dutch law as “purposely ending the life of someone at his or her explicit request.” Bregje D. Onwuteaka-Philipsen et al., *Dutch Experience of Monitoring Euthanasia*, 331 *BRIT. MED. J.* 691, 691 (2005).

¹¹⁰ Physician assisted suicide is defined by Dutch law as “the prescription or supply of drugs with the explicit intention to enable the patient to end his or her own life.” *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ The Dutch legal system has dealt with the formerly controversial issue of how to define “unbearable” through its court system. Two cases pressed the Dutch Supreme Court to conclude that unbearable suffering could be defined as “‘increasing loss of personal dignity’ and ‘the prospect of an undignified death,’” and one not necessarily linked to a terminal illness. *The Netherlands: The Physician-Patient Relationship in Specific Terms*, in *INTERNATIONAL ENCYCLOPAEDIA OF MEDICAL LAW* 79, 87-88 (Herman Nys, ed. 2006). More thorough discussion amongst legislators may foster the creation of more objective criteria that may aid doctors in determining the degree of a patient’s suffering.

¹¹⁴ Onwuteaka-Philipsen et al., *supra* note 109, at 691.

¹¹⁵ Onwuteaka-Philipsen et al., *supra* note 109, at 691.

¹¹⁶ Onwuteaka-Philipsen et al., *supra* note 109, at 691.

¹¹⁷ Nys, *supra* note 113, at 85-86 (the Dutch Supreme Court discussed this issue in a 1984 case).

¹¹⁸ Stb. 2002, 194.

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articulates a legal exemption for physicians who perform euthanasia or physician-assisted suicide and comply with certain requirements from being held criminally liable for the deaths of their patients.¹¹⁹ The Dutch conflict, however, differs from the conflict discussed in Britain and Switzerland. One scholar explained that the “success of the review procedure depends largely on the extent to which doctors report euthanasia and physician assisted suicide.”¹²⁰ The results of the Dutch review procedure are somewhat contradictory; while doctors have been reported as expressing positive attitudes about the use of a committee as a cushion between a doctor and a public prosecutor, the rates of doctors reporting cases have not risen significantly.¹²¹ However, there is hope for improvement. One reason for the lack of full disclosure is that the law permits a review committee to contact the reporting or consulting doctor if desired,¹²² physicians may feel uneasy about reporting if they are uncertain about the law itself.¹²³ An important step has been the establishment of a special training program for consulting physicians, organized by the Royal Dutch Medical Association.¹²⁴ The use of a training program in the British system is advisable and should be written into the Assisted Dying for the Terminally Ill bill.

The Netherlands has become the first country to legalize the euthanasia of infants, with the formation of a regulatory committee to follow.¹²⁵ Minors between sixteen and seventeen years old are already capable of making a request for physician-assisted suicide

¹¹⁹ Nys, *supra* note 113, at 87.

¹²⁰ Onwuteaka-Philipsen et al., *supra* note 109, at 691.

¹²¹ The Dutch government’s third nation-wide study on the incidence of euthanasia and other end-of-life medical decisions revealed that doctors may choose not to report cases because of “the belief that not all criteria of due care have been met; the belief that euthanasia is a matter between the physician and his patient; the desire to avoid the stress and the administrative upset of a review procedure or a judicial inquiry; [and] uncertainty about the consequences of a report.” Nys 2006, *supra* note 113, at 95; *see also* Onwuteaka-Philipsen et al., *supra* note 109. According to a recent 2001 survey, almost half of all cases of euthanasia and physician assisted suicide remain unreported. *See id.*, at 692.

¹²² Onwuteaka-Philipsen et al., *supra* note 109, at 693.

¹²³ The suggested instrument for change in this area is greater education for doctors in order to “increase doctors’ awareness of whether and when they have to report a case, how to meet the requirements for prudent care, and help them to realise that the chances of prosecution are close to zero if they comply with the requirements.” Onwuteaka-Philipsen et al., *supra* note 109, at 691.

¹²⁴ Nys, *supra* note 113, at 92.

¹²⁵ *See* Matthew Campbell, *Holland to Allow “Baby Euthanasia,”* TIMES ONLINE (London), March 5, 2006, available at <http://www.timesonline.co.uk/tol/news/world/article/737519.ece> (describing case of infant with spina bifida whose feeding tube was withdrawn). Before the law was passed, at least 15 unreported infant deaths were facilitated by doctors

under the condition that their parents be consulted before proceeding.¹²⁶ But the fact that babies are incapable of expressing consent has sparked fervent debate about a potential “slippery slope” that could ultimately allow doctors to lawfully perform euthanasia on non-consenting adults, as well. Statistics reveal that many active euthanasia cases, in which a doctor kills a patient without his or her explicit consent, go unreported in the Netherlands.¹²⁷ While unreported cases are often discussed as evidence of abuse in the Dutch system, legitimate reasons such as the “double effect” doctrine may explain the prevalence of these reported instances.¹²⁸ The effectiveness of Dutch assisted suicide law is apparent—an official government study revealed that 85 percent of Dutch doctors found their assistance in helping their patients to die strongly improved the quality of their dying.¹²⁹

III. ANALYSIS

A. *The Assisted Dying for the Terminally Ill Bill: Addressing Criticisms*

The criticisms of the Assisted Dying for the Terminally Ill Bill are primarily grounded in fears of abuse of its proposed system. It is essential to begin with what are commonly characterized as the “slippery slope” arguments. While the current bill includes more safeguards than the previous version, many critics have failed to acknowledge them, particularly those who attempt to use fear and unease to win over people who are uncertain about its risks.¹³⁰

with parental consent per year, mostly involving infants with spina bifida or other chromosomal abnormalities. *Id.*

¹²⁶ *Netherlands First Nation to Approve Physician-Assisted Suicide*, 36 *PSYCHIATRIC NEWS* 12, 12 (2001).

