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## Assisted Dying for the Terminally Ill Bill (HL)

Second Reading, 10 March

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### Summary of BMA views

The Bill seeks to legalise assisted suicide and also purports to make provision for terminally ill individuals to receive pain relieving medication. In respect of the first part of that aim, the BMA has consistently opposed euthanasia and physician assisted suicide for the following reasons:

- Legalising physician assisted suicide would fundamentally alter the ethos of medicine;
- Arguments for such legislation are generally based on arguments about competent individuals' rights to choose the manner of their demise. Although the BMA respects the concept of individual autonomy, it argues that there are limits to what patients can choose when their choice will inevitably impact on other people and on society at large;
- Legalising assisted suicide would affect patients' ability to trust their doctors and to trust medical advice;
- In particular, it could undermine the trust that vulnerable, elderly, disabled or very ill patients have in the health care system;
- If assisted suicide were to be an available option, there would inevitably be pressure for all seriously ill people to consider it even if they would not otherwise entertain such an idea;
- Health professionals explaining all options for the management of terminal illness would have to include mention of assisted suicide. Patients might choose it for the wrong reasons. They might feel obliged to choose that option if they feel themselves to be burdensome to others or concerned, for example, about the financial implications for their families of a long terminal illness.
- It would also weaken society's prohibition on intentional killing and could weaken safeguards against non-voluntary euthanasia of people who are both seriously ill and mentally impaired.
- In 2000, the BMA held a two day conference to promote the development of consensus on physician assisted suicide. Overwhelmingly, BMA members from a wide range of moral viewpoints, agreed that they could not recommend a change in the law to allow voluntary euthanasia and physician assisted suicide. Part of the reason for this consensus concerned the high risks if assisted suicide came to be accepted as a viable option for the people not specifically mentioned in this Bill but who would inevitably be affected by it: vulnerable, dependent or very impressionable sick

people.

Although views in society differ about the legitimate or appropriate uses of medical skills, the primary goal of medicine is still seen as promoting welfare, protecting the vulnerable and giving all patients as good a quality of life as is possible. In the BMA's view, permitting euthanasia or physician assisted suicide would irrevocably undermine this primary goal of medicine, impacting on how doctors relate to their own role and to their patients. The BMA recognises that patients are not only benefited by physical and clinical improvements but are also benefited by having their own values respected and being enabled to achieve their personal goals. Nevertheless, we believe that in the case of euthanasia and assisted suicide, benefit for an individual in terms of having their wishes respected, is only achievable at too high a cost in terms of potential harm to society at large.

The Bill's second proposition is that there needs to be legal provision for pain relief. In the BMA's view, this plays on unjustified public fears about the possibility of intolerable or unrelieved pain at the end of life. In fact, the law and ethical position is already clear on the right of patients to receive the most effective pain relief available. This right – and doctors' ability to prescribe appropriately – is not compromised by the fact that effective medication might have the side effect of shortening some patients' lifespan. Control of pain, or other symptoms, and of psychological, social and spiritual problems, is paramount. The goal of care in terminal illness is achievement of the best quality of whatever life remains for patients and their families.

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# 11: Euthanasia and physician assisted suicide

The questions covered in this chapter include the following:

- What are the differences between withdrawing and withholding treatment, refusal of treatment, euthanasia, and physician assisted suicide (PAS)?
- Why does the BMA oppose euthanasia and PAS?
- May doctors tell patients about the quantity, or combination, of medication that would kill?
- How should doctors respond to patients who ask for advice about going abroad for euthanasia or assisted suicide?

## End of life: what are the issues?

The previous chapter focused on what most health professionals see as the important discussion about the end of life: the provision of a high standard of palliative care and support that aims to sustain and prepare patients and their families for the approach of inevitable death. Although palliative care and its values are central to health care, medical ethics debate has tended to focus more on areas of controversy. Euthanasia and PAS are illegal in the UK, but they continue to raise profound and fascinating social questions about personal and societal values, autonomy and its limits, the purpose of medicine, and the duties owed to patients who want to die. The way in which the health professions and society resolve the dilemmas posed by life or death cases reflect deeply held moral beliefs about the value of life and the qualities that make it valuable, the scope and limits of individual autonomy, and the balancing of benefit for one patient with the possibility of causing harm to others. Legal and practical considerations also apply. What, if any, would be the legal ramifications of weakening the ban on intentional killing? Would patients nearing the end of their lives view their doctor in a different light, knowing that they could ask the doctor to kill?

This book's main focus is on the types of questions people ask the BMA's ethics department. For euthanasia and PAS, the questions from doctors are relatively few because doctors know these acts are illegal, but it is not always clear where the boundaries lie and some practising doctors do find themselves in very difficult situations when they know that a seriously ill patient is accumulating medication with the intention of committing suicide. Other doctors are asked for assurances from patients that they will be "seen right" at the end of their lives. This chapter addresses these practical questions, and explains the scope and limits of legal and ethical practice.

The majority of questions sent to the BMA about euthanasia and PAS come from the media, academics, students, and others with an interest in the BMA's views. This chapter therefore sets out the BMA's policy opposing euthanasia and PAS, together

with the Association's reasoning. In doing so, the chapter touches on the experiences of jurisdictions that permit euthanasia or assisted suicide. It does not try to recreate all of the arguments that are relevant to these issues, but mentions the key points. There is a vast literature on euthanasia and PAS for those who are interested in the detailed philosophical debate.<sup>1</sup>

## General principles

The previous chapter identified the key principles that underpin the care of dying patients. Many overlap with those that also underpin the BMA's views on euthanasia and PAS.

- Doctors must listen to patients, try to understand their fears about dying and act within the law to help them to achieve a good death.
- A goal of medicine is to relieve suffering and a good death has an important place in medicine, but these should not be achieved by intentionally bringing about death.
- Autonomy has limits, and patients' choices are, rightly, curtailed where there is an unacceptable impact on others.
- Patients can refuse medical treatment that they do not want to receive.
- Withdrawing or withholding treatment differs fundamentally from intentionally ending life. Doctors must analyse their own actions and be certain of their motives when considering withdrawing or withholding treatment.
- The BMA is opposed to euthanasia and PAS, both of which are illegal in the UK.

