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**A critical examination of the reasons why all UK  
Bills to introduce an Assisted Suicide Act of  
Parliament have failed and recommended actions  
on a potential way forward for parliament to  
introduce an Assisted Suicide Act in the UK**

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## **1.0 Signed Statement**

### **Declaration:**

I declare that this Dissertation has not already been accepted in substance for any degree and is not concurrently submitted in candidature for any degree. It is the result of my own independent research except where otherwise stated.

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Signed:

## **1.1 Abstract**

The purpose of this dissertation is to examine the reasons why all UK bills to introduce an Assisted Suicide Act of parliament have failed, as well as examining other jurisdictions to assess how they have implemented a form of euthanasia in to the legal system. This is done to then recommend to the government on how they could implement an Assisted Suicide Act. This dissertation was completed through undertaking a literature review, a discussion and analysis of findings and a conclusion.

A literature Review was completed using a variety of sources to collect information to analyse the arguments for and against the legalisation of euthanasia and assisted suicide. This was done to show public and theorists opinions on a major topic in the UK.

Secondary research was conducted through researching online, books and journals. Using all this to find relevant information from respected theorists, such as Keown (2012) and Grayling (2008).

To conclude, this dissertation provides an analysis and discussion of findings and then gives recommendations to the government on how they could implement an Assisted Suicide bill, using the safeguards shown in other jurisdictions.

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## **1.4 Definitions**

**Euthanasia:** *Translated from the Greek to mean 'good death'. Commonly referred to as 'Mercy killing'.*

**Assisted Suicide:** *The suicide of a patient from an incurable disease, affected by the taking of lethal drugs provided by a doctor, or helped by a family member acquiring the drugs or putting them within reach.*

**Physician Assisted Suicide:** *A doctor assists another person to end his or her life. For example, by prescription of lethal drugs.*

**Voluntary Euthanasia:** *This is when the patient specifically requests their desire to die.*

**Non-Voluntary Euthanasia:** *This occurs when the person is unconscious or otherwise unable to make a meaningful choice between living and dying, and an appropriate person takes the decision on their behalf.*

**Involuntary Euthanasia:** *This is Euthanasia performed without consent.*

**Indirect Euthanasia:** *This means providing treatment that has the side effect of speeding the patient's death.*

**Active Euthanasia:** *This occurs when the medical professionals, or another person, deliberately do something that causes the patient to die. For example, lethal injection.*

**Passive Euthanasia:** *This occurs when the patients die because the medical professionals either don't do something necessary to keep the patient alive, or when*

*they stop doing something that is keeping the patient alive. For example, switching off life support machines.*

**Palliative Care:** *An approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual. (World Health Organisation, 2002)*

**Human Rights:** *Rights inherent to all human beings, whatever our nationality, place of residence sex, national or ethnic origin, colour, religion, language, or any other status, which we are all equally entitled to without discrimination.*

**Parliament Bill:** *A proposal for a new law, or a proposal to change an existing law that is presented for debate before parliament.*

**Jurisdiction:** *Country and/or state.*

## **1.5 Introduction**

This dissertation will assess why all the UK Bills to legalise an Assisted Suicide act of parliament have failed, and then recommend ways forward for the UK government using similar approaches from other jurisdictions. Euthanasia is illegal under English law, but some countries have adapted their laws to add a form of euthanasia.

Euthanasia has been recognised since Ancient Greek and Roman times and comes from the Greek meaning of 'pleasant death'. 'It typically refers to the killing of a person for their own (or another) good, usually to end their suffering.' (Firth, 2011) However, euthanasia has always had heavy opposition, especially from the Christian and Jewish religious standpoint. The American colonies implemented euthanasia in to the common-law system in the 17<sup>th</sup> century, but in 1828 New York created a statute that prohibited the use of euthanasia, and they became the first state to do this. Many Bills to implement an act of euthanasia across the world have been defeated, such as Ohio in 1905, but the Nazis use of euthanasia changed the US perception of euthanasia. In the UK three major bills have been put forward, but have all been defeated and the reasons for this are discussed in this research. This research includes an introduction in to the chosen topic, a literature review, a discussion of findings and then concluded with recommendations. This research will be undertaken through secondary research only.

Euthanasia is a major topic within the UK and the media, and three high profile bills have been discussed in parliament. There have also been several notable court cases, involving patients who wish to die, and some patient's family who want to understand whether they would be prosecuted for helping the patient to die. Case law shows that the law on assisted suicide is not understood, as some people are putting forward their case to change the law. Euthanasia is interesting to research as countries, some geographically close as Belgium, have managed to implement a law on euthanasia. This shows that the law can be implemented and accepted, although there will always be opposition. Euthanasia is also important as it impacts everyone in society, and effects their lives not just their deaths. Also, it is important as public

support is at its highest ever. This is shown from a survey (Ipsos Reid Poll) that showed 84% of Canadians supported assisted suicide in 2014, an increase on 77% when the supreme court ruled against assisted suicide in 1993.

The aims of this research are:

1. To analyse and discuss the for and against arguments surrounding euthanasia
2. To discuss efforts made to legalise euthanasia in the UK through parliament Bills, and an analysis of UK case law
3. To analyse jurisdictions that have allowed a form of euthanasia
4. To recommend how the government can implement and control the use of euthanasia, based on safeguards from other jurisdictions.

This research aims to analyse the literature surrounding the arguments for and against euthanasia, which outline the main reasons why the UK bills have been rejected, as well as the public opinion on euthanasia. This is essential in understanding the current themes and trends around euthanasia, and what arguments are being put forward against the legalisation. This chapter sets the scene on the current position of euthanasia, and provides a history to the arguments that have been put forward since euthanasia first was recognised. This chapter is designed to show the major for and against arguments, to show the reader why the bills and euthanasia have been rejected in the UK.

It is also important to understand that the UK has already tried to implement an assisted suicide bill, this chapter is highly important as it shows that the euthanasia movement is growing within the UK. Therefore, it must be assessed whether it is likely that parliament will accept this and vote in favour. The bills show three high profile attempts to legalise euthanasia, therefore showing that it is a much-debated topic on either side of the argument. Case law helps understand the courts position on euthanasia, as well as the law, and allows us to assess how the public are trying to change the law in certain circumstances. Although assisted suicide is illegal, cases

coming through courts involve the individual trying to expand and change the law. This chapter is designed to give the reader an in-depth idea of the euthanasia movement within the UK, as it never seems to disappear.

An analysis of other jurisdictions is important to research as it shows how euthanasia and assisted suicide can be implemented in to the countries legal system. This gives a basis and understanding of safeguards that could potentially be implemented in the UK. It also shows that it is possible to overcome those that are against the legalisation of euthanasia. This chapter also shows how some arguments are not recognised, such as the medical ethics argument, as in some countries the medical profession has accepted the use of euthanasia. This chapter also helps to assess whether there being an option of euthanasia has pushed people towards it or towards life prolonging treatment such as palliative care. The aim of this chapter is to show how euthanasia can be legalised and accepted in countries and states.

Switzerland was an obvious choice for research, as prior to undertaking this dissertation there were regular news stories about euthanasia. They are also arguably the most well-known country in terms of euthanasia laws. Another reason for choosing Switzerland is to do with the organisations DIGNITIS and EXIT, who are organisations set up to help those dying. These organisations believe that there is a human right to die. This is interesting, as organisations like this can't be found anywhere else in the world. Belgium was chosen for research as the legalisation of euthanasia was publically backed by the senate. This is remarkable as this has never happened before when euthanasia has been put forward, and the senate being a high-profile position within government. Belgium also implemented safeguards, such as only being available to 'competent adults', which could be considered as a safeguard to be used by the UK. Belgium also has the most radical extension of euthanasia, as it now allows euthanasia for children. Therefore, portraying the 'slippery slope' argument.