¹²⁷ *COMPASSION IN DYING BRIEFING*, *supra* note 74, at 13 (providing in-depth summary of the October 2005 debate).

¹²⁸ *Id.* at 9.

¹²⁹ 674 *PARL. DEB.*, H.L. (5th ser.) (2005) 46.

¹³⁰ This notion was well-illustrated by the Earl of Glasgow, who explained:

[O]nce [assisted suicide] becomes legal, it could be abused for selfish or even criminal ends. Old, infirmed grandmothers are often cited as the likely victims: still with a desire to go on living but encouraged, pressurised or bullied into believing that they have become an intolerable burden on the rest of the family, and eventually agreeing to have themselves be put down.

Id. Surely, inducing people to picture their own elderly, frail relatives being “put down” like animals is quite the crude attempt to persuade the ill-informed. Another poorly drawn argument is that of a “death in demand culture.” See White, *Swiss Euthanasia Group Demands Assisted Suicide for the Depressed: Proves Euthanasia/Assisted Suicide Movement Is Essentially a “Death in Demand Culture,” supra*, note 95. This argument frequently

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However, the numerous safeguards included in the bill, as well as its provision regarding the use of a strict monitoring system,¹³¹ effectively counter broad conjectures about the fate of the British medical practice. Law Professor Graeme Laurie¹³² succinctly summarized the importance of a regulatory framework:

[L]egality is a threshold issue, while regulation ensures continued control of the practice being regulated, protection of both the instant patient and others, a means to monitor activities, and a mechanism to respond more effectively to abuses, should they occur. These are issues which reach far beyond the particular needs of any one individual; they point to the need in all of this debate to resist over-zealous reliance on autonomy-driven arguments to support PAS [physician-assisted suicide] or other euthanistic practices.¹³³

A major question has been, “while we might sympathise with each individual who is suffering and requests to die, can we be sure of establishing a regulatory framework that will respect their wishes while protecting the interests of those who have not, and cannot, express any such wish?”¹³⁴ This argument is linked to the concern about the potential for abuse of vulnerable patients and the likelihood that older patients will feel pressure to end their lives early to preclude undue emotional or financial burden on their families. In other words, ending life prematurely will become “such an accepted medical procedure that people who don’t choose to die this way may be seen as selfishly using medical resources that could better help curable patients.”¹³⁵

An effective response to this concern lies in the language¹³⁶ of the Assisted Suicide for the Terminally Ill Bill, which is limited to

arises with regard to the goal of Ludwig Minelli to extend his organization’s services to individuals who are not terminally ill. But, in reality, the British bill’s safeguards are so extensive that the process entailed in granting an individual’s request cannot be deemed as “on demand.” An individual’s ability to have his life ended is contingent upon the medical opinions of multiple doctors and a required waiting period, to say the very least. *See Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.)*.

¹³¹ The monitoring system is very similar to that used in the Netherlands. *See Nys, supra* note 113, at 87-88.

¹³² Professor of law at Edinburgh Law School in Edinburgh, Scotland.

¹³³ Laurie, *supra* note 80, at 6.

¹³⁴ Laurie, *supra* note 80, at 7.

¹³⁵ Nickerson, *supra* note 87. Some allege that the desire to save medical resources will result in the decline of palliative care. *See supra*, subsection titled “Misinterpretation of the Bill” of this Note.

¹³⁶ Guillod and Schmidt note that “the ‘cultural sensitivity’ of a nation is reflected in the language of its law.” Laurie, *supra* note 80, at 8.

only those individuals who can voluntarily express their wish to die. Examination of the Oregon and Dutch legal models also point to a lack of a “slippery slope.” The number of patients receiving assistance to die in the Netherlands has become stable in recent years,¹³⁷ suggesting that legalization of assisted suicide does not necessarily lead to an excessive number of deaths. Also, the number of individuals requesting euthanasia has declined, while palliative care has allegedly improved over the past five years.¹³⁸ According to one doctor’s study, 84% of individuals asking for euthanasia did so only on the basis of unbearable pain.¹³⁹ Similarly, the director of the Oregon Hospice Association reported that the number of state citizens dying under hospice care increased following the introduction of the state legislation.¹⁴⁰ The Select Committee held ten sessions in Oregon to discuss the existence of abuses, and concluded in nine out of the ten sessions that there was no evidence of abuse.¹⁴¹ As mentioned later in this Note, the experience from other countries that allow assisted suicide indicates that only a small, distinct category of people would even consider ending their lives in such a manner.¹⁴²

The “slippery slope” argument misconstrues the legislation as a mandate rather than a mere option. The current version of the bill provides more safeguards in response to concerns about abuse of vulnerable parties. One new provision regards the making of a determination of lack of capacity.¹⁴³ The other safeguards include: a necessary written request on behalf of the patient; the requirement that the patient have a terminal illness and be in unbearable suffering due to that terminal illness; the doctor’s obligation to provide instruction about palliative care and notification to family members; and the requirements that the doctor obtain informed and voluntary consent to refer the patient to a consulting physi-

¹³⁷ Joffe, *supra* note 10, at 47.