## Definitions and distinctions

Definitions in this area are often imprecise. The purpose of this section is to explain how the BMA uses terms such as euthanasia and PAS, and to demonstrate where it believes the distinctions lie between these illegal acts and areas of legitimate medical practice, including decisions to withdraw life prolonging treatment and the doctrine of double effect.

### *Euthanasia*

By "euthanasia", we mean deliberate, active steps to end a patient's life. Although euthanasia literally means a gentle or easy death, it has come to signify a deliberate intervention with the intention to kill, often described as the "mercy killing" of people who are in pain or with terminal illness. In law, such deliberate taking of life is categorised as murder.

The term euthanasia is sometimes qualified by the terms "voluntary", "involuntary", and "non-voluntary", used to indicate the degree of patient

involvement. Many advocates of euthanasia limit their support to the “voluntary” category, where death is brought about at the patient’s request. “Non-voluntary euthanasia” is used to describe the mercy killing of a patient who does not have the capacity to request or consent to it, including, for example, severely disabled babies. “Involuntary euthanasia” describes the mercy killing of competent people against their will or without their consent. All categories are legally prohibited.

All of these categories, where there is a positive intervention such as lethal injection, are sometimes referred to as “active euthanasia”. This is contrasted with situations where death occurs as a result of an omission to provide treatment, for example when life prolonging treatment is withheld or withdrawn, which is sometimes termed “passive euthanasia”. The qualifiers aim to identify the nature of the doctor’s involvement and are often used by those who wish to equate non-treatment with active killing. As is discussed in Chapter 10 (pages 353–4) and also on pages 391–2, the BMA believes that there is a fundamental difference between avoiding treatment that cannot provide an overall benefit to the patient and deliberate killing. It shares the view of the House of Lords Select Committee on Medical Ethics that the qualifiers “active” and “passive” are unhelpful.<sup>2</sup>

### *Physician assisted suicide*

Physician assisted suicide differs from euthanasia in that the patient undertakes the final act. The doctor may not even be present, but might have provided equipment, advice, or a lethal substance. What constitutes the “final act” may not be clear cut, however, especially when patients are physically incapacitated and need considerable help in getting to the stage where the final step can be taken.

Euthanasia and PAS were legal in Australia’s Northern Territory for a brief period between July 1996 and March 1997.<sup>3</sup> During this time, a computerised machine was used that allowed patients to commit suicide by instructing it to deliver a lethal injection. A doctor attached the needle into the patient’s arm, and the lethal injection was delivered after the patient had responded to the computer’s three questions, confirming that death was his or her true wish. The final act that instructed the computer to deliver the lethal dose was taken by the patient, but such considerable assistance was needed to set up the machine and connect patients to it that, arguably, this activity fell more within the definition of euthanasia than PAS.

It is illegal for any person in the UK to assist suicide: “A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.”<sup>4</sup>

Assisting suicide is not an activity that is necessarily restricted to health professionals and could be done by anybody with the appropriate expertise and access to the means to kill. In practice, jurisdictions that permit assisted suicide almost invariably give doctors a clear role, for example in determining the patient’s condition and prognosis, and providing a prescription for lethal medication. This chapter is concerned primarily with the role of doctors, although some legal cases



are also mentioned where people have sought assistance from their loved ones because these raise important matters of principle.

## *Intention*

As shown in the detailed discussion of withholding and withdrawing life-prolonging treatment (see pages 352–64), it is not only the nature of an act but the intention, purpose, or objective behind it that is a key factor in end of life decisions. The health professional's intention in prescribing a medication or withdrawing treatment may be the least demonstrable facet of a case, but may ultimately be what tips the balance between an act being legally and morally permissible or unlawful and, in the BMA's view, unethical. To summarise the BMA's advice, a doctor may withhold or withdraw life-prolonging treatment if the purpose of doing so is to withdraw treatment that is not a benefit to the patient and is therefore not in the patient's best interests. The BMA thus supports the legal position that, although a doctor may foresee that a patient will die if treatment is not provided, he or she may withdraw or withhold treatment only if the overriding purpose or objective is to ensure that treatment that is not in the best interests of the patient is avoided.<sup>5</sup>

It has also been shown in the previous chapter (see pages 378–9) that the BMA and the law embrace the principle of "double effect", which provides the justification for the provision of medical treatment that has bad effects when the intention is to provide an overall good effect. An example is the use of pain-relieving drugs that risk shortening life.

## *Significant differences between withdrawing or withholding treatment, double effect, treatment refusal, euthanasia, and PAS*

Some argue that when withdrawing or withholding life-prolonging treatment is the morally right thing to do (because the treatment provides no benefit or its burdens outweigh the benefits), and death is the inevitable outcome, there are no morally relevant differences between not providing the treatment and taking active steps to end life.<sup>6</sup> The argument may be taken further to say that active steps to end a patient's life that are carried out in a way that is dignified, quick, and painless is the morally right thing to do because unnecessary suffering is avoided.

However, logically appealing this argument may appear, the BMA does not believe that it leads to the conclusion that, if one accepts the withdrawal of life-prolonging treatment, or the doctrine of double effect, one must also accept euthanasia and PAS. The BMA believes that it is unhelpful to look at these ethical arguments in isolation from the additional issues that society and the health professions must consider in relation to deliberate killing. These include the likely impact that allowing doctors to kill could have on the practice of medicine, as discussed below, and the

justification for allowing the withdrawal of life prolonging treatment in limited circumstances, as discussed in the previous chapter.

It was noted in Chapter 10 that some argue that a decision to withdraw life prolonging medical treatment necessarily involves a judgment that the patient's life is not worth living and that the withdrawal is, therefore, morally equivalent to euthanasia. It was also explained that the BMA does not believe that deciding to withdraw life prolonging treatment, or to provide treatment to relieve suffering in the knowledge that it may shorten life, means that death is necessarily "in the patient's best interests". The BMA believes that there is a fundamental distinction between decisions about the value or worth of the *patient*, and those about the value of the *treatment*. Although it is entirely appropriate to make decisions about the value of treatment in terms of its ability to benefit the patient (and this is an essential part of good medical practice), it is not acceptable to make decisions about the value of the patient. It is not for doctors to decide that certain patients are better off dead, but doctors, in consultation with patients and people close to them, are well placed to decide about whether a particular treatment can provide any benefit for a patient. Few believe that doctors must strive to prolong life at all costs, with no regard to the benefits or burdens to the patient. Balancing benefits with burdens in this way is the basis of most, if not all, decisions in medicine.