The Netherlands was chosen for research as it was the first European country to allow a form of euthanasia. The law created means that euthanasia is illegal, unless certain criteria is met. These are to safeguard against the abuse of the law. Another reason for choosing The Netherlands is based on the opinion that one of the major reasons for euthanasia being legalised is due to a lack of palliative care and the medical backing by physicians. This directly contrasts to the current situation in the UK, as palliative care is an option in the UK. The state of Oregon (USA) was chosen for research to give the reader a wider perspective of euthanasia, which has been accepted worldwide. At the time, Oregon was the only state to accept a form of euthanasia in the USA, and the safeguards implemented in Oregon could be considered for the UK.

The final chapter is based on recommendations for the UK government on how they could implement an Assisted Suicide Act of parliament. As it is likely to meet fierce opposition, certain safeguards shown in other countries will help control the use of euthanasia. This chapter will use the research undertaken, to then come to conclusions based on the findings. This chapter is important as it is an advance on all research surrounding euthanasia, and will advise the government on how the law could be implemented. This chapter will put together other jurisdictions law on euthanasia and will apply them to the UK. This chapter is also important as it focuses on the control of euthanasia after implementation, as in many cases a form euthanasia has been legalised but not controlled.

Overall, this research is aimed to solve the problem of legalising euthanasia. This is done through recommendations to the government on legalising and controlling euthanasia. This is important as euthanasia is currently a much-debated topic, as shown by three UK bills, therefore there is likely to be a repeat of these parliament bills. In fact, there will be another UK bill reading in 2017. This research also solves a problem by proposing a way forward for the government to control euthanasia if it was to become legal, and from research there have only been few recommendations made before. However, there are some limitations and constraints to this research.

Ethically, research could not be undertaken to ask the views of the terminally ill on euthanasia. This would have provided an insight in to the opinions of those who may use euthanasia. Another constraint being that due to limited funds available, research in to other countries had to be through journals and websites, rather than asking the public themselves how they feel about the legalisation of euthanasia and assisted suicide.

## **1.6 Literature Review**

### **1.6.1 The main arguments For and Against the use of Euthanasia**

#### **1.6.1.1 Introduction:**

The two main types of argument in support of euthanasia are the ethical argument and the pragmatic argument. There are considerably more arguments against euthanasia and assisted suicide; the main arguments against euthanasia discussed are the religious argument, the 'slippery slope' argument, medical ethics argument and the alternative argument. These are the main reasons that will be cited throughout this research and have been referenced in the bills put forward in the UK.

#### **1.6.1.2 Ethical Argument:**

The Ethical argument surrounds the statement that everyone should be able to choose when and how he or she dies and therefore it should become a human right. Robinson (2008) states that 'some terminally ill patients are in intractable pain and/or experience an intolerably poor quality of life. They would prefer to end their life rather than continue until their body finally gives up.' The ethical argument rejects the religious argument that life is sacred, and is therefore always better than death. This argument agrees with Robinson (2008) as it suggests that life should only continue if a person feels their life is worth living. The idea of 'quality of life' is an important part of this argument. The idea of the ethical argument is to give the patient dignity in dying, and the physician will act to relieve the pain and suffering of the patient. McKhann (1996) stated 'for the dying patient, suffering may go far beyond pain. This includes: progressive loss of activity, mobility and freedom, increasing helplessness and dependence on others, physical discomforts such as nausea, dyspnoea, inability to swallow or talk, fear of dying, incontinence, weakness, loss of dignity, and dementia.' McKhann (1996) shows how it can be more than just

pain that terminally ill people are experiencing and that life loses all quality and meaning to the point that the option to die is preferable. However, Rodriguez (2001) argues that life has an intrinsic value and 'the dignity of the person cannot be erased by illness.'

The argument of palliative care is put forward in most cases, however Quill et al (1992) stated that 'even with adequate palliative care there are cases in which it is not possible to avoid suffering.' Another Ethical argument put forward is that the patient, who cannot commit suicide, is being discriminated against. This is seen in both the Pretty and Nicklinson cases in the UK. This argument states that in most jurisdictions suicide is legal, and therefore the terminally ill person should be able to commit suicide. Due to their condition this is impossible. Therefore, they are being discriminated against because of their disability, as able-bodied people are given the option.

#### **1.6.1.3 Pragmatic Argument:**

The second argument in favour of Euthanasia is the Pragmatic argument. This argument states that euthanasia, particularly passive euthanasia, is allegedly already a widespread practice, so it is better to regulate it properly. An example of this is the practice of making a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order. It has been argued that DNACPR is a type of passive euthanasia, because a person is being denied treatment that could potentially save their life. An anonymous writer on the NHS Choices website (2014) agree that euthanasia is being used illegally as they stated, 'many of the practices used in end of life care are a type of euthanasia in all but name' when referring to palliative sedation. Many of the sedatives used in Palliative sedation can potentially speed up the dying process; therefore, is a type of active euthanasia.

Fendert (2014) stated that 'state involvement would, supposedly, assure that safeguards would be put into place to regulate the euthanasia process.' Safeguards implemented may be like those in Holland, Belgium, Switzerland and Oregon.

However, on the other hand it could be argued that the state may not be able to control the use completely. The Canadian Medical Association Journal (CMAJ) agree that euthanasia cannot be controlled, as a study they published suggested that almost half of Belgium's euthanasia deaths may be carried out on patients who have not asked for their lives to end. The study found that 120 nurses had been involved in killing patients without their 'explicit request'.

#### **1.6.1.4 'Slippery Slope' Argument:**

One of the main arguments against euthanasia is the 'Slippery Slope' argument, which is based on the concern that legalising euthanasia could lead to significant unintended changes in our healthcare system. It also believes that allowing certain cases to use euthanasia, for example Pretty or Nicklinson, or Physician assisted suicide, will eventually lead to full-scale euthanasia being accepted. Walker (2000) states that 'there is little to stop a slide from Physician-Assisted suicide to voluntary euthanasia.' Keown (2012) argues that there are two different aspects to the Slippery Slope argument, the first being the 'logical' argument that, as discussed before, believes the acceptance of voluntary euthanasia leads to non-voluntary euthanasia. Keown (2012) believes that even 'if a line can, in principle, be drawn between voluntary and non-voluntary euthanasia, a slide will occur in practice because the safeguards to prevent it cannot be made effective.' This is known as the 'Empirical' argument.

This argument put forward by Keown (2012) shows that the acceptance of euthanasia will eventually lead to all euthanasia regardless of the safe guards implemented. The Slippery Slope argument doesn't concern whether the right to die is a human right, it focuses on the widespread use of euthanasia leading to 'mercy killings' and prefers end of life care, such as palliative care, rather than choosing to die. The Netherlands is a prime example of the slippery slope argument, as euthanasia is accepted if certain criteria are met. Boer (2003) believes that Holland 'has become a guiding country' on both sides of the argument surrounding euthanasia as it is 'setting the example for those advocating legalisations of

euthanasia and assisted suicide' and on the other hand 'a haunting perspective for those opposing euthanasia.' Boer (2003) goes on to say that this argument is limited by its 'reference to future developments which cannot empirically be sustained.'

#### **1.6.1.5 Medical Ethics Argument:**

Those against euthanasia in the reading of the 2006, 2010 and 2015 UK Bill attempts have put the medical ethics argument forward, as a reason for voting against. This is also an argument found in the public, particularly by the elderly and disabled. A ComRes survey ([www.scope.org](http://www.scope.org)) found that 70%, of 533 disabled people asked, would be concerned if the law on assisted suicide were to change because they believe it would lead to added pressure on them to end their lives. The Full Survey can be found in appendix 2. This survey agrees that disabled people would feel concerned if the law on assisted suicide were to change. This argument puts forward that the legalisation of euthanasia will change the doctor-patient relationship, as well as being a violation of fundamental medical ethics. The International Code of Medical Ethics states that 'a physician shall always bear in mind the obligation to respect human life.' (Anon, NHS, 2014)

Pelaez (2010), a doctor, wrote that 'the physician-patient relationship is the cornerstone of medical practice and therefore of medical ethics.' This shows that if the law was changed, the patient-doctor relationship would lose trust and uncertainty would be created. Dr David Jeffery (2012), a former palliative care consultant, agrees with this as he stated that the legalisation of euthanasia 'would require a new ethos in medicine' as the duty of care would be overturned. It is recognised that trust is essential for medical care and the law covers this. The Mental Capacity Act 2005 (MCA) states that 'an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.' (C.9 Section 1 (5)) This shows that the duty of care is in the patient's best interest, therefore ensuring trust is maintained. If euthanasia were legalised, doctors would be obliged to raise assisted suicide as an option to dying patients. This

could cause fears to be raised by patients that the doctor had an interest in speeding up the death of the patient, therefore breaking the trust of the relationship.