¹³⁸ SELECT COMMITTEE REPORT, *supra* note 9, at 66.

¹³⁹ SELECT COMMITTEE REPORT, *supra* note 9, at 66.

¹⁴⁰ 681 PARL. DEB., H.L. (5th ser.) (2006) 1188.

¹⁴¹ 674 PARL. DEB., H.L. (5th ser.) (2005) 46. These results add fuel to the argument that the legalization of assisted suicide should be seen as no more than giving people the autonomy to decide their own threshold for pain and suffering, which others have no right to dispute.

¹⁴² Joffe, *supra* note 10.

¹⁴³ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

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cian.¹⁴⁴ These steps are the same as those taken when a patient wishes to refuse treatment. According to M.A. Branthwaite:

Some people would argue that because assisted dying introduces new intervention—the drug used with specific intent to procure death—it is different from allowing death by withholding or withdrawing life sustaining treatment. But if life sustaining treatment such as mechanical ventilation is withdrawn, whether at the patient's request or because it is deemed futile, death is a virtually certain consequence and doctors are aware of this when they act. In other words, their action fulfills the legal criteria for indirect intent. The motive may be benevolent but the intention is to kill or to permit a preventable death.¹⁴⁵

That these steps are already accepted by the medical community concerning a decision that will result in potentially premature death lends credence to their use in decisions about assisted suicide. While the practices differ in a technical sense, the purpose of lessening unnecessary suffering is the same. This point should not be muddled by the formalities involved. More importantly, research studies reveal that, to some extent, British doctors are already employing physician-assisted suicide.¹⁴⁶

Some have criticized the bill's provision allowing physicians to provide assistance to patients physically unable to administer the lethal drug themselves, arguing that it straddles the boundary between physician assisted suicide and active euthanasia.¹⁴⁷ However, the solution may be a set of stricter safeguards surrounding this procedure, such as a required number of witnesses, a longer waiting period to provide more time for the possibility of revocation, and additional psychological examinations close to the patient's selected date. While these circumstances might incur extra costs, the situations would likely be rare. It must also be expected that some patients may lose physical capacity during the process of gaining approval and should not instantly lose their opportunity to make this important end-of-life decision because of it.

¹⁴⁴ *Id.* at §2 (2) (First of two qualifying conditions for grant of an assisted suicide request: the first condition states the procedures required by the attending physician, while the second condition states the procedures required by the consulting physician).

¹⁴⁵ Branthwaite, *supra* note 9, at 681.

¹⁴⁶ Steven Ertelt, *British Doctors Use Euthanasia to Kill Nearly 3,000 Patients*, LIFE NEWS.COM, Jan. 17, 2006, available at <http://www.freerepublic.com/focus/f-news/1560289/posts>.

¹⁴⁷ Laurie, *supra* note 80, at 7.

The question of whether a patient's pain and suffering is of an unbearable quality has also been criticized for being too discretionary and under the scrutiny of a few physicians who may be unintentionally biased in their perspectives on pain.¹⁴⁸ Yet, such is the long-time difficulty involved in making bioethical decisions that do not have concrete answers. If a person can be lawfully found to have decision-making capacity with regard to withholding or withdrawing treatment after having been examined for related difficulties, such as depression, the determination of capacity in this situation should not be held to a higher standard. The ultimate result (the premature termination of a life) is the same.¹⁴⁹

Many critics have yet to comment on the extensive safeguards included in this comparatively¹⁵⁰ conservative bill. The bill requires that the patient first acquire the professional opinion of both her attending physician and a second physician with regard to the extent of her suffering and competence, the autonomy of her decision, and the accuracy of her diagnosis. Following the patient's initial request, a "cooling off" period of fourteen days is also required for the purpose of giving the patient the opportunity to revoke her declaration. These regulations are necessary to make assisted suicide a viable alternative. They make certain that the practice will be continually monitored and also provide a way of efficiently countering abuses if they do arise.¹⁵¹

¹⁴⁸ Celia Milne, *Brits Delay Latest Push to Legalize Physician-Assisted Suicide*, 42 *MED. POST* 51, June 2, 2006.

¹⁴⁹ Also, the doctrine of "double effect" has been used as an ethical defense. This practice of administering increased amounts of sedatives to dying patients and consequently accelerating their deaths is an accepted medical practice. While alleviation of pain is the primary purpose, and accelerating death is not, the point is that early death is, in effect, justified by the doctors' intent to lessen patient suffering. It is not difficult to see how assisting a patient to commit suicide can be similarly justified. Nigel Sykes & Andrew Thorns, *Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making*, 163 *ARCHIVES INTERNAL MED.* 341 (2003); *see also* National Legal Center for Medically Dependent & Disabled, Inc., 18 *Issues L. & Med.* 293, 294 (2003) (discussing the previously cited source).