As well as there being, in the BMA's view, ethical distinctions between the types of legitimate medical decisions discussed above, and euthanasia and PAS, there are also legal distinctions. The former, provided that there is no suggestion of negligence, are lawful. Euthanasia and PAS are not. In the former it is not the doctor who causes death but the patient's illness or injury. Such acts or omissions by a doctor have "an incidental effect on determining the exact moment of death" but the law does not consider them to be "the cause of death in any sensible use of the term".<sup>7</sup> In contrast, the law makes clear that "no doctor, nor any man, no more in the case of the dying than the healthy, has the right deliberately to cut the thread of life".<sup>8</sup>

Euthanasia and PAS have been defined separately above, and there is some evidence that health professionals perceive a moral difference between the two. A detailed survey of health professionals' attitudes to PAS in 1996 found that, among those who supported the option of intentional killing, there was a preference for PAS over euthanasia, by a margin of around 2:1.<sup>9</sup> Doctors may consider that less responsibility or culpability attaches to the act of participating in another's suicide where that seems to be the individual's sustained and reasoned wish.

Philosophers, on the other hand, may argue that there is no moral difference between injecting a patient, at his or her request, with lethal medication, and watching a patient drink a lethal cocktail having provided the drugs. Additionally, they may cite the argument that, if able bodied citizens can legally commit suicide, it is discriminatory not to offer severely disabled people a means to end their lives. (A legal challenge to the UK's prohibition of assisted suicide that argued in part on the basis of this right was lost in 2002; see pages 399–400.) The BMA's approach is that, although there may be some distinctions, euthanasia and PAS are inextricably linked and the moral arguments for and against each are similar. To avoid repetition, wherever possible this chapter addresses the two together.

## BMA policy and the views of UK doctors

The previous chapter identified the factors that contribute to a good death. Although a "good death" has an important place in health care, the BMA does not consider that this should ever be achieved by deliberately bringing about death. Such end of life issues have been firmly on the BMA's agenda since the Association's first rejection of the concept of euthanasia in 1950. BMA policy opposing euthanasia was established in 1969, when the Association's annual meeting affirmed the fundamental objective of the medical profession as the relief of suffering and the preservation of life. By 1997, PAS was also the subject of policy. The early policy statements categorically rejected the notion of euthanasia. Later statements have acknowledged the existence of a wide spectrum of views within the membership, but also the consensus that the law should not be changed to permit euthanasia or PAS for the time being.

The General Medical Council (GMC) too reminds doctors that they must act within the law.<sup>10</sup> In 1992 the Council stated that treatment whose only purpose was to shorten the patient's life was wholly outside the doctor's professional duty and fell short of the high standards that the medical profession must uphold.<sup>11</sup>

Individually, some doctors believe that euthanasia and PAS acts are morally justified in some exceptional circumstances. In the largest survey of the views of health professionals in the UK, just under 50% of the 804 doctors surveyed were in favour of a change in the law to allow PAS in specified circumstances.<sup>12</sup> Despite this, however, BMA policy and the outcome of a consensus conference on PAS held in 2000 reflect considerable agreement among BMA members that the Association should not press for legal change.<sup>13</sup> Like any profound shift in public policy there would first need to be very significant public pressure for such change.

The debate within the BMA about euthanasia and PAS has also encompassed discussion of whether the Suicide Act 1961 should be amended to reduce the maximum penalty for assisting suicide. Those in favour of reducing the penalty draw attention to the gap between the penalties available to the courts and those they actually impose. The courts are entitled to pass sentence of up to 14 years' imprisonment for assisting suicide, but use discretion and often give much lower sentences.

### Sentencing

Charlotte Hough had been a regular visitor of an 84-year-old woman who was partially blind, partially deaf, and suffered from arthritis.<sup>14</sup> Ms Hough was described by the court as being a woman "of unblemished character, who was opposed to the taking of life and euthanasia" who had tried to dissuade the elderly woman from taking her life. Nevertheless, when the elderly woman was found dead with a suicide note pinned to her clothing, Ms Hough pleaded guilty to attempted murder. She had provided the woman with sodium amytal.

(Continued)



tablets and placed a plastic bag over her head once she became unconscious after taking the tablets. It was not clear whether the elderly woman was already dead when the bag was placed over her head, and therefore whether Ms Hough had actually caused her death. The charge, to which Ms Hough pleaded guilty, was therefore "attempted murder".

Although Ms Hough's conviction was of attempted murder, the Court of Appeal noted that her actions fell to a great extent within the scope of the Suicide Act. She was sentenced to nine months' imprisonment, which the Court felt was appropriate in relation to a charge of attempted murder or assisted suicide.

*R v Charlotte Helen Hough*<sup>14</sup>

In 2002, although rejected as BMA policy, 44% of the BMA's Representative Body believed that, in the light of high profile media cases where people had wanted assistance to commit suicide, the Suicide Act should be changed "to take account of mentally competent individuals who wish to take their own lives but are physically incapable of so doing".<sup>15</sup> Again, however, this is an area where public policies need wide societal debate before change is envisaged.

## Moral, legal, and pragmatic arguments

The key principle underpinning the BMA's views on euthanasia and PAS is that this is an area where it is unacceptable for individuals' choices to impinge pejoratively on others. Although there may be, and many believe that there are, cases in which euthanasia or PAS is the morally best option for the individual concerned, the BMA currently holds that the impact of a general lifting of the ban on intentional killing by doctors would have detrimental effects on society and medical practice that outweigh the benefits for the small number of people who would use these types of legal provisions. Although there is consensus within the BMA that the balance is currently in favour of not changing the law, members hold a wide spectrum of opinions and it is important that the Association's views are analysed carefully and open for public debate.