The opposition to this argument comes from the ethical argument that patients should be able to choose when and how they die, and not influenced by doctors. The medical ethics argument shows that there is not a human right to die. In fact, it suggests that a medical professional's job is to keep the patient alive if possible until a natural end, and to not suggest the choice of dying painlessly. Therefore, taking the rights away from the patient, and putting them in the hand of someone else.

#### **1.6.1.6 Alternative Argument:**

Another considerable argument against Euthanasia is the 'alternative argument' that looks at alternative reasons other than dying. This argument believes there is no reason to suffer mentally or physically because effective end of life treatment is available. An example of this is palliative care (see definitions), and is an argument put forward several times throughout this research. Hennon et al (2011) wrote that 'the goal is to improve quality of life for individuals who are suffering from disease'. This argument believes that any life is better than no life. There is a common misconception that palliative care is only for the patient, however Rome (2011) stated that 'once death has occurred, the role of palliative care focuses primarily on the support of the patient's family and bereavement.' This is essential in understanding the palliative care process. Radbruch et al (2015) stated that 'the human being is the focus of the care.' It could be argued that in fact they are not the focus, as if they truly want to die their wishes are not being granted and the prolonging of life is inflicting more pain and suffering for them.

#### **1.6.1.7 Religious Argument:**

The final argument against Euthanasia is based on religion. The religious aspect argues that only God has the right to end human life, and that beings are the sacred creation of God. This is known as the 'sanctity of life'. Christian, Jewish and Islamic faiths share the view that committing euthanasia is acting against the will of God and

is sinful. Traina (1998) discusses different religious viewpoints towards euthanasia and stated that in many cases of religion 'the natural process of dying is traceable to the belief that our final days or hours have profound significance for reincarnation, afterlife, or resurrection.' Using the religious argument, the right to die isn't a human right at all and is based on the belief that god should chose when the person dies. However, some religions allow abortion, which can be argued is a type of euthanasia as the unborn baby is not given an option whether they want to live.

#### **1.6.1.8 Chapter Conclusion:**

This research also highlights the significance of Palliative care being an option at the end of patients' lives. The medical profession, such as Dr Jeffery (2012), put forward this argument several times and several theorists believe this is the way forward. There are some theorists, such as Quill (1992), who believe in some cases pain cannot be stopped by palliative care. However, the majority seem to believe in palliative care. This argument links to the medical ethics argument and the religious argument. The medical ethics argument is of huge concern to those voting in parliament on the bills, as this essentially would make killing an option and change the doctor patient relationship. As the YouGov surveys show, this would make the elderly feel uncomfortable and may be forced or pressured in to choosing assisted suicide. The religious standpoint also agrees, as this firmly believes that god should choose when we die. Arguably one of the biggest arguments, as stated by Walker (2000) and Keown (2012), is the slippery slope argument. This argument is very significant as other jurisdictions, such as Oregon, that have accepted a form of Euthanasia have not been able to control abuse and mercy killings have become common. However, Fendert (2014) and Boer (2003) firmly believe that the government can control the use of euthanasia and that these safeguards should be based on the Dutch approach.

The arguments against euthanasia, such as medical ethics, slippery slope, religious and alternative, have no consideration for human rights. Not one of these arguments state that the human should have the choice to die. The ethical argument has been

put forward in this research and this believes that everyone should have the right to decide when they die. It also highlights the point that capable people can commit suicide themselves without any consequences and essentially stop the pain they are in. Whereas those who are terminally ill and incapable of committing suicide, do not have a choice and must suffer for longer until the natural end of their lives. This is a discrimination of their disability, as they do not have the same rights as capable people. These arguments are vital in assessing whether the legalisation of euthanasia is possibly in the UK and will be assessed to make recommendations on the potential safeguards that could be implemented.

## **1.7 Methodology**

The methodology for this dissertation includes a detailed and comparative analysis of the use and control of Euthanasia in countries and states that have legalised a form of euthanasia. This is with the view to then recommend the government in the UK on how they can safeguard and control euthanasia. These countries have been chosen as during their history, one form of euthanasia has been legalised and safeguards have been implemented to try and control abuse. Although this isn't always possible. Therefore, they provide a comparative law that could be followed. References are used to give an insight in to other jurisdictions, as well as adding depth and support to arguments.

This dissertation is primarily theoretical based. This is a selection and discussion of theoretical material and descriptive material, and a detailed comparison of theories in terms of applicability. This is key to making recommendations based on the theory, essentially if the aim of legalising euthanasia is possible or not. This research will be undertaken through secondary research only. Secondary research was chosen as this dissertation aims to bring together possible solutions that have been used in history, rather than building themes based on opinions. Secondary research involves an analysis of research and utilising existing published data, such as online journals, websites, books and law databases such as Westlaw. These sources were initially collected for the purposes of a prior research study, and are referenced using Harvard referencing throughout. Westlaw was used to provide an in depth factual analysis of each case, to then analyse each case in terms of what happened and what could be taken from these cases.

The sources used in this dissertation are also reliable. Many are trusted theorists, and well known within the topic area. This has been found through extensive research, which pushed towards choosing these theorists. To give this dissertation balance, arguments have been made for and against to give the reader an un-biased picture of the current state on euthanasia. Data collection was ethical and did not

contravene any of Cardiff Metropolitan University's ethical regulations. An ethics approval document is attached in to the appendix of this dissertation (Appendix 1).

## **1.8 Analysis and Discussion of Findings**

### **1.8.1 Parliament Bills in the UK and Case Law**

#### **1.8.1.1 Introduction:**

Euthanasia is a major talking point within the UK and its media, and it is important to realise that there have already been several efforts to try and legalise the use of euthanasia and assisted suicide in the UK. There have been three bills put forward, in 2006, 2010 and 2015. All three have been met with overwhelming opposition and have failed. However, there are examples where members of parliament have changed their mind. In 2006 Lord Rix voted against the legalisation of euthanasia, but he has now pleaded for euthanasia to become legal after being diagnosed with a terminal condition. This example shows how people can change their opinion based on their health. Should euthanasia be an option for those who feel they may want to proceed with assisted suicide and end suffering, should they have to suffer in pain or should palliative care increase in the UK? At this current time, palliative care is the preferred option.

#### **1.8.1.2 Lord Joffe's 2006 Parliament Bill:**

Lord Joffe brought the Assisted Dying Bill forward in 2006 which was the first attempt made in the UK and was modelled on Oregon's Death with Dignity Act. It was put forward to 'enable 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.' The safeguards put forward included only people with less than six months to live, those who are suffering unbearably and deemed to be of sound mind would be able to end their life under this bill. This bill, that was blocked, highlighted the divisions between supporters of the right to die and those who want better palliative care. Palliative care being one of the options considered other than assisted suicide for terminally ill patients. Palliative care, as defined by the World

Health Organisation (2002), is 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness.' Lady Finlay, a professor in palliative care said, 'let us get on with working for patients to live as well as possible until a naturally dignified death, not taken up with becoming complicit with suicide.'

The main concern of this bill, as stated by Lord Carlile, was that the legalisation would eventually lead to voluntary euthanasia. Voluntary euthanasia is when the physician would help the patient die, for example administering a lethal dose of drugs. This form of euthanasia is used in other European countries. There was also concern that it could lead to pressure on vulnerable people to take their own lives. Other concerns came from the medical profession; the legalisation would effectively change the role of the doctor from curing to killing and be against the Hippocratic oath. The Medical Law Review of the bill also stated, 'irrespective of the compassionate feelings which motivated its sponsor, the bill invited both extension and abuse.' (Keown, 2007) This is supported by Tallis (2011), who chaired a medical ethics committee regarding Lord Joffe's bill, who stated 'The hostility of many, including myself, against the assisted dying legislation was based on assumptions we had about its possible longer-term consequences on the practice of medicine and more broadly in society.' However, there was also support for the bill from right to die campaigners. The main arguments for the bill were that people should have the right to decide how they died and whether they would prefer this to palliative care.