¹⁵⁰ The Assisted Dying for the Terminally Ill Bill contains far greater safeguards than the Dutch and Swiss models and it encourages the use of a closely monitored system such as that used in Oregon. *See SELECT COMMITTEE REPORT, supra* note 9, at 69-73, 83. For a comparative analysis of the Oregon, Swiss and Dutch systems, *see id.* at 54-74.

¹⁵¹ Laurie, *supra* note 80, at 6.

B. *Misinterpretation of the Bill*

In spite of Lord Joffe's reassurances, the Select Committee's thorough report, and the careful additions made to the 2005 bill, the bill has continuously been rejected. Further work must be done to increase the probability of the bill's survival in a future parliamentary session; much of this work appears to involve supplying legislators and doctors with more information and a clear explanation of the bill. The primary concerns expressed by members of the House of Lords during the debate held in October of 2005 included the lack of protection of vulnerable parties, harm to the quality of palliative care, and the undermining and obstruction of the medical profession.¹⁵² While much of the debate about the bill involves moral objections, the greater part of the debate concerns the likelihood of the aforementioned "slippery slope" and detrimental effects to medical practitioners who would be involved in assisted suicide procedure. This may be largely attributed to widespread misinterpretation of the bill and its parameters.

Two major misinterpretations of the bill involve its purpose and intended beneficiaries. An archbishop's comment on the bill reveals this confusion, as he stated that "the government could better help the dying by providing more money for hospices and institutions offering palliative care."¹⁵³ Similarly, the verdict from BMA physicians in their June 2006 vote was that better palliative care for the terminally ill will provide the dignity in dying so fervently discussed.¹⁵⁴ This conclusion misses the objective of the bill, which is primarily to provide the option of assisted suicide to individuals whose pain cannot be helped by palliative care¹⁵⁵ or who wish to die because of their terminal illnesses.

¹⁵² 674 PARL. DEB., H.L. (5th ser.) (2005) 46.

¹⁵³ Nickerson, *supra* note 87.

¹⁵⁴ Press Release, Care NOT Killing, Latest on BMA Vote (June 29, 2006), available at <http://www.carenotkilling.org/uk/?show=368>. Care NOT Killing is a UK-based alliance whose objective is to join human rights groups, healthcare groups, palliative care groups, faith groups, and concerned individuals to promote improvements in palliative care, protect laws against euthanasia and assisted suicide, and to support continued reliance upon these laws.

¹⁵⁵ Lord Joffe asserted before the second House of Lords vote, "We must find a solution to the unbearable suffering of patients whose needs cannot be met by palliative care. This bill provides that solution in the absence of any other." Woodward, *supra* note 49. Wanting to die because of a terminal illness cannot simply be equated to depression; this concern is dealt with in the determination of capacity provision included in the Assisted Dying for the Terminally Ill bill, which mandates that the patient be of sound mind before proceeding with his or her assisted suicide request. The possibility of the patient's thought

Those individuals who wish to die on the premise of their terminal illnesses may be better described as “suffering from their suffering.” This argument is primarily rooted in autonomy and one’s ability to define one’s own humanity. It may also be construed to mean emotional suffering, which cannot be alleviated by palliative care and may theoretically be more painful than the physical effects of a terminal illness. The reality that palliative care cannot help every suffering individual (whether physically or mentally) cannot reasonably be taken as an insult to its general use.¹⁵⁶ More importantly, waiting for improvements in palliative care currently leaves terminally ill patients who cannot respond to care without the opportunity for relief. The bill’s provision titled “Offer of Palliative Care” should be reworded to assure that a patient would not merely receive a rushed reminder about palliative care, but a thorough education about its advantages. While it may be argued that time restraints would be problematic, the required waiting period could allow for this procedure. Although it was suggested during the October 2005 debate that the legislation require patients to first try palliative care before making a decision, Lord Joffe justly rejected this recommendation because it would strip patients of autonomous decision-making.¹⁵⁷ Requiring that a patient undergo palliative treatment before making a decision cannot be rationally characterized as a mere condition of the decision-making procedure, just as holistic treatment could not logically be made a prerequisite to deciding upon whether to undergo chemotherapy.

Another misunderstanding discussed in the October 2005 debate is also one of great concern to British physicians—the unwarranted fear that palliative medicine would be neglected and medical research would be inhibited.¹⁵⁸ The bill is narrowly tailored to apply only to individuals who are in intolerable pain and

processes being distorted by depression is a factor taken into account during a psychological examination.

¹⁵⁶ See Ann Sommerville, *Changes in BMA Policy on Assisted Dying*, 331 *BRIT. MED. J.* 686, 688 (Sept. 24, 2005).

¹⁵⁷ Jacqueline Herremans, head of Belgium’s Association for the Right to Die with Dignity, explained the rising respect for autonomous decision-making, stating, “Any pluralistic society must allow every citizen to live this last act of their life, that of choosing their own death,” noting that the “feeling of the right to choose one’s destiny is certainly growing in the [European] population.” Nickerson, *supra* note 87. Graeme Laurie identifies the right to “choose the mode, manner and timing of one’s own death” as one of the most vital manifestations of autonomy. Laurie, *supra* note 80, at 6.