This section takes the ethical and practical issues, where there is often overlap with the law, to discuss the arguments supporting the BMA's position. It begins with a summary of some of the arguments for and against euthanasia and PAS.

## Summary of arguments

The notion of ending a human life deliberately is obviously a profound and disturbing concept. The large and scholarly literature on the subject of euthanasia and PAS reflects continuing attempts by philosophers, judges, lawyers, and others to marshal the arguments on either side of the debate and draw firm boundaries. This

is an area in which establishing coherent limits is complicated. It may, therefore, appear simplistic to attempt to summarise briefly the bare bones of such arguments here. Nevertheless, medical students in particular often ask for a quick overview of the key issues that the BMA has debated and this is what the following section provides. A fuller explanation of the points is given in the sections that follow.

- In support of euthanasia and PAS
  - Autonomy and human rights mean that patients are entitled to exercise control over aspects of their death, and that those who need assistance to do so must be provided with it (pages 395–7 and 399–401).
  - Doctors have a duty to benefit patients by relieving pain and suffering; for some patients euthanasia or PAS is the only way to achieve this (page 397).
  - Empirical evidence from jurisdictions that permit euthanasia or PAS do not provide convincing evidence that their acceptance begins a slide down a “slippery slope” (pages 397–9).
  - Society should not fail to pursue options that would be beneficial for fear of being inadequately equipped to resist the dangers (pages 397–9).
  - Permitting euthanasia or PAS would show sympathy for patients who find living intolerable for various reasons (pages 401–3).
- Opposed to euthanasia and PAS:
  - Autonomy should be limited when its exercise would have an unacceptable impact on others (pages 395–7 and 399–401).
  - Permitting euthanasia and PAS would undermine patients’ ability to trust their doctor’s role as healer (page 397).
  - The “slippery slope” argument suggests that euthanasia and PAS could come to be seen as desirable not only for people able to choose for themselves but for others who cannot (pages 397–9).
  - Permitting euthanasia and PAS would weaken society’s prohibition of intentional killing, and thus weaken the safeguards against non-voluntary euthanasia (pages 397–9).
  - A convincing justification for euthanasia or PAS in an individual case is distinct from justifying their availability (pages 401–3).

### *Autonomy and the impact on others*

Supporters of PAS and euthanasia usually argue on grounds of autonomy, empowerment, self determination, and the right to choose. Throughout this book, however, ethical dilemmas are often found where autonomy ceases to be the trump card because of the impact of an individual’s choices on others. Confidentiality, which is discussed in Chapter 5, is a good example: information about an individual may be disclosed without consent in order to prevent serious harm to somebody else. The rights of one person cannot be permitted to undermine disproportionately

the rights of others. The case of Dianne Pretty (see pages 399–400) showed that the law is clear that autonomy has its limits, and that the rights of one group cannot be permitted disproportionately to undermine the rights of others. This was also a key argument of the House of Lords Select Committee.<sup>16</sup>

As well as the potential impact on the doctor–patient relationship, the BMA believes that there is a danger that even a limited change in the legislation would bring about a profound change in society's attitudes. By removing legal barriers to the previously "unthinkable" and permitting people to be killed, society would open up new possibilities of action and thus engender a frame of mind whereby some individuals may well be pressured to explore fully the extent of those new options. The choice of exercising a right to die at a chosen and convenient time could become an issue all individuals would have to take into account, even though they might otherwise not have entertained the notion.

It is frequently argued that if a patient's desire to be killed by a doctor was recognised as a legitimate right, some elderly or disabled people could see their lives as burdensome to others and feel pressured to choose to end them. The UN Human Rights Committee,<sup>17</sup> when it considered the Dutch criteria for euthanasia and PAS in detail, reported that the Dutch system "may fail to detect and prevent situations where undue pressure could lead to these criteria being circumvented". Willingness by society to supply or condone euthanasia could confirm patients' sense of worthlessness, resulting in a society in which individuals are not deemed valuable unless they are demonstrably useful.

There are, of course, inevitable pressures that influence people's choices. Some, however, society decides are too great to permit. If euthanasia or PAS were permitted, some people may well voluntarily choose to take account, for example, of being a burden on their families. The BMA believes, however, that it would be unacceptable if patients felt pressured to consider precipitating the end of their lives. People should be assured of their worth and efforts made to avoid the impression that their lives lack value. Of patients who made use of Oregon's Death with Dignity Act during its first five years, 44% cited their fear of being a burden to their family, friends, and carers as part of their reasoning for wanting to end their life.<sup>18</sup>

The BMA fears that, if the law in the UK were relaxed, euthanasia and PAS would become an option for anybody facing death. Not only might that put pressure on people to consider a premature death, but some could realistically fear that others would choose it for them. In the debates before the brief legalisation of euthanasia and PAS in Australia's Northern Territory, there was evidence of considerable disquiet from the indigenous Aboriginal population. The Australian Select Committee on Euthanasia reported that some Aborigines were afraid to attend health clinics and hospitals for fear of doctors having "the power to kill".<sup>19</sup> In the Netherlands, families request euthanasia more often than patients<sup>20</sup> and studies there too show that some elderly people fear their lives will be ended without their consent.<sup>21</sup> This is likely to be a continuing suspicion among patient groups who feel particularly marginalised within the system of health care provision.

The BMA believes that there is also a danger that people close to patients who choose suicide will be harmed. At a consensus conference on PAS in March 2000,

BMA members agreed that an important factor was the impact on doctors' relationships with people who are close to their patients, and the potential for distress among those relatives, friends, and carers.<sup>22</sup>

### *The doctor–patient relationship*

Some believe that providing euthanasia or PAS would be a natural extension of the medical profession's role as relievers of suffering. Since doctors may cease to strive to prolong life in certain limited circumstances (see pages 352–64), knowing that the patient will inevitably die as a result, why not achieve that result by active steps to kill? The BMA's views on this are discussed in detail on pages 353–4 and 391–2. The BMA believes that the debate is not about whether there is a difference of omission or commission – killing and letting die – but it is rather about the intention behind the doctor's actions. When treatment is withheld or withdrawn, the intention is not to kill but to avoid providing a treatment that cannot benefit the patient.