#### **1.8.1.3 Margo McDonald's 2010 Parliament Bill:**

The End of Life Assistance Bill was put forward in 2010 in the Scottish Parliament to legalise assisted suicide and euthanasia. Margo Macdonald put forward the bill, and due to her medical condition of Parkinson's disease she was strongly for the legalisation. The 2010 bill was like the 2006 bill, as it would have allowed people whose lives had become intolerable through a progressive degenerative condition, a trauma or terminal illness to seek a doctor's help in dying. This bill would try to

legalise assisted suicide, where a physician for self-administration provides a patient with lethal drugs. As well as Euthanasia, where a physician administers lethal drugs to a patient directly. Various safeguards were put forward by Margo Macdonald and included; that the request must be made to and approved by a doctor, there must be a 15-day cooling off period, they must be over 16 years old only and applicants must be registered with Scottish GP for 18 months. Macdonald suggested these safeguards meant terminally ill people could have some dignity, and they would prevent abuse of the legislation. However, this bill was met with serious opposition. The opposition came from the belief that life's value would become insignificant and put the elderly at risk. These are the same as the 2006 bills opposition. This bill also faced opposition from the Royal College of Medicine, where it was stated 'the clear majority of medical practitioners do not support assisted suicide.' (carenotkilling.org) The opposition also drew on evidence from the Netherlands and the US state of Oregon, which showed it's impossible to prevent abuse from occurring. 21,000 people have signed up to the Care Not Killing campaign opposing the bill and it is 'by far and away the biggest campaign response since the Scottish Parliament was established.' (Anon, carenotkilling.org)

Another important factor that contributed to the blocking of the bill was 'suicide tourism'. Edward Turner the leader of Dignity in Dying, the leading euthanasia group in the UK, has warned that 'the bill that was introduced by Margo MacDonald to legalise euthanasia and assisted suicide in Scotland, would also encourage suicide tourism to Scotland.' (Schadenberg, 2010) This is where non-Scottish citizens would travel to Scotland to use the laws of assisted suicide and end their lives. This is also common in Switzerland, which progressed rapidly and between 2010 and 2014 'suicide tourism' doubled. There was also uncertainty of how many deaths a year would come from assisted suicide and euthanasia. Margo Macdonald was 'seriously misleading the Scottish people about the number of deaths that would result if her bill were to be passed' (Saunders, 2010) Her claims were of 50 deaths per year based on the Netherlands and Oregon. However, these claims were disrupted after an investigation found that Oregon accounted for 80 deaths per year just through

assisted suicide and not euthanasia. The death toll was also rising every year from 2008. This investigation caused a huge amount of uncertainty and ultimately caused members of parliament to vote overwhelmingly by 85 to 16 to reject the End of Life Assistance bill.

#### **1.8.1.4 Lord Falconer's 2015 Parliament Bill:**

Lord Falconer put the assisted dying bill forward in 2015, which seeks to legalise assisted suicide, but not euthanasia. It proposed that mentally competent adults of 18 years and over, with less than six months to live might choose to end their lives. This would be under two doctors' signature model like the Abortion Act 1967. The safeguards put forward for this bill to legalise assisted suicide included a clear intention to end their life, aged over 18, a resident of England or Wales for over a year, diagnosed with a terminal illness and a signed witness declaration. The 2015 bill was also based on the Oregon Death with Dignity act. 'The bill was almost identical to the Assisted Dying Bill, which made it through to committee stage in the House of Lords before running out of time in the last parliament.' (Dyer, 2015) This shows that pro assisted suicide campaigners are growing, as another bill has been the topic of a heated 10-hour debate. The main reasons discussed were from personal experiences of loved ones dying, others spoke of their fear of death and some cited faith as for and against the proposal. Jim Patrick, a labour MP, stated that due to his condition and what lies in store for him, he is pro legalisation, as he would like to be in control of his own death. Norman Lamb, a Liberal Democrat, seemed to agree with this statement but said 'he doesn't know if he would exercise it himself, but would like the option.'

Opposition from various members of parliament came from religious standpoints of the sanctity of life and how life is a gift from god with all it entails, including pain and suffering. The sanctity of life is the main religious argument against euthanasia. This was also met with opposition from the medical profession; the GP Sarah Wollaston had several patients contemplating taking their life through fear and depression.

However, after time many of them came through to find the real meaning in their lives. There was also concern for deaths that would be caused. 15 times more people die in England and Wales per year compared to Oregon, If the same proportion of those chose assisted dying there would be several thousand cases a year before high court. Maria Caulfield, MP, stated that 'it's hard to see it working.'

#### **1.8.1.5 The case of Pretty V UK (2002):**

One of the leading cases in the UK of assisted suicide is *Pretty v United Kingdom* (2002). The applicant, who was paralysed and suffering from a degenerative and incurable illness (Motor Neuron Disease). She alleged that the Director of Public Prosecutions refusal to grant immunity to her husband from prosecution if he helped assist her in committing suicide infringed her human rights, under article 2 and 8 European Convention on Human Rights (ECHR). To begin with, *Regina (On the application of Pretty) V Director of Public Prosecutions and Secretary of state for the home department* (2001), was rejected by the House of Lords, stating that the right to life was not the right to die. This was then appealed by the applicant to the European Court of Human Rights (ECtHR) in *Pretty v UK*. The facts of the case state that 'her life expectancy is very poor, measurable only in weeks or months.' and goes on to say, 'her intellect and capacity to make decisions are unimpaired.' The applicant is frightened and distressed at the suffering and indignity that she will ensure if the disease runs its course. Motor Neuron Disease has no treatment that can prevent the progression of the disease. It is important to note that it is not a crime to commit suicide under English law, however Mrs. Pretty's disease prevents her from committing suicide without assistance.

Regardless of the criteria in Mrs Pretty's case, that would meet the requirements in Belgium, Switzerland and the Netherlands, her case was dismissed. The judge gave statements regarding the articles in question. The judge said that article 2 of the ECHR, that protects the right to life, 'recognises that it is for the individual to choose whether to live and so protects the individual's right to self-determination in relation to issues of life and death. Thus, a person may refuse lifesaving or life prolonging

medical treatment, and may lawfully commit suicide.’ The judge goes on to say that ‘the state has a positive obligation to protect both’ (the right to die and the right to life). This is important, as the judge’s interpretation and application of the law is that the right to life is not the right to die in any case. However, this may have found an opening in the law on assisted suicide. This is because the law doesn’t specifically mention the right to die, and the judge is applying his interpretation.

The applicant’s representatives in *Pretty V United Kingdom* (2002) cited *Airedale NHS Trust v Bland* (1993), where the applicant was in a Persistent vegetative state, and the court allowed the withholding of medical treatment after the victim was severely injured in the Hillsborough disaster. Another example of this is *Regina v Malcherek and Steel* (1981) where life support was withdrawn. This shows that the court does have the power to withhold treatment from those who need it, and in this case Mrs Pretty could have used this. However, there are cases where the applicant has specifically requested that their life support and resuscitation continues when the applicant loses capacity, such as in *Regina (Burke) v General Medical Council* (2004). This is another example of the ‘slippery slope’ argument, as the Suicide Act (1961) was tested and pushed, which could lead to further legalisation. Odone (2010) agrees that any case of assisted suicide may lead to outright euthanasia as ‘once the principle is breached that a doctor may act knowingly to bring about a patient’s death, the way to full-scale euthanasia lies open.’ (Odone, 2010) This is what many people feared would happen if legislation was approved, and led MP’s to vote against the three bills in the UK.