¹⁵⁸ A recent national survey of end-of-life decisions made by medical practitioners in the UK, which reported a lower frequency of physician-assisted dying and a high frequency of

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estimated to die within a few months. Additionally, the bill requires that a patient as a first step be fully informed about the option of palliative care. Perhaps surprising to some, Lord Joffe has explained that improvements in palliative care are crucial to the credibility of the bill itself.¹⁵⁹ An appropriate alternative choice for patients is important to establish assisted suicide as a plausible preference.¹⁶⁰ While one may argue that the desire to keep hospital costs down would result in reduction of the quality of palliative care, this consequence seems highly unlikely given the mass acclaim for the advancement of palliative care in the United Kingdom.¹⁶¹ One might conjecture that cutting down on palliative care would actually harm hospitals, as well as the reputation of doctors, rather than benefit them. The medical research feared to be neglected should be outweighed by the suffering of terminally ill patients, many of whom would not live to benefit from their participation in studies.

Lord Joffe responded to complaints about the 2004 bill's procedure by creating more flexibility for physicians involved with dying patients. The bill now provides that a physician may work in conjunction with a member of a health care team in handling assisted suicides.¹⁶² While the 2004 bill explained that the attending physician would have the responsibility of assisting the patient, the 2005 bill permits that the newly-coined "assisting physician," who may be either the attending or consulting physician, may play this role.¹⁶³

The fine lines between end-of-life care methods, including assisted suicide, euthanasia, and the withholding and withdrawing of treatment must also be defined more precisely in order to accurately express the bill's scope. Such analysis will not only respond to the fears of individuals who are not fully informed about the

non-treatment decisions (withholding or withdrawing treatment), indicated a "culture of medical decision making informed by a palliative care philosophy." Seale, *supra* note 64.

¹⁵⁹ Sommerville, *supra* note 156. ("As part of the bigger picture, safeguards for patients must also include the availability of alternatives, especially good palliative care. Calls for legalisation of assisted dying lack credibility if patients have no proper alternative, and Lord Joffe has repeatedly emphasised how unsatisfactory are the current gaps in availability of palliative care.")

¹⁶⁰ Sommerville, *supra* note 156, at 688.

¹⁶¹ 441 PARL. DEB., H.C. (6th ser.) (2006) 1443 (Jim Dobbin admitted, "I am proud of the fact that the UK leads the world in palliative care.")

¹⁶² Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] §5 (Gr. Brit.).

¹⁶³ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

potential for a “slippery slope” but also speak to the reality of British medical practices. Studies of British medical practice reveal that the physician-assisted suicide that the bill proposes already is being employed.¹⁶⁴

C. *Switzerland and the Netherlands:
Comparative Legal Paradigms*

The strengths and weaknesses of Swiss and Dutch law have been examined by the Select Committee on the Assisted Dying for the Terminally Ill Bill, and the resulting bill reflects the committee’s acquired knowledge. The bill incorporates the review procedures (including a monitoring commission) and important physician involvement refined by the Dutch system.¹⁶⁵ The bill also outlines specific threshold requirements for patient eligibility.¹⁶⁶

The dangers inherent in a law lacking strict restraints are seen in the prevalent use of unregulated suicide clinics. The fact that almost 90% of individuals who visit the Dignitas clinic are foreigners lends support to the notion that assisted suicide procedures in Switzerland should be subject to greater constraint.¹⁶⁷ Further, this statistic shows that the issue of public desire to legalize assisted suicide should gain more recognition as an international issue. At least fifty-four Britons have traveled to Switzerland to evade British law and rid themselves of their suffering.¹⁶⁸ One example was a British doctor with progressive supranuclear palsy, a brain disease, who had a seven-year life expectancy but chose to travel to Zurich before she would be incapable of swallowing a barbiturate solution.¹⁶⁹ Parliament’s neglect of these people’s wishes has led to the addition of Britons to the ever-increasing flow of suicide tourists. Critics explain that people feel forced to die in a country that is not

¹⁶⁴ See Ertelt, *supra* note 146.

¹⁶⁵ Assisted Dying for the Terminally Ill Bill, 2005, H.L. Bill [36] (Gr. Brit.).

¹⁶⁶ See Allen, *supra* note 14, at 555.

¹⁶⁷ *Suicide Helper Claims He is Saving Lives*, *supra* note 95. Dignitas is most recently the subject of intense criticism due to a German woman’s painful death at its Zurich clinic after ingesting the usual lethal dose of drugs. She experienced pain for four minutes, screaming “I’m burning. I’m burning,” before falling into a coma and dying almost forty minutes later. Minelli refused to comment on the incident. This sort of unfortunate instance seems as though it was likely foreseeable, however, given the lack of strict regulation surrounding assisted suicides in Switzerland. “Assisted Suicide” in *Spotlight After Report of Painful Death*, HEALTH, Jan. 9, 2007.

¹⁶⁸ Kirby, *supra* note 95.

¹⁶⁹ Boseley & Dyer, *supra* note 92.

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their own, sometimes prematurely,¹⁷⁰ and are unprotected by any legislative safeguards in doing so.¹⁷¹ The cost of travel limits those who cannot afford it. There are also, of course, individuals who attempt suicide on their own, but fail, only to end up in the lingering state they had originally feared.