If doctors are authorised to kill or to help to kill, however carefully circumscribed the situation, they acquire an additional role that the BMA believes is alien to the one of caregiver and healer. The traditional doctor–patient relationship is founded on trust, which risks being lost if the doctor's role also encompasses intentional killing. In a famous quote, Capron summed this up:

I never want to have to wonder whether the physician coming into my hospital room is wearing the white coat ... of a healer – concerned only to relieve my pain and to restore me to health – or the black hood of the executioner. Trust between patient and physician is simply too important and too fragile to be subjected to this unnecessary strain.<sup>23</sup>

In some circumstances it may be that neither patient nor carers, and perhaps not even the doctors themselves, can be quite certain which role has been adopted.

### *“Slippery slope” arguments*

In this area, “slippery slope” arguments are commonly invoked. Once a previously prohibited action becomes allowed, according to the “slippery slope” argument, it may come to be seen as desirable not only for people able to choose for themselves, but also for others who cannot. In other words, the reasoning underpinning claims for a right to voluntary euthanasia could easily be extended to those who are incapable of making any claim for themselves. The fear is that those “others” will typically be elderly people, which is a particular worry at a time when an ageing population is raising the question of imbalance between financial providers and financial dependants in many developed countries.

In 2001 the UN Human Rights Committee considered the Dutch criteria for euthanasia and PAS in detail, and reported its concern “that, with the passage of time, such a practice may lead to routinization and insensitivity to the strict



application of the requirements in a way not anticipated".<sup>24</sup> This is another of the concerns about "slippery slopes", that permitting voluntary euthanasia may result in non-voluntary euthanasia because the safeguards against the latter would have been weakened.

In contrast, some philosophers argue that not all slopes are necessarily slippery but may reflect reasoned choices about changing moral boundaries. It could be considered irrational or immoral to decide not to pursue options that would be beneficial for fear of being inadequately equipped to resist the dangers outlined throughout this chapter.<sup>25</sup>

It is worth looking to the Netherlands, whose 30 years' experience with euthanasia and PAS has been subjected to continuous scrutiny, for evidence of slippery slopes. Guidelines, which were later to be given statutory force by the Termination of Life on Request and Assisted Suicide Act 2001, were published by the Royal Dutch Medical Association in 1984, when the Dutch Supreme Court ruled that euthanasia and PAS were lawful in certain circumstances. It is clear that over the years, the rules were sometimes neglected.

#### **Due care criteria for euthanasia and assisted suicide in the Netherlands**

Doctors must:

- (a) be satisfied that the patient has made a voluntary and carefully considered request
- (b) be satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement
- (c) have informed the patient about his or her situation and his or her prospects
- (d) have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation
- (e) have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in points a–d above
- (f) have terminated the patient's life or provided assistance with suicide with due medical care and attention.<sup>26</sup>

Breaches of the rules included involuntary euthanasia, failure to consult another practitioner before carrying out euthanasia, and certifying the cause of death as natural.<sup>27</sup> Some may see this as lending credence to the view that even careful circumscription of the practice cannot guarantee observance of the rules. The existence of rules permitting euthanasia in some circumstances may well have the effect of making instances of non-voluntary euthanasia, or even medical error, harder to detect.

Similarly, of course, rules prohibiting euthanasia and PAS may be ignored in countries that ban these activities completely. Evidence supports the claim that these acts undoubtedly occur clandestinely everywhere. In a survey of UK doctors in

1996, 4% reported providing a patient with the means to kill himself or herself and 12% reported personally knowing another health professional who had assisted a patient to kill himself or herself.<sup>28</sup>

Keown claims that the lack of adherence to the rules in the Netherlands "lends weighty support" to the slippery slope argument.<sup>29</sup> Griffiths and colleagues, on the other hand, claim that Keown's work does not show evidence of a slope at all, much less one that is slippery.<sup>30</sup> Looking specifically at non-voluntary euthanasia, they claim that there is no evidence that its incidence increased in the 30 years during which euthanasia was practised openly, nor that the rates are higher in the Netherlands than elsewhere, although data can be hard to compare, especially where the practice is clandestine and definitions unclear.

The empirical evidence about other jurisdictions' experiences cannot tell us whether permitting euthanasia or PAS in the UK would begin a slide down a slippery slope towards deliberately ending the lives of patients who have not chosen this for themselves. The BMA believes, however, that this risk cannot be ruled out.

### *Human rights and assistance in dying*

Supporters of a right to die often present this issue as one of personal liberty, maintaining that individuals should be entitled to end their lives at the time and in the manner they choose, and to be given the assistance they need. During 2001 and 2002, Dianne Pretty sought to persuade the domestic<sup>31</sup> and European<sup>32</sup> courts of her entitlement to these things by reference to the Human Rights Act 1998. She claimed that the UK's prohibition on assisted suicide infringed her rights.

#### **Assisted suicide – a human right?**

Dianne Pretty suffered from motor neurone disease. No treatment can prevent the progression of the disease, and respiratory failure and pneumonia are the usual causes of death. Mrs Pretty told the courts that she was frightened and distressed at the suffering and indignity that she would endure if the disease ran its course, and that she very strongly wanted to be able to control how and when she died. The nature of the disease prevented her from taking her own life. Although she wanted assistance primarily from her husband, he made it clear that he wanted medical advice in order to be able to do so. Mrs Pretty sought an undertaking from the Director of Public Prosecutions that her husband would not be prosecuted under the Suicide Act 1961 if he assisted her suicide.

Losing her case in the domestic courts, Mrs Pretty took her human rights arguments to the European Court of Human Rights. Her case rested on a number of Human Rights Act points. She claimed that the right to life in Article 2 of the European Convention on Human Rights<sup>33</sup> guaranteed her the right to choose whether or not to live, and that failure to guarantee this right breached

*(Continued)*



her Article 3 right to be free from inhuman or degrading treatment. Throughout her legal battle, the individual judges were sympathetic to her position, but they dismissed claims that Article 2 protected not only the right to life but also the right to choose whether or not to go on living. Mrs Pretty argued that allowing her assistance to commit suicide could not conflict with Article 2 because, otherwise, those countries in which assisted suicide was lawful would breach this provision. The European Court of Human Rights acknowledged that the extent to which a state permits, or regulates, the possibility for the infliction of harm on individuals raised conflicting considerations of personal freedom and public interest that could be resolved only on examination of the concrete circumstances of the case. It concluded, however, that, even if the circumstances prevailing in a particular country did not infringe Article 2, the proposition that the UK breached its obligations by not permitting assisted suicide was a different issue.