Mrs Pretty’s case was rejected due to no found violation of the convention. The court found that there is no right to die derived from Article 2 of the ECHR. In relation to the right to respect for private life under article 8, the court considered that the interference in this case might be justified as ‘necessary in a democratic society’ for the protection of the rights of others. However, in contrast to this it has been argued by Professor A C Grayling (2008), a Dignity in Dying patron, who stated that ‘decisions about the time and manner of death belong to the individual as a

human right' This is important in terms of the application of the law, the judge is interpreting article (the right to life) to include the right to die. The applicant also believed that Article 8, the right to respect for private and family life, had been refused by the DPP's rejection. 'Everyone has the right to respect for his private and family life, his home and his correspondence.' (Article 8 ECHR) The DPP, on referral, stated 'that the right to private life under Article 8 relates to the manner in which a person conducts his life, not the manner in which he departs from it.' This links to the religious argument, which argues 'only god should choose when a human life ends, so committing an act of euthanasia or assisting in suicide is acting against the will of God and is sinful.' (Norman, 2007) The religious argument is a common argument and was put forward by a Roman Catholic cleric, in Belgium, when euthanasia became legal.

#### **1.8.1.6 The case of R (Nicklinson) v Ministry of Justice (2012):**

Another important case in the UK in terms of assisted suicide is Nicklinson v Ministry of Justice 2012. The most important aspect of this case surrounds the law on suicide, which in the UK suicide is legal, therefore why should a mentally ill and incapable person not be able to commit suicide. This case is similar to the Pretty v UK case, as both cases were appealing against Article 8 of the ECHR and seeking clarification to whether the right to life was also the right to die. The applicant believed he should be able to end his life under Article 8 ECHR, and believed the policy published by the DPP should identify facts and circumstances with clarification where those willing to assist him to commit suicide in Switzerland would know if they would face prosecution. The judge, Lord Neuberger, held that it was up to parliament to change the laws. He continued to say that 'parliament would not legalise any form of euthanasia without a surrounding framework regarding end of life care and procedural safeguards.' Therefore, the judge is unable to make assisted suicide criteria in this case as it remains illegal under UK law, and the judge cannot change this. He also referred to how the courts cannot implement and control the law; they only can apply and interpret.

This is important as it shows the lack of law making power the judge has, and that it is down to the government to decide on legalisation. Although this case was rejected, the law was again tested and may have made a bigger impact than *Pretty v UK* (2002). As this case had been appealed, through it made a bigger impact in terms of the legalisation as the Supreme Court, the highest court in the UK, stated that they could not make laws regarding assisted suicide and that it is in fact up to parliament to make the law. This means that there is likely to be another bill put forward in parliament, which could be a success for the euthanasia and assisted suicide movement as the topic is again being discussed.

#### **1.8.1.7 Chapter Conclusion:**

Based on the facts, the parliament bills haven't made a sufficient case for euthanasia, however the cases seem to be making more of a movement. The majority of MP's rejected all the bills, but this won't stop more bills being discussed and put forward in parliament due to the high-profile nature of euthanasia and assisted suicide. This is due to the on-going uncertainty about euthanasia in the public and media. A YouGov poll (appendix 3) found that 69% of 2853 GB adults asked, believe the law should be changed to allow assisted suicide in circumstances where the patient has an incurable disease. The cases of *Pretty* and *Nicklinson* are unsettling the courts and from the *Nicklinson* case the judge specifically applied the law he knew but stated how parliament need to implement a law concerning the act of euthanasia and assisted suicide. The main argument surrounds whether the applicant's human rights are affected, and that there are no clear provisions on whether family who travel to Switzerland will face prosecution. Although the judges have disregarded the human rights element, the more cases that are put forward to courts will create more uncertainty on the laws of euthanasia and assisted suicide.

Cases of applicants looking for assisted suicide will bolster any attempts to legalise assisted suicide in the UK, however, if parliament implement a law surrounding assisted suicide in the UK and outline in what circumstances people will be

prosecuted for assisting suicide these cases will be controlled and the bills will be the only way forward. At this current time, the bills are not enough to legalise euthanasia and assisted suicide, as seen in the three bill attempts. However, if there are more high profile cases, such as Pretty v UK, support will increase and eventually euthanasia and assisted suicide will become legal with certain safeguards. These cases are likely to gain support due to the nature and facts of the case, such as the patient being in constant pain that can't be stopped, which is likely to cause an increase in support for the law to change in certain circumstances. This belief comes from looking at other European countries such as Switzerland and Belgium who have legalised some form of assisted suicide.

## **1.8.2 Analysis of other jurisdictions**

### **1.8.2.1 Introduction:**

Euthanasia is widely not accepted in society, and in the UK the Suicide Act 1961 (s.2 (1)) states that it is illegal when 'assisting or encouraging the suicide or attempted suicide of another person'. Assisted suicide in the UK carries a maximum prison sentence of 14 years, and cases described as euthanasia are treated as murder or manslaughter. It is important to note, that under English law a patient has the right to refuse medical treatment even if that treatment will save their lives. Therefore, it could be argued that euthanasia is the same kind of practice. In some countries 'assisted suicide' is legal. This is where the dying person consents to his or her fate, and a doctor prescribes them a lethal dose or injection. Assisted Suicide and Euthanasia is subject to major debate in the UK, and bills that have been put forward to legalise euthanasia in 2006, 2010 and 2015 but have all been rejected by majority vote. Countries such as the Netherlands, Belgium, Switzerland and the US state of Oregon have legalised some form of Euthanasia and certain guidelines and procedures have been created to stop 'mercy killings' and practice euthanasia in the correct way.

### **1.8.2.2 The Netherlands:**

In April 2001, the Dutch Parliament approved the 'Termination of Life on Request and Assisted Suicide Act'. However, Dutch Penal Code Articles 293 and 294 make both euthanasia and assisted suicide illegal. Criminal code sections were amended due to court cases and specifically states that the offenses of euthanasia and assisted suicide are not punishable if certain criteria had been met. The legislation requires that due care be used by the physician, that the doctor believe the suffering to be 'lasting' and 'unbearable', permits 16 to 18 year olds be killed without parental approval, permits 12 to 16 year olds to be killed if a parent or guardian agrees. The legalisation of Euthanasia in certain circumstances in the Netherlands, as stated by

Hendin (2011), was due to four factors 'National character traits, key court rulings, lack of palliative care training and Royal Dutch Medical Association approval'. This marked a major shift in the Euthanasia movement, as the Netherlands became the first European country to allow a form of Euthanasia. This came after several attempts to legalise Euthanasia in European countries such as France and England, and outside the EU in Japan.

The legalisation of Euthanasia in Netherlands came several years after Dr Gertruida Postma received a 'light' sentence after giving her dying mother a lethal injection. This case, and the controversy surrounding it launched the Euthanasia movement in the Netherlands. The highest profile case surrounding euthanasia and assisted suicide in the Netherlands is the 1973 court case in which Dr Gertruida Postma, a Dutch physician, was convicted of the crime of Euthanasia after she ended her seriously ill mother's life. This case was high profile due to Dr Postma's insistence of her actions being made public, and became a rallying point those seeking to change the law. Dr Postma received a one week suspended sentence and a week's probation, compared to the maximum sentence of 12 years. Dr Postma's admission, and medical association backing, of giving her ill mother a lethal injection forced a public and legal reconsideration of the assisted suicide and euthanasia laws. Unlike other countries, physicians have played a hugely significant role in the legalisation of Euthanasia and Assisted Suicide in the Netherlands. Dutch Physicians have led the way in permitting the practices, that illustrate how physician backing of induced death can grow and be used to justify virtually unlimited euthanasia and assisted suicide.

### **1.8.2.3 Belgium:**

The use of Voluntary Euthanasia in Belgium was passed and came in to effect in 2002; this result was widely expected following the Belgian Senate's approval of the law. The criteria for the use of Euthanasia are considerably different from those in the Netherlands. The Belgian Act on Euthanasia (2002) limits euthanasia to

'competent adults' aged 18 and above and 'emancipated minors' who are boundary cases of 16-17 year olds, as well as having to reside in Belgium. A minor being someone who is not under control of his or her parents or guardian and emancipated being in constant and unbearable physical or mental suffering. Each case will have to be filed at a special commission to decide if the doctors are following the regulations. The killing performed by a physician is legal only if they follow a certain procedure; this is informing the patient of his or her state of health, life expectancy and the available palliative care. Both the patient and physician must be convinced there is no other 'reasonable' option available. There was overwhelming support in Belgium for the 'right to die' and in 2013, 1,800 people chose to die via lethal injection. Belgium parliament legalised euthanasia by lethal injection for children aged under 18 in 2014, which is the world's most radical extension of euthanasia law and is a prime example of the 'slippery slope argument' against euthanasia. This sanctions euthanasia where children have a terminal and incurable illness, are near death, and suffering 'constant and unbearable physical' pain, and where parents and professionals agree.