Contrary to the Swiss legal system, the Assisted Dying for the Terminally Ill Bill provides extensive safeguards so that assisted suicides are open only to individuals with terminal illnesses and unbearable suffering and are conducted in closer association with doctors who can most accurately assess each patient's condition. While possible conflicts brought about through physician involvement in assisted suicide have been hotly debated in the United Kingdom, the benefits and safeguards that exist in Lord Joffe's proposed procedure should be juxtaposed with Swiss procedure, where physicians play only a minor role by prescribing the barbiturates.¹⁷² Swiss physician organizations have not actively approved of this practice, but merely tolerate its use.¹⁷³ The weakness in excusing physician involvement is most apparent in the rise of suicide clinics, which are conducted by individuals who presumably lack the education and medical knowledge of physicians. Recent criminal investigations of Dignitas suicide clinics should provide incentive to prioritize doctor-regulated assisted suicide. While some Swiss physicians admit relief from feeling morally burdened by working alongside right-to-die societies,¹⁷⁴ a more restrictive sys-

¹⁷⁰ Kirby, *supra* note 95. Minelli has said, "These people have to make a decision to travel to Switzerland. So, sometimes they come prematurely when they could live on, if we had the possibility to come to them where they live, to help them there." *Id.*

¹⁷¹ Madeleine Brindley, *Why Welsh Man Chose Death in a Swiss Clinic*, WESTERN MAIL, June 3, 2006, at 1. The *Re Z* case is demonstrative of this safety issue; by lifting the injunction upon Mr. Z, the local authorities appeared to have merely looked the other way without considering Mrs. Z's welfare or the welfare of the many Britons who seek relief in Swiss suicide clinics. *Re Z; Local Authority v. Z*, [2004] EWHC (Fam) 212, 2004 All ER (D) 71 (Eng.).

¹⁷² Bosshard et al., *supra* note 2, at 530.

¹⁷³ Harding, *supra* note 87, at 12 (reporting that the Swiss Medical Association and the National Committee on Ethics both state that "to respect the wishes and independence of patients, assisted suicide should be permitted in exceptional cases, but it should never become a routine procedure").

¹⁷⁴ Bosshard et al., *supra* note 2, at 532. For example, one family doctor recently concluded in his report on his work with a right-to-die organization in the assisted suicide of a terminally ill patient that "to respect the freedom of the patient, to help him over obstacles, to guide him through the twilight and confront death with him; this [was] all part of [his] work as a doctor. But these tasks (respecting another person's freedom, giving someone support, confronting death) are by no means specific medical tasks but much rather general humanitarian requirements. Therefore, why not suggest to others – people from

tem of review appears to be a method more favorable to government monitoring and protection of vulnerable parties. Some individuals travel alone to the Dignitas clinic.¹⁷⁵ Allowing assisted suicide in Great Britain might better allow for them to be surrounded by family (which might ultimately affect individuals' revocations of their assisted suicide requests and, perhaps, encourage stricter monitoring of procedural violations). The Swiss medical procedure serves as a useful example of what the British system must avoid, especially in light of the dominating concerns about abuse of vulnerable parties and the undermining of British physicians.

D. *Challenging Tradition*

As with any legal proposal that challenges traditional and deeply held moral convictions, such as those surrounding abortion,¹⁷⁶ mere textual changes to a bill will not eliminate entrenched, somewhat philosophical concerns—some of which were expressed during the October 2005 debate.¹⁷⁷ One such objection is that doctors intend to save lives rather than terminate them. Yet, doctors in contemporary times are certainly cognizant of the extensive advancements in medicine and technology the last few decades have yielded. People have largely praised these advancements for allowing humans to live longer; yet, it is though many do not take responsibility for, or merely acknowledge, the difficulties that have arisen from them. Many may assert that the pain people experience in old age is inevitable and natural, neglecting the fact that the older an individual becomes, the more likely he or she is to suffer

the church, lawyers, and everyone who feels motivated – that they assist those close to them in committing suicide?” *Id.*

¹⁷⁵ Linda MacDonald, *Founder of Swiss Suicide Clinic Explains How He Helps People Take Their Lives*, *GUARDIAN* (London), Dec. 3, 2004, available at <http://www.buzzle.com/editorials/12-3-2004-62473.asp> (Ludwig Minelli explaining that some clinic visitors travel alone).

¹⁷⁶ See Allen, *supra* note 14, at 535-75. Allen comments on a systematic perspective of the controversies surrounding end-of-life medical practice and abortion: “First, each religious, philosophical, or legal argument constitutes a self-defining belief system that may or may not be compatible with competing belief systems. Second, the degree to which an individual adheres to a particular belief system, aside from environmental or sociological pressures, depends upon an individual’s intuition. Third, all modern legal systems, as well as the vast majority of modern belief systems, recognize that the intentional killing of another individual is usually wrong and therefore the practice of euthanasia must be justified as an exception to the general rule.” *Id.* at 567-68.

¹⁷⁷ See 674 *PARL. DEB.*, H.L. (5th ser.) (2005) 46.

from multiple health problems. Such problems can collectively cause more pain than would have been suffered without the aid of modern medicine.¹⁷⁸ More people would have actually died without these medical improvements, as well.