Article 8 of the Convention protects people's private lives. Mrs Pretty argued that the state was unduly interfering with her right to choose to die. Interference with a person's Article 8 right is acceptable in some circumstances, where it is in accordance with the law, has a legitimate aim, and is necessary in a democratic society. Although the European Court found that Mrs Pretty's Article 8 right had been engaged, it did not consider the UK's blanket ban on assisted suicide in order to protect the vulnerable was a disproportionate interference with this right.

The European Court also considered whether Mrs Pretty's Article 14 right to be free from discrimination in her enjoyment of other Convention rights had been breached. She argued that she was prevented from exercising a right enjoyed by others who could end their lives without assistance and were not legally prevented from doing so. The relevant provisions of the 1961 Act existed to protect the weak and vulnerable, but Mrs Pretty argued that she was not in that category. The court noted that there are clear risks of abuse if assisted suicide is permitted, and that it is for states to assess these risks. The risk of abuse of those who are vulnerable was a reasonable justification for treating people in analogous situations differently (or treating people in different situations the same way) so there was no breach of Article 14.

*Pretty v United Kingdom*<sup>34</sup>

In all, 15 judges in the domestic and European courts found that the UK's prohibition on assisting suicide was not incompatible with the European Convention on Human Rights. Dianne Pretty's initial approach to the courts was to ask for a declaration that the Director of Public Prosecutions (DPP) would not take action against her husband if he assisted her suicide. The European Court's judgment focused on whether the Convention required the UK to permit Mrs Pretty's request, rather than whether it would have been within the remit of the DPP to grant immunity. It has been suggested that this is unfortunate because this is an area in which states take different approaches, all of which may well be compatible with the Convention.<sup>35</sup> That the courts often give relatively minor, even non-custodial, sentences to people involved in mercy killings could suggest that a

declaration from the DPP would not have been incompatible with the law's approach.

Dianne Pretty's case also highlights the definitional problems in this area. Although her challenge was to the prohibition of assisted suicide, circumstances forced her to need euthanasia, not just assistance.

### *Compromising principles to suit the circumstances?*

Doctors have a duty to try to provide patients with a peaceful and dignified death with minimal suffering but, as is indicated throughout this chapter, the BMA considers it contrary to the doctor's role to kill patients, even at their request. Requests may come from patients with terminal illness, people with severe and intractable physical and emotional suffering, or those with progressive neurological disease. Despite the patients' condition, assisting their suicide remains deeply controversial, particularly when a psychological rather than a physical problem is concerned.

#### **Assisted suicide in a case of psychological suffering**

In the mid-1990s, the Dutch courts found that psychological suffering, even in the absence of terminal illness, was legitimate grounds for a doctor to assist suicide. Dr Chabot had helped a 50-year-old woman to commit suicide. The woman's two sons had died: one from cancer, and the other had committed suicide. She had been abused by her alcohol dependent husband. Dr Chabot, a psychiatrist, came to know his patient well over several months and concluded that she was not suffering from any diagnosable psychiatric disorder. Notwithstanding this, he recommended antidepressants and psychotherapy, but her wish was to commit suicide in a foolproof and painless way. Dr Chabot thought that her condition fell within the Royal Dutch Medical Association's rules of due care, and provided her with a lethal drink, which she took in her own home. He reported the death to the coroner, and was subsequently charged under article 294 of the Dutch Penal Code. His case went to the Supreme Court in 1994.

The court ruled that psychological suffering could fulfil the necessary criteria to make assisted suicide lawful, since what mattered was the amount of suffering, not its origin. Dr Chabot, however, had failed to obtain the opinion of an independent medical expert, as required in the rules of due care, and accordingly was found guilty of an offence. The Supreme Court declined to impose a penalty, although in February 1995 Dr Chabot received a reprimand from a Medical Disciplinary Tribunal.

Although the Dutch accept that psychological suffering may be grounds for euthanasia and PAS, in almost all its cases the patients are terminally ill; in 58% the shortening of life was estimated to be one week at most and in 83% less than one month.<sup>36</sup>

*Supreme Court of the Netherlands. Arrest-Chabot*<sup>37</sup>



Clearly, doctors have a very profound sympathy for patients who find living intolerable for various reasons, and arguments in favour of legalisation often use moving examples of patients in this situation. Timothy Quill describes in detail the response of one of his patients to the offer of treatment for acute myelomonocytic leukaemia that offered her a 25% chance of long term survival: "it became clear that she was convinced she would die during the period of treatment and would suffer unspeakably in the process (from hospitalisation, from lack of control over her body, from the side-effects of chemotherapy, and from pain and anguish)".<sup>38</sup> His patient, Diane, chose to end her life with barbiturates, which he provided to her together with information about the amount needed to commit suicide. His account is profoundly moving. Many people believe that euthanasia or PAS would be morally justifiable in cases such as this. As Beauchamp and Childress put it, however, "to justify an act is distinct from justifying a practice or a policy that permits or even legitimises the act's performance".<sup>39</sup> The BMA strongly supports this view, and believes it is right that this issue is fought not only on ethical grounds but also on grounds of public policy.

It is obvious that the profession must hope soon to arrive at the situation where skilled management of pain and distress is available and effective for everyone. The BMA and others<sup>40</sup> believe that this will minimise the number of requests for euthanasia and PAS from people near the end of their lives, although it will not eliminate them altogether. Many requests for euthanasia are not based on the presence of pain, but on patients' increasing sense of worthlessness and distress about their dependence on others.

#### **Reasons for requests for physician assisted suicide – experience from Oregon**

Oregon's Death with Dignity Act came into force at the end of 1997. It permitted doctors to prescribe lethal medication for competent patients over the age of 18. The action to end life, if it is taken, is carried out by the patient.