This law was met with opposition in the medical profession most notably by some Belgian paediatricians. As well as from a Religious aspect, the country's leading Roman Catholic cleric publicly opposed the decision. Although there are several safeguards, a study published by the Canadian Medical Association Journal (CMAJ), suggests that almost half of Belgium's euthanasia deaths may be carried out on patients who have not asked for their lives to end. 'Once you have legalised voluntary euthanasia, involuntary euthanasia will inevitably follow.' (Saunders, 2016) The study found that 120 nurses had been involved in killing patients without their 'explicit request'. This study shows that although euthanasia is legal, mercy killings are still happening and cannot be controlled.

#### **1.8.2.4 Switzerland:**

The practice of Assisted Suicide has led many people to believe euthanasia has been

legalised in Switzerland, however this is not the case. Article 115 of the Penal Code of Switzerland states 'Whoever, from selfish motives, induces another to commit suicide or assists him therein shall be punished, if the suicide was successful or attempted, by confinement in a penitentiary for not more than five years or by imprisonment.' However, a person will not face prosecution if they successfully claim that he is acting 'unselfishly', and is 'non-medical'. Therefore, it is only punishable if a selfish motive is proven, such as money. This is an important distinction between Switzerland and that of Oregon, the Netherlands and Belgium where the law considers euthanasia and/or assisted suicide to be a 'medical treatment'. A person assisting a suicide does not have to be a medical professional to escape prosecution. 'Dignitas' and 'Exit' are organisations within Switzerland that provide assisted dying services, which cost around £6000 and allow foreigners to come for death if they believe they are terminally suffering. Switzerland has had many high-profile cases, and has become a 'Euthanasia tourism' attraction. As of August 2015, approximately 300 British citizens had travelled to Switzerland from the UK to use Dignitas services. This 'Euthanasia tourism' was of high concern when the bills to legalize euthanasia were put forward in the UK, specifically Margo McDonalds 2010 bill, and caused many to vote against.

In 2012, the Swiss public health law was expanded to require health facilities, such as nursing homes and hospitals, to permit assisted suicide. The law stated that public subsidies 'must allow assistance for suicide to be provided in their establishments' (Article 71b Public Health). There have been many different types of assisted suicide cases in Switzerland, from the terminally ill requesting suicide as they are legally allowed, to Alda Gross, a Swiss citizen, requesting lethal drugs even though she had no known pathological condition and believed she had the right to die, as she's 'frail' and has 'no desire to continue life'. This shows an extension of the law, that has been implemented in to Switzerland as now people without terminally illnesses are trying to use euthanasia.

#### **1.8.2.5 Oregon:**

The use of physician-assisted suicide was legalised during 1997 in the state of Oregon in the United States of America, and at the time they became the only state allowing physician-assisted suicide. This came through the 'Death with Dignity Act' which allows terminally ill citizens of Oregon to end their lives through the voluntary self-administration of lethal medications, prescribed by a physician. During the first 3 years, 2 people a month used this to end their life. The 'Death with Dignity Act' legalised physician-assisted suicide, but specifically prohibits euthanasia, where a physician or other person directly administers a medication to end another's life. The patient must be an adult of 18 years of age or older and a resident of Oregon. The act also states the patient must be 'capable', which is defined as able to make and communicate health care decisions, and diagnosed with a terminal illness that will lead to death within six months.

#### **1.8.2.6 Chapter Conclusion:**

This chapter shows the different reasons for allowing a form of euthanasia. However, as shown in the research Holland, Switzerland and Oregon does not allow euthanasia itself, they allow a different form. This is a medical professional administering the drug themselves, compared to assisted suicide which is the professional supplying the lethal dose or pill to the patient. Holland made Euthanasia and assisted suicide illegal, unless certain safeguards are met, in 2001. The main reason this could happen was due to high profile cases and a lack of palliative care.

This is vastly different to Belgium, who have legalised the use of Euthanasia by a physician. When researching, the main reasons for the legalisation in 2002 that stood out were the public backing and the senate's approval of euthanasia. Belgium is the only jurisdiction in the world that allows outright Euthanasia, but to safeguard this they made Euthanasia illegal unless the act is for 'unselfish' reasons. In Switzerland, they do not see euthanasia as a medical treatment, and it doesn't have

to be a medical professional that provides the lethal dose. This is unique to Switzerland. This law was created through parliament, and the creation of end of life organisations such as Dignitas and Exit have caused increased support. The state of Oregon allowed Assisted suicide in 1997, and was the only state that allows this at the time. Assisted Suicide was legalised due to the bills and eventually the 'dignity in dying' act. This research highlights the ways in which these countries or states have legalised euthanasia and assisted suicide, but have tried to control the use with certain safeguards.

This research also highlights that the main reason why these jurisdictions have allowed a form of euthanasia, for example the Netherlands, is so that the public have the option to end their life, but this way must be controlled and sanctioned properly so that the law isn't abused. The safeguards implemented are there to stop mercy killings, but make euthanasia legal if the criteria are met. The main criteria involve seeking medical advice from two doctors, as well as age and mental capacity factors. However, Schadenberg (2012), who researched in to the 18% increase in euthanasia deaths in the Netherlands in 2011, stated that 'legalising euthanasia and assisted suicide is not safe and the safeguards that are devised to control euthanasia only protect the doctor and not those who die by euthanasia.' Safeguards also aims to stop major criticism from the public. This is because euthanasia and assisted suicide are by law illegal, except from in Belgium. However, this doesn't always stop medical professionals criticising the laws. For example, in Belgium, no medical association has supported euthanasia like the medical association did in the Netherlands.

Cohen-Almagor, the author of 'The Right to Die with Dignity', from a study taken place in Belgium stated that 'Belgium doctors voiced opposition to the new law because it opened the door for ending life too wide.' This allows the use of euthanasia or assisted suicide if the safeguards are met, such as being terminally ill with less than 6 months to live. Eventually, full scale Euthanasia will be allowed in these countries. This is due to the slippery slope argument, 'where the acceptance of

a form of euthanasia will lead to the acceptance of all euthanasia.' (Keown, 2007). This research shows that government and medical approval as well as individual cases can go a long way to legalising euthanasia, such as in Belgium, whereas in the UK both the government and medical association have opposed euthanasia.

## **1.9 Recommendations and Conclusion**

### **1.9.1 Legalisation Recommendations**

This chapter is focused on making recommendations to the government on how they could implement an Assisted Suicide Act in the UK, therefore answering the research question. Recommendations are based on a suggested course of action to solve a problem. In this case, this is how the UK could implement assisted suicide. The legalisation of Euthanasia would be impossible without safeguards, and these are the recommendations suggested to the government in this chapter. These can be implemented to control the use of euthanasia to certain cases. Safeguards are used in Holland, and other EU countries, and Stephenson (2013) highlighted that that safeguards would 'prevent any kind of abuse or unintended extension.' This recommendation will identify and discuss the safeguards that are currently implemented in Belgium, Switzerland, Holland and Oregon and suggest which safeguards could be taken forward. Following this, research recommendations will be made and justified, as well as a conclusion.

These recommendations are listed in order of importance but must be looked at collectively:

Safeguard 1: The patient must be terminally ill

Terminally ill is described as having a disease that cannot be cured or adequately treated and that is reasonably expected to result in the death of a patient within a short period of time. This safeguard is first as this narrows down the number of patients that can request euthanasia, and this stops doctors killing patients in 'mercy killings' as they must be terminally ill. This safeguard is important as it means those who are in unbearable pain that cannot be helped, have an option to ease the pain. This safeguard is the norm in all four jurisdictions that have been analysed in this

research. However, the patient must also be of sound or capable mind to make this decision, which will be determined by doctors.