Broad tolerance of this perspective may be a nearly impossible task, but it may be possible to diminish certain hesitations. Constituents might be better assured of the fact that palliative care and assisted suicide will not be treated as an “either/or” situation. It is possible to support improvements in palliative care while also supporting, or merely accepting, the practice of assisted suicide.¹⁷⁹ Since pain and suffering are subjective matters, a patient with a higher tolerance for pain may be a better candidate for palliative care, while another patient might find the same pain unbearable and determine assisted suicide to be his best option. Fears about sending the message that “certain kinds of life are not worth living”¹⁸⁰ undermine the intention of the bill to provide individuals with the liberty of making this decision for themselves, given that they must personally endure the pain and suffering related to their terminal illnesses.

Another theory is that physicians will be faced with the unjust burden of overseeing or engaging in a medical practice that they likely had not contemplated before entering the medical profession. The tension between patient autonomy and medical paternalism is ingrained in the fabric of contemporary medical practice, and the practice of assisted suicide should not be treated as a more radical topic than it actually warrants. Regardless, the focus should be on the suffering patients, rather than on the exaggerated notion of overturning the medical profession itself, as was the situation concerning withdrawal cases.

Lastly, religious assumptions have also been an impediment to acceptance of the bill. It has been assumed that if a person is strongly religious, he or she cannot tolerate assisted suicide.¹⁸¹ Yet, even a Bishop explained during a House of Lords debate that the

¹⁷⁸ Ludwig Minelli of Dignitas agrees, as he has been quoted, “because of the long life expectancies, and if you look at the results of statistics on suicide, you will find every second suicide is of somebody aged over 60.” Kirby, *supra* note 95.

¹⁷⁹ See Sommerville, *supra* note 156, at 688.

¹⁸⁰ Woodward, *supra* note 49 (citing Roman Williams, the Archbishop of Canterbury).

¹⁸¹ According to a survey spoken of by the chief executive of the Dignity in Dying organization, “most doctors want neutrality, and resent a religious minority dictating policy across their profession.” *Doctors in Britain Give Thumbs-Down to Euthanasia*, *supra* note 68.

bill should be evaluated on a rational basis, rather on than its religious implications.¹⁸² The Select Committee's report reveals that religious Dutch doctors do not perceive the existence of a dilemma between their assisted suicides and their religious convictions.¹⁸³

E. *Facing Reality*

Ultimately, the protection of citizens' welfare should reign supreme in this legal debate. Some House of Lords members argue that the small number of "determined"¹⁸⁴ people that would actually utilize the option of assisted suicide cannot justify the implementation of a new law,¹⁸⁵ drawing upon the "utilitarian" perspective of the greater good. House of Lords members estimate that about 650 assisted suicides a year might be expected in Great Britain, based on a comparison to the number of individuals who have requested assisted suicide in Oregon.¹⁸⁶ Yet, it certainly would not be more appealing if the number of people who actually requested assisted suicide were far greater than anticipated. Additionally, individuals requesting assisted suicide in Oregon are "younger, more highly educated, and accustomed to being in control of their lives,"¹⁸⁷ which "detracts from the contention that permissive legislation will pressurize elderly or vulnerable patients into seeking death for the perceived benefit of others."¹⁸⁸ The Select Committee also explained that the number of people who would take comfort in knowing that the option is merely available to them, consequently preserving their feeling of control over their own condition, is substantial.¹⁸⁹ While the proportion of people who would use assisted suicide may be small, this number should not serve as a measure for the humanity and respect such individuals deserve.

¹⁸² 674 PARL. DEB., H.L. (5th ser.) (2005) 46.

¹⁸³ *Id.*

¹⁸⁴ 681 PARL. DEB., H.L. (5th ser.) (2006) 1185; *see also* Joffe, *supra* note 10, at 47 ("It is clear to us that the demand for assisted suicide or voluntary euthanasia is particularly strong among determined individuals whose suffering derives more from the fact of their terminal illness than from its symptoms and who are unlikely to be deflected from their wish to end their lives by more or better palliative care.").

¹⁸⁵ 681 PARL. DEB., H.L. (5th ser.) (2006) 1185.

¹⁸⁶ Branthwaite, *supra* note 9, at 682.

¹⁸⁷ Branthwaite, *supra* note 9, at 682.

¹⁸⁸ Branthwaite, *supra* note 9, at 682-83.

¹⁸⁹ 674 PARL. DEB., H.L. (5th ser.) 17 (2005) (Lord Joffe stated, "[i]t is only for these patients that assisted suicide was proposed as an option, which they may wish to exercise").