Of the patients who sought a lethal prescription in the first five years of Oregon's Death with Dignity Act, fear of inadequate pain control was a factor for only 22%.<sup>41</sup> Only the financial implication of treatment was reported less frequently as being a factor. Aspects that patients reported as more relevant included being a burden on their family, friends, or carers, losing their autonomy, a decreasing ability to participate in activities that make life enjoyable, and losing control of bodily functions.

Skilled and compassionate palliative care, with good communication and patient involvement, can help with these issues. There will always be people, however, for whom palliative care does not meet their needs and wishes, for example those who believe that they have a civil right to choose when and how to die. Requests for euthanasia and PAS are therefore unlikely to be eliminated entirely.

Evidence suggests that the current numbers who actually want assistance in dying are very small. Between 1998 and 2002, 38 Oregonians died after ingesting legally prescribed lethal medication, an average of less than 9/10 000 deaths per year. During this period, 198 lethal prescriptions were written.<sup>42</sup> Although the cases of the individuals who did choose to die in this way may, to many, justify euthanasia or PAS, the BMA remains swayed by the public policy argument that the risks of harm to the vast majority are too great.

The House of Lords Select Committee on Medical Ethics concluded similarly. Although it had been profoundly moved by the people and arguments in favour of euthanasia, ultimately it did not believe the arguments to be sufficient reason to weaken society's prohibition of intentional killing. The Committee acknowledged that "there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions".<sup>43</sup>

### Summary – moral, legal, and pragmatic issues

- A line is drawn between an active decision not to continue with futile treatment and so allow a patient to die as "nature takes its course", on the one hand, and any affirmative action undertaken with the intent of ending life, on the other. The former, unless an omission resulting from negligence, is both ethical and legal, whereas the latter is both illegal and ethically unacceptable.
- In the BMA's view, legalising euthanasia and PAS would have a profound and detrimental effect on the doctor–patient relationship.
- Although people's right to choose is important, it must be limited where offering choice would cause harm to others.
- Not all slopes are slippery, but there is little evidence on which to base an assessment of whether permitting euthanasia and PAS would lead to non-voluntary acts. We do know, however, that where it is allowed and regulated, the rules are sometime disregarded. This danger should not be dismissed.
- It would be unacceptable to put vulnerable people in the position of feeling they had to consider precipitating the end of their lives.
- Widespread and equitable availability of palliative care services will minimise the number of requests for euthanasia and PAS.
- The BMA acknowledges that there are some patients for whom palliative care will not meet their needs and wishes, but considers that the risks of significant harm to a large number of people are too great to accommodate the needs of very few.
- Despite the wide range of views among its membership, there is consensus within the BMA that the law should not be changed to permit euthanasia or PAS in the UK.
- Because these issues are complex and fascinating, the BMA welcomes open and transparent discussion.

## Practical issues for doctors in the UK

This section covers the kinds of questions with which practising UK doctors approach the BMA. As has already been noted, doctors know that euthanasia and PAS are illegal. With euthanasia, the boundary of the law is fairly clear. With PAS, however, it may be less so. Handing somebody a cup containing a lethal cocktail of drugs knowing he or she was going to drink it would clearly be assisting suicide, but what about writing a prescription for a quantity of medication that could be fatal or advising about how much medication, and in what combination, would kill?

### Identifying legal boundaries

In the early 1980s, the Voluntary Euthanasia Society (or Exit as it had formerly been known) produced and distributed a booklet entitled *A guide to self-deliverance*. Its preface said:

When people talk of "the fear of death", they often fail to distinguish between two types of fear which may be combined in experience but are separate in origin. One is the fear of the state of death (or non-existence); the other the fear of the process of dying, the agony of the transition to that state. The aim of this booklet – and of the society which, after much soul-searching, decided to publish it – is to overcome the second of these fears.

The booklet claimed not to encourage suicide, and indeed to discourage it for frivolous or ill thought out reasons. It advised that a decision to commit suicide should be taken over a substantial period – months rather than weeks – and that alternative solutions should be considered. It claimed to aim to reduce the number of unsuccessful suicides, described "how not to do it" and set out five separate methods of "self deliverance".

Whether it was lawful to publish and distribute the book was considered in 1983 in the High Court.<sup>44</sup> The case centred around the Suicide Act 1961, which made aiding, abetting, counselling, or procuring the suicide of another unlawful.<sup>45</sup> The court considered all four parts of the offence together, and drew on academic writings<sup>46</sup> to identify the following criteria for an offence:

- that the accused knew that suicide was contemplated
- that he or she approved or assented to it and
- that he or she encouraged the suicide attempt.

The court found that there was nothing objectionable about the booklet's content, and that it could deter many a would-be suicide, but in some cases it would assist people to commit suicide when they may not otherwise do so. The Society was therefore found to have the intent necessary for an offence. It intended the booklet to be used by somebody who was contemplating suicide and to help that person to do so. It knowingly distributed the booklet to people in this position. Finally, an offence would be committed when the booklet assisted or encouraged people to take their own lives. It was subsequently withdrawn.

*Attorney General v Able and others*<sup>44</sup>



Many patients are articulate and vocal about their wishes for the end of their life. Against this background, doctors can feel more insecure and morally uncertain. Not least among these dilemmas is the degree to which a doctor can be frank and open with a patient about the effects of medication while not endorsing or facilitating a patient's implied or explicit intention to commit suicide. By attempting to do what they perceive to be the best for patients and to comply with their wishes, doctors can very easily fall foul of the law. It is essential to remember that assisting suicide carries a legal penalty of up to 14 years' imprisonment. Clearly, if a patient is depressed or suffering from a mental disturbance, therapy and counselling should be recommended. In any case, when the patient could enjoy more years of life, all reasonable efforts should be made to achieve that. Patients who are terminally ill or feel that their quality of life is irretrievably low present a dilemma. Doctors should listen to patients who ask for assistance to commit suicide, and give them control of their decision making as far as possible, in the hope that they will not resort to an extreme act. Doctors must not, however, advise patients about the quantity or combination of medication that would kill. Prescribing or supplying drugs with the intention of enabling patients to shorten their lives could lead to prosecution for assisting suicide. As the case above shows, so could the provision of advice or literature on the subject. For example, a doctor who makes drugs available knowing that the patient is likely to take a fatal overdose could be committing a crime.<sup>47</sup> The courts have also held that putting people in touch with someone who will help them to end their life is an offence.<sup>48</sup> Doctors have to be honest with patients and explain that they will not act illegally but will do all they can to provide the care and support they need at the end of their lives.