Safeguard 2: The request must be accepted by two doctors

This means that the patient has two medical professionals assessing their condition and request. This stops the chance of mercy killings happening as the request will be assessed by two different doctors. If accepted by two doctors, then the request will be accepted. However, if one doctor believes the patient is not of capable mind then a further investigation will take place. Both doctors must believe there is no other 'reasonable' option, such as palliative care, which is a safeguard used by Belgium. This also stops help from family to commit suicide, as assisted suicide must be sanctioned by medical professionals only.

Safeguard 3: End of life options must be made available

This involves making the patient aware of other available options to them, such as palliative care. This ensures that the patient has every chance to change their mind and is not influenced by the doctor's decision. This safeguard is used in Belgium. An advantage of this is that the patient may change their mind, and then choose palliative care until the natural end of their life. This shows how the use of euthanasia should be a last resort rather than a first option. The World Health organisation stated that 'Good quality care towards the end of life must be recognised as a basic human right.' (Addington-Hall, 2002)

Safeguard 4: The patient must be over 18

This safeguard is used by all jurisdictions that have been considered, however Belgium now allow children to die by euthanasia. To begin with, this is not the right route for the UK to go down. Over 18 has been chosen as a safeguard as being over 18 is considered being an adult, who can make their own decisions. To allow

ethanasia on children would cause major criticism and opposition against it. From research, legalising euthanasia must be step by step, not full scale implementation.

Safeguard 5: The patient must live in the UK

This safeguard is important as it is used to stop 'suicide tourism'. This is not used by Switzerland, and there have been cases of UK citizens travelling to Switzerland to end their lives. Wilson (2014) stated that 'suicide tourism has doubled in Switzerland since 2009.' This safeguard would stop any 'suicide tourism' and restrict the use of euthanasia to UK residences, thus stopping the further bad image that euthanasia brings. This safeguard is used in Oregon, Belgium and the Netherlands.

These five safeguards are commonly used when legalising euthanasia and could potentially help the UK to control abuse of the law. Jay (2010) stated that 'an assisted dying law for those who are terminally ill and mentally competent with up-front safeguards would better protect all people.' The reasons for this are that abuse can be stopped before it happens, rather than when the patient has died. However, sometimes these safeguards are still not enough to prevent mercy killings. An example of this, as stated earlier in this research, shows how patients are still being killed regardless of their wishes. There will also be cases where the public try to change the law and extend the boundaries. There are several other safeguards implemented in these jurisdictions. Such as the request must be in written format, this safeguard was not put forward in the recommendations of this research as some diseases cause patients to lose complete control of their bodies. Therefore, this stops the patient being able to make a request.

Another safeguard used in other jurisdictions is that there must be less than 6 months to live. From research, this safeguard wasn't chosen as some diseases (such as Multiple Sclerosis) last years and slowly wear down the person. Therefore, the patient would be in unbearable pain for a long time, without the possibility of improving, before eventually reaching the six-month mark. Without this safeguard

those who have a terminal disease can end their suffering. A disadvantage of this could be that doctors don't know how long patients have left to live. To counter this, doctors must make the patient aware that treatment could prolong life, although this is unlikely with a terminal illness, and two doctors would decide on how long the patient has left to live. These safeguards suggested are aimed at stopping the abuse of the law and must be considered collectively. The conclusion of this research will assess whether these safeguards can be implemented, as well as whether they can completely stop abuse and extension of the law.

### **1.9.2 Research Recommendations**

Further research in to this topic could be focused around the public opinion on the legalisation of euthanasia. This may help to understand more why the bills were rejected. Although the surveys used in this research are useful, surveys that involve more of the population would give a greater view of the publics opinion on euthanasia. Further research in to the effectiveness of safeguards could also be undertaken, although each jurisdictions safeguard seems solid from the outside, these have sometimes been extended which questions their applicability. The main area for further research would be surrounding the human rights aspect of dying, as there is uncertainty as to whether article 2 and 8 (ECHR) are giving a right to die. In some cases, such as *Pretty*, the court was unable to interpret the law and the looked for further clarification.

### **1.9.3 Conclusion**

Overall, the aim of this research was to assess why all the UK bills had failed to implement an assisted suicide act of parliament. From the research undertaken, the main reason for the bills failure has been due to the lack of control over the use of euthanasia. This reason, along with the other arguments against euthanasia as shown in the literature review, has caused people to fear the consequences of legalising euthanasia. The consequences are likely to be unfair practice, mercy killings and the rapid extension of the law. This is a justified and acceptable opinion, as through research it was found that 'in 1990, 52 per cent of intentional doctor-assisted deaths were not explicitly requested by the patient.' (Kosalka, 2012) This is supported by Hollins (2011) who stated that 'licensing doctors to supply lethal drugs to some of their patients would be an extremely worrying development because, if you look at what has happened in the small number of other countries that have legalised assisted suicide, there have been mistakes.' Therefore, this shows that the public should have a right to feel scared about the consequences of legalising euthanasia, as there have been no worldwide positive outcomes of the legalisation. However, it is important to understand that worldwide efforts have been made to legalise assisted suicide and several have been successful. Jurisdictions that haven't been mentioned in this dissertation that have succeeded or failed to legalise euthanasia include South Africa, Canada, Luxemburg and the US states of California, New Mexico, Vermont, Massachusetts, Montana, Washington, Maine, Michigan, and New York.

From undertaking this research, it has shown that there is a lack of research in to the families of the patients or the patients (before death) assessing how they feel about the use of euthanasia on themselves or a family member. If more research was to be done, support for euthanasia could increase and would add support to parliament bills. The research that has been done, to show that that support is growing for the 'right to die', by McCord (2010) who stated that due to the case of Debbie Purdy

'56% of the 3,874-people asked indicated that they felt that assisted suicide was acceptable if the demand to die came solely from the terminally ill patient.' Gaining support over such a dangerous topic like this is hard to achieve, as there is a lot of contrasting views especially about other jurisdictions that could portray how the UK would become. For example, in the Netherlands there are contrasting views, some that see how the Netherlands have implemented euthanasia as a model example and some that believe it represents danger (Boer, 2003). However, cases such as Purdy and Nicklinson are going to gain support for the right to die due to media coverage and this then builds people's opinions.

Another aim of this research was to provide safeguards as recommendations, and this is done in chapter 1.9.1. At this current time, even with these safeguards it is unlikely that euthanasia will be made legal. This is due to the unpredictable nature of euthanasia. This statement is supported due to the amount of No votes each bill has received, as the voting outcome was largely a majority against the legalisation and only a few votes were for the bill. Also, due to the negative medical coverage of other jurisdictions, this is also likely to cause opposition.

However, in the next 10 years (by 2027) the possibility of an assisted suicide act of parliament is only going to shorten. It may not be known to the public or broadcasted by the media, but euthanasia is being used within the UK already and there are increasing attempts to amend the law. This is supported by Humphrey (1991) who stated that 'there is evidence of considerable public and legal sympathy for mercy killers, those desperate people who unilaterally kill their loved ones in the belief that it is the only compassionate thing to do.' The first example of this is that patients can refuse medical treatment from doctors. Although this is not pain free, the doctor is essentially allowing the patient to die, due to the patient's request. This is an act of voluntary euthanasia, which is considered murder under English law. This is against the Hippocratic oath which is the cornerstone of medical ethics. The second example of this, which was publicised during this research (11<sup>th</sup> April 2017), came from Judge Francis who ruled that doctors can withdraw a baby's life support

machine against the parents' wishes. This ruling has given the all clear for a doctor to end the terminally ill baby's life, without permission from the parents. This is a form of involuntary euthanasia, as it is performed without consent.

The third example, also publicised during this research (12<sup>th</sup> April 2017), comes from the Noel Conway case. The High Court Judges (Lord Justice McFarlane and Lord Justice Beatson) assessed Mr. Conway's case and allowed him to appeal against the assisted dying ban in a higher court. This shows how some judges are beginning to believe that assisted dying should be an option, depending on the severity of the case. In this case, Mr. Conway has Motor Neuron Disease and isn't expected to live longer than 12 months. The judges stated, "It is arguable that the evidence demonstrates that a mechanism of assisted dying can be devised for those in Mr. Conway's narrowly defined group." This was allowed as there had been no change since the Nicklinson case, therefore Mr. Conway could appeal. These two recent cases could have major implications for an assisted dying act of parliament.