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The reason for the small number of anticipated assisted suicides may be due to the general effectiveness of palliative care. One must be aware that palliative care is not effective for all individuals and that receiving such treatment is always a matter of personal choice, just as is refusing or withdrawing treatment (both legally authorized). Terminally ill patients who only *anticipate* greater pain and suffering and believe it is in their best interest to end their lives prematurely do not have a remedy under the law.¹⁹⁰ These people are forced to either act alone or flee the country earlier than they might have otherwise to end their lives peacefully in Swiss suicide clinics. This demonstrates that “illegality . . . can be a singularly ineffective approach.”¹⁹¹

Great Britain is directing more attention to patient autonomy.¹⁹² A British court recently struggled to balance the tension between patient autonomy and medical paternalism in *W Healthcare NHS Trust v H*.¹⁹³ While concluding that it could not legally grant the family’s wishes to not have the patient’s gastrostomy tube that had fallen out be re-inserted, the court closed the case with an undoubtedly sympathetic voice for the family of the patient, expressing discomfort with its inability to relieve the patient of her pain.¹⁹⁴ The intent to respect patient wishes is present in British

¹⁹⁰ See Branthwaite, *supra* note 9, at 682. These people may not accept terminal sedation or may not have the opportunity to pursue that option; for example, patients with motor-neuron disease may suffer sudden and frightening suffocation as a result of terminal sedation. *Id.*

¹⁹¹ Laurie, *supra* note 80, at 8.

¹⁹² The British Medical Association’s Patient Liaison Group reported in a memorandum of evidence compiled in January 2007 that “[h]ealthcare policy decisions, at whatever level they are made, ultimately affect patients’ lives. Therefore it can be argued that patients have a moral and ethical right to play a meaningful role in developing healthcare policies.” Memorandum from British Medical Association’s Patient Liaison Group, Health Select Committee—Public and Patient Involvement in the NHS (Jan. 12, 2007). A related matter rooted in autonomy and fundamental rights is the practice of abortions. It is interesting to note the United Kingdom’s liberal treatment of this practice in comparison to that of assisted suicide—after legalizing abortion in 1967, it was the second country (after France) to approve the use of RU-486, the abortion pill, in 1991. See U.N. DEP’T OF ECON & SOC. AFFAIRS, POPULATION DIV., ABORTION POLICIES: A GLOBAL REVIEW (2002), available at <http://www.un.org/esa/population/publications/abortion/pop830.pdf> (study of national policies concerning induced abortion); see also Abortion Act 1967, c. 87, § 1 (Eng.) (1967).

¹⁹³ *W Healthcare NHS Trust v. H*, [2004] EWCA (Civ) 1324 (Eng.).

¹⁹⁴ *Id.* The Court felt compelled to order the continuance of treatment because the patient no longer had the mental capacity to make such decisions, had not made an advanced directive based on her specific circumstances, and was technically not in a vegetative state. This was, however, in spite of oral testimony from the patient’s daughter that she would not have wanted to be kept alive by machines. Perhaps, there is a hint of irony

law, but its structure unjustly excludes some suffering individuals over others. The law allows people physically capable of ending their own lives and people currently under hospital care to end their lives as they wish (allowing patients to refuse treatment, accept terminal sedation, or commit suicide on their own), but leaving others floundering. Patients who can withhold or withdraw consent to life support measures should not have greater personal autonomy to control the time and manner of their death on this basis.¹⁹⁵

IV. CONCLUSION

The question to ask, then, might be how these deep-seated notions and questionable assumptions can be shaken from their foundations. Perhaps some cannot be. The potential for change in attitudes toward physician-assisted suicide has been questioned.¹⁹⁶ Reliance upon religious creed and ancient ideals, however, should not and cannot play a role in the administration of justice for suffering patients in contemporary times. The pain that British terminally ill patients experience is real and remains unalleviated under the law. Education about the realities of current medical care and the anticipated impact of permitting physician-assisted suicide for the terminally ill may be the most effective instrument. As one House of Lords member explained, assisted suicide will ultimately join the ranks of other equally controversial subjects that have been addressed by the law in spite of strong disagreement.¹⁹⁷ It is therefore only rational to tackle the issue when it is in its early stages and open to future complication.

in the fact that current legal mechanisms, such as advanced directives, are meant to further patient autonomy, yet shut out those who do not exactly meet the official formalities. *Id.*

¹⁹⁵ See generally Branthwaite, *supra* note 9, at 683.

¹⁹⁶ Graeme Laurie asked, "What, then, are we to make of a plethora of (failed) reforms? Do we focus on their sheer number as a mark of where we are going, or do we take their failure as an indication of continued resistance to the very idea of physician assisted suicide? Only time will tell." Laurie, *supra* note 80, at 8.

¹⁹⁷ 674 PARL. DEB., H.L. (5th ser.) (2005) 46 (the Earl of Arran expressed this view). For more on a comparison of end-of-life law to abortion, see *Suicide Helper Claims He is Saving Lives*, *supra* note 95 ("Drawing parallels with abortion, once restricted to back alleys and now part of mainstream medical care in most Western countries, [Ludwig Minelli] said it was critical that suicide be openly acknowledged, discussed and regulated.").

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APPENDIX: COMPARISON OF ASSISTED
SUICIDE LEGAL PROCEDURES

	Oregon	United Kingdom (Procedure proposed in Assisted Dying for the Terminally Ill Bill)	The Netherlands	Switzerland
ELIGIBILITY:				
Terminal Illness Required	Yes	Yes	Yes	No
“Unbearable” Suffering	Yes	Yes	Yes	No
Children Eligible (with restrictions)	No	No	Yes	No
PROCEDURE:				
Required Physician Involvement	Yes	Yes	Yes	Yes*
Reporting/Monitoring System	Yes	Yes	Yes	No
Physician Training Program	No	No	No	No

* Doctors are *only* involved in prescribing the lethal drug.