## Medical tourism

Oregon chose to prohibit non-residents from using the provisions of its PAS legislation. Other jurisdictions do not have equivalent conditions, but arguably some do prevent people travelling to the country specifically for the purpose of having their life ended, by including a requirement that there is a close relationship between the doctor and the patient. In the Netherlands, for example, the legal procedure for the notification and assessment of each case of euthanasia requires the patient to have made a voluntary, well considered request, and to be suffering unbearably without any prospect of improvement. The Dutch Government claims that, in order to be able to assess whether this is indeed the case, the doctor must know the patient well.<sup>49</sup> This implies that the doctor has treated the patient for some time. The Government also notes that granting a request for euthanasia places a considerable emotional burden on the doctor. Doctors do not approach the matter lightly. From this point of view too, longstanding personal contact between the doctor and the patient plays an important role.

In Switzerland, euthanasia is illegal, but the penalty may be mitigated if the actor's motives are honourable, for example, in a case of mercy killing at a person's request. Assisted suicide is unlawful too, but only where the assistance involves a selfish motive.



Swiss right to die organisations provide assistance with dying in accordance with these aspects of Swiss law. There is nothing to require a longstanding doctor–patient relationship, nor for the person seeking assistance to be resident in the country.

### **Suicide tourism**

In 2002 a 74-year-old man from Liverpool died after travelling to Switzerland for assisted suicide using barbiturates supplied by the right to die organisation Dignitas. Mr Reginald Crew, who had motor neurone disease, was accompanied to Switzerland by his wife and a television crew.<sup>50</sup>

Merseyside police investigated the circumstances of Mr Crew's death and concluded that there was insufficient evidence of an offence to seek the consent to pursue a prosecution under section 2(1) of the Suicide Act 1961.<sup>51</sup>

This high profile case reportedly caused alarm within the Swiss authorities because of Switzerland being seen as a centre for "suicide tourism".<sup>52</sup>

Travelling abroad for procedures that are prohibited in the UK is an issue in several areas of medical practice (see Chapter 8, pages 302–3). As the case of Mr Crew shows, however, travelling abroad for assisted suicide may have implications for the people involved. In the BMA's view it would be unethical, as well as unlawful, for UK doctors to provide information about the availability of euthanasia or assisted suicide in other jurisdictions. If patients ask, doctors should explain that they cannot advise about such matters.

### **Views of the public**

Opinion polls provide some indication of the views of the public, and how these change over time. Polls tend to show considerable public support for euthanasia. In 1996 the British Social Attitudes Report noted that 82% of the British population said that individuals should have the right to ask a doctor to end their life if they are suffering from an incurable and painful disease.<sup>53</sup> Opinion polls in other countries where euthanasia and PAS are illegal appear to show similar levels of support: 70–85% in Germany, the USA, Spain, and France.<sup>54</sup> Where voters are given the opportunity to register their views about proposed legal change, there is also considerable support. In 2002, 72% of Belgians were in favour of changing the law to permit euthanasia.<sup>55</sup> In 1994, 51% of Oregon's voters were in favour of changing the law to permit assisted suicide. A move to repeal Oregon's legislation in November 1997 was defeated by a margin of 60% to 40%.<sup>56</sup> These figures give some indication of society's views, although it is notoriously difficult to gain a clear picture of support for euthanasia and PAS because much depends on the way in which the questions are put, definitional overlap, and confusion with other end of life issues such as withdrawing and withholding treatment.

This substantial public support does not translate into large numbers of people who actually seek these forms of assistance in dying. In Oregon, for example, less than 1 in 1000 deaths involve a lethal prescription.<sup>57</sup> Some patients who obtain a prescription for lethal medication do not use it. Again, in Oregon, of the 58 people who received prescriptions in 2002, 16 had died from their underlying disease by the end of the year (six were still alive).<sup>58</sup> The fact that not all people who receive a prescription go on to use it could show that even those who are apparently determined to end their lives may change their minds or never reach the stage when they feel the need. Alternatively, it may reinforce the view that personal control is what is really at stake.

## The future?

Despite significant public<sup>59</sup> and professional<sup>60</sup> interest in the possibility of doctors intervening to end life, there is little indication that lawmakers would welcome change. Bills brought before the UK Parliament have failed to progress,<sup>61</sup> the legal problems associated with undermining the law of homicide being as likely a cause for this as ethical reasoning. The House of Lords Select Committee on Medical Ethics, appointed to consider the likely effects of a change in the law on euthanasia, also rejected law reform.<sup>62</sup>

In its concluding remarks the Committee said that, despite the very moving cases of deaths that were far from peaceful or uplifting, and the moral arguments in favour of euthanasia, ultimately it did

not believe that these arguments are sufficient to weaken society's prohibition of intentional killing. The prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia.<sup>63</sup>

In the months preceding the implementation of the Human Rights Act there was considerable speculation about its likely impact on medical practice. Even after the courts ruled in Dianne Pretty's case (see pages 399–400) that the UK was not required to permit assisted suicide, legal commentators challenged the courts' findings and argued that the prohibition is incompatible with the Convention.<sup>64</sup> Others remarked that the courts' conclusions were inevitable.<sup>65</sup>

Debate within the healthcare professions and society about legalising euthanasia and PAS will continue. It is essential that society's decisions are made on the basis of a thorough examination of the values it wants to uphold. In relation to euthanasia and PAS, this involves looking at notions of harm and benefit, autonomy and its limits, how to benefit patients while at the same time avoid harming others, whether stepping beyond one legal boundary would lead inevitably to further steps, whether permitting an action trivialises it and makes it easier to undertake, and how important that ultimately is. Although the medical profession has an important voice in the debate, ultimately these decisions are for society as a whole, not just doctors.

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