To conclude, this research has achieved its aims to examine why the parliament bills have all failed, and to make a comparison to other jurisdictions on how the UK could implement safeguards for euthanasia. It also gives the reader both sides of the argument in an unbiased manner. This is important as it gives the reader an overview of the arguments for and against, to then make their own opinion. Personal opinions have not been used in this research, to keep the arguments unbiased and based on facts only. However, the main points that have come from completing this research have led to three conclusions:

- The Euthanasia movement doesn't need to constantly be in the public eye, as behind closed doors it is happening and eventually will become legal.
- Judges are also becoming increasingly unsure as to what the law states, and in recent cases have looked to the government for clarification.

- The parliament bills won't stop, due to the increased support in the right to die campaign. There is already due to be another reading in 2017, which adds significant weight to this conclusion

## **1.10 Appendices**

### **Appendix 1 -**

#### **Cardiff Metropolitan University Application for Ethics Approval**

Name of applicant:	Adam Phippen
Supervisor (if student project):	Styliani Diamantidi
School / Unit:	Cardiff Metropolitan University
Student number (if applicable):	20060705
Programme enrolled on (if applicable):	Business Management with Law
Project Title:	An examination of the reasons why all UK Bills to introduce an Assisted Suicide Act of Parliament have failed and recommended actions on a potential way forward for parliament to introduce Assisted Suicide in the UK
Expected start date of data collection:	N/A
Approximate duration of data collection:	N/A
Funding Body (if applicable):	N/A
Other researcher(s) working on the project:	N/A
Will the study involve NHS patients or staff?	No
Will the study involve taking samples of human origin from participants?	No

Does your project fall entirely within one of the following categories?

Paper based, involving only documents in the public domain

No

Laboratory based, not involving human participants or human tissue samples

No

Practice based not involving human participants (e.g curatorial, practice audit)

No

Compulsory projects in professional practice (e.g Initial Teacher Education)

No

A project for which external approval has been obtained (e.g., NHS)

No

If you have answered YES to any of these questions, expand on your answer in the non-technical summary. No further information regarding your project is required.

If you have answered NO to all of these questions, you must complete Part 2 of this form

In no more than 150 words, give a non-technical summary of the project

The purpose of this research is to examine the reasons why all UK bills to introduce an Assisted Suicide act of parliament have failed, as well as examining other jurisdictions and how they have implemented a form of euthanasia in to the legal system. To then recommend to the government on how they could implement an assisted suicide act

#### **DECLARATION:**

**I confirm that this project conforms with the Cardiff Met Research Governance Framework**

**I confirm that I will abide by the Cardiff Met requirements regarding confidentiality and anonymity when conducting this project.**



## Appendix 2 -

### ComRes survey

Full Question – Helping another person to commit suicide is currently against the law. How concerned or otherwise would you be about a change in the law to legalise assisted suicide?

Table 18/1

**SCOPE NDPP SURVEY FEBRUARY-MARCH 2011**

**Q11 Helping another person to commit suicide is currently against the law. How concerned or otherwise would you be about a change in the law to legalise assisted suicide?**  
Base: All respondents

		DISABLED PEOPLE														Gender		
		Impairment																
	DISABLED PEOPLE	Deaf	Physical	Blind / visual	Mobility	Learning	Specific learning	Mental health	Social, emotional or behavioural	Speech, language, or communication	Long-term	Developmental condition	Autistic spectrum	Other	Male	Female		
	Total	676	533	72	318	47	358	28	42	118	40	54	214	79	32	79	185	293
		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Very concerned	(2.0)	209	178	25	117	20	128	10	22	41	15	25	71	30	11	26	64	102
		31%	33%	35%	37%	43%	36%	36%	52%	35%	38%	46%	33%	38%	34%	33%	35%	35%
Slightly concerned	(1.0)	138	104	12	56	15	59	4	4	20	6	9	44	14	8	14	39	54
		20%	20%	17%	18%	32%	16%	14%	10%	17%	15%	17%	21%	18%	25%	18%	21%	18%
Not very concerned	(-1.0)	115	86	13	49	3	57	3	7	22	3	7	39	10	5	16	21	60
		17%	16%	18%	15%	6%	16%	11%	17%	19%	8%	13%	18%	13%	16%	20%	11%	20%
Not at all concerned	(-2.0)	132	102	11	62	7	77	4	4	24	10	9	41	17	3	15	40	52
		20%	19%	15%	19%	15%	22%	14%	10%	20%	25%	17%	19%	22%	9%	19%	22%	18%
Don't know		63	47	10	26	2	30	4	3	8	4	3	14	6	3	7	19	20
		9%	9%	14%	8%	4%	8%	14%	7%	7%	10%	6%	7%	8%	9%	9%	10%	7%
Not Stated		19	16	1	8	-	7	3	2	3	2	1	5	2	2	1	2	5
		3%	3%	1%	3%	-	2%	11%	5%	3%	5%	2%	2%	3%	6%	1%	1%	2%
Mean Score		.30	.36	.44	.41	.84	.32	.62	.89	.30	.38	.68	.33	.42	.70	.28	.40	.35
Std Deviation		1.62	1.63	1.62	1.65	1.46	1.68	1.66	1.54	1.66	1.78	1.62	1.62	1.69	1.46	1.64	1.66	1.62
Std Error		.067	.075	.207	.098	.218	.094	.362	.253	.161	.304	.229	.116	.200	.282	.195	.130	.099

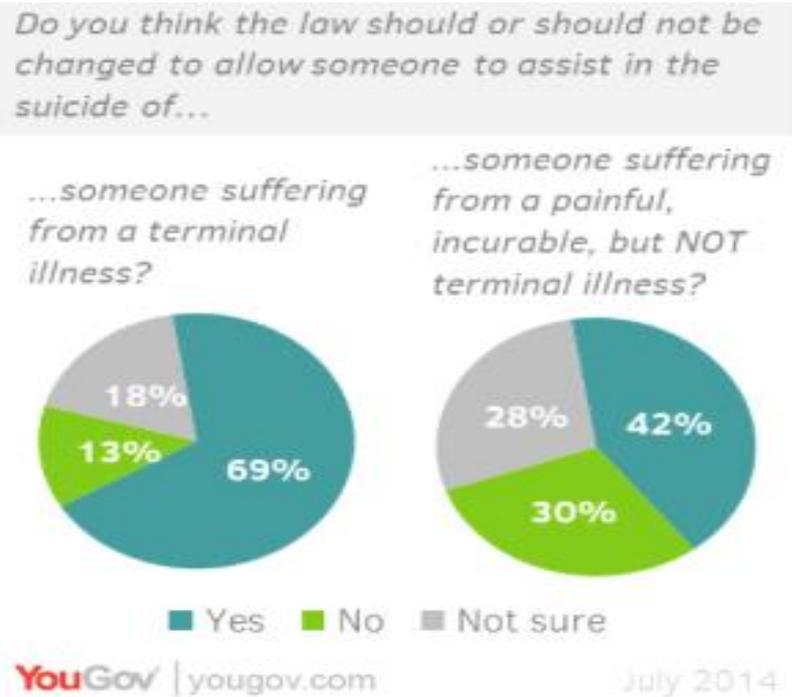
533 Disabled People. 21<sup>st</sup> Feb – 16<sup>th</sup> March 2011.

Source: Scope ([www.comresglobal.com](http://www.comresglobal.com))

### Appendix 3 –

YouGov Poll

Full Question – Do you think British law should be kept as it is, or should be changed so that people with incurable diseases have the right to ask close friends or relatives to help them commit suicide, without those friends or relatives risking prosecution?



2853 GB adults. 19-20 July 2011.

Source: Assisted Suicide Laws YouGov plc. ([www.yougov.com](http://www.yougov.com))

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## **Legislation**

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European Convention on Human Rights (1950)

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## **Dissertations**

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## **Surveys**

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