Assisted suicide and human rights in the UK

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Summary Assisted suicide is an emotive issue that will undoubtedly continue to grab media headlines, especially as medical science is able to prolong survival in chronic medical disorders. The law in the UK as applied under the Suicide Act 1961 is currently very sympathetic to cases of assisted suicide, whereby the individual has travelled abroad to a country where it is lawful to end their life, in that people assisting them and thus committing an offence have not been prosecuted. This article analyses a recent High Court case pertaining to the Suicide Act 1961 demonstrating the central importance of the Human Rights Act 1998 in such cases. It then discusses implications for clinicians and the future of the Suicide Act itself.

Declaration of interest None.

The issue of assisted suicide has come to the fore recently in a flurry of media headlines to an extent that the Prime Minister commented on the subject in Parliament.[1] In September 2008, 23-year-old Daniel James died by assisted suicide in a Dignitas clinic in Switzerland. In November that year, BBC1 Panorama[2] had a prime time programme on the subject and in December the assisted suicide of Craig Ewert, who suffered from motor neurone disease, was broadcast.[3]

In October 2008 the High Court in *Purdy, R (on the application of) v. Director of Public Prosecutions*[4] ruled that the latter had not acted unlawfully in failing to publish detailed guidance as to the circumstances in which individuals will or will not be prosecuted for assisting another person to die by suicide. This case was based on the Suicide Act 1961 (further referred to as the Act) which makes it an offence to assist in someone's suicide. The judgment put the extent of the issue into context when it noted the actual number of possible offences being committed annually is 'not large'. It further noted that since October 2002 at least 90 UK citizens have travelled abroad for the purpose of lawfully carrying out an assisted suicide, but that in no single instance has a prosecution resulted, despite police investigations (as indeed happened with the parents of Daniel James).[5]

This article elucidates the main issues from the Purdy judgment, demonstrates how the Human Rights Act 1998 was pivotal in bringing the case to court and discusses future implications for clinicians and UK legislation.

The Suicide Act 1961

In the UK it has been codified in law since the Suicide Act 1961 that the act of suicide itself is not a criminal offence. It is, however, an offence to assist another person to die by suicide. Section 2(1) of the Act provides that:

> 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.

This subsection is widely phrased to encompass all cases, whatever the circumstances, and in doing so creates no exceptions. The Purdy judgment pertinently observes that the 'nature of the offence created by s.2(1) is such that the variety of facts which may give rise to the commission of that offence, and therefore which may result in a person being prosecuted, is almost infinite.'[4] The Act provides in Section 2(4) that no proceedings shall be instituted except by, or with the consent of, the Director of Public Prosecutions (DPP).

Debbie Purdy's case

At the time of going to the High Court, Ms Purdy was aged 45 and had been diagnosed in 1995 with primary progressive multiple sclerosis. Because of the progressive nature of the illness she accepted there will come a time when her existence may potentially become unbearable to a point where she may wish to end her own life. Should she decide to carry this out she will have to travel to a country where assisted suicide is lawful. This would probably be Switzerland where she would be able to use the services of Dignitas, an organisation which assists those with 'medically diagnosed hopeless or incurable illness, unbearable pain or unendurable disabilities' to end their life with dignity (www.dignitas.ch). Ms Purdy anticipated that she would be unable to make the necessary arrangements without the assistance of her husband. Consequently, if her husband did assist her he would be at risk of prosecution and conviction under Section 2(1) of the Suicide Act.

The core issue was whether the DPP had acted unlawfully in failing to publish detailed guidance as to the circumstances in which individuals will or will not be prosecuted for assisting another person to die by suicide. The judgment made it clear the issue was not about whether

it should continue to be a criminal offence in this country to help another person to take their own life; nor was the case about whether someone can obtain, in advance, immunity from prosecution for helping another person to travel abroad, where assisted suicide was lawful, for the purpose of carrying out an assisted suicide, which had already been decided in the negative by the House of Lords in the case of *R (on the application of Pretty) v. DPP* [2001].[6] Diane Pretty, who suffered from motor neurone disease, thereafter took her case to the European Court of Human Rights, which concluded there was no breach of her human rights (in light of this Ms Purdy accepted she could not ask for a 'proleptic decision' that her husband would not be prosecuted).[7] Ms Purdy's counsel contended that the offence created by Section 2(1) of the Act did interfere with the Article 8(1) (of the Human Rights Act) rights of both the person who wishes to die by suicide and anyone who would assist them. She instead argued that there was a duty on the DPP to publish a specific policy outlining the circumstances in which a prosecution under Section 2(1) of the Act would or would not be appropriate or setting out the public policy factors that would be taken into account for and against prosecuting in each case (the DPP, although not duty bound to do so, has published more detailed policies and guidance for more prevalent social problems such as domestic violence, bad driving and football-related offences).

Article 8 of the Human Rights Act

Article 8 was pivotal in this case and indeed, had it not been for the Human Rights Act, both the Pretty and Purdy cases would have been unarguable in court.

Article 8 covers the 'Right to respect for private and family life'. It states:

> 1 Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2 There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety . . . for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Ms Purdy's claim raised specific issues as to whether the prohibition on aiding or abetting, counselling or procuring a suicide in Section 2(1) of the Suicide Act engaged Article 8(1); and if so, whether the prohibition on assisted suicide meets the requirement of Article 8(2) in that any interference with Article 8(1) rights must be 'in accordance with the law'. Counsel contended that these issues could only be fulfilled if the DPP produced a public statement of policy on assisted suicides.

The House of Lords in the Pretty case concluded that her rights under Article 8 were not engaged at all and her claim was dismissed. The Secretary of State's argument was that the right to private life under Article 8(1) relates to the manner in which a person conducts their life, not the manner in which they depart from it. Thus, Article 8(1) protects the physical, moral and psychological integrity of the individual, including rights over the individual's own body, but there was nothing to suggest when or how they would die. The court in Purdy's case concurred and concluded that Article 8(1) was not engaged on the facts of the case, that is, personal autonomy did not encompass being able to decide to end one's life with assistance.

Article 8(2)

Ms Purdy's counsel accepted that in creating the offences identified in Section 2(1) of the Act the aims of the State – to safeguard life thereby protecting the lives of others – are legitimate and such aims are necessary for a democratic society. However, counsel did not accept that interference created by Sections 2(1) and 2(4) of the Act was 'in accordance with the law'. The crux of the case was whether the Code for Crown Prosecutors[8] promulgated by the DPP was sufficiently clear and precise so as to fulfil the requirements of Article 8(2).

The court concluded that the present Code was sufficient to satisfy the requirement that the discretion be 'in accordance with the law' of Article 8(2) and therefore any infringement of Debbie Purdy's rights under Article 8(1) could be justified under Article 8(2). Accordingly, the court ruled Ms Purdy's Article 8 rights were not infringed and her claim for judicial review failed, meaning that the DPP did not have to produce a specific policy on assisted suicides.

The House of Lords judgment

The High Court judgment was upheld by the Court of Appeal in February 2009.[9] Following this, Ms Purdy appealed to the House of Lords who released their judgment in July that year.[10] The core issue relating to Article 8 was again dissected and analysed by the House of Lords, who unanimously overturned the Court of Appeal judgment. The crux of the decision was 'simply that the Article 8 rights of Ms Purdy entitle her to be provided with guidance from the Director (of Public Prosecutions) as to how he proposes to exercise his discretion under Section 2(4) of the 1961 Act.' The effect of allowing the appeal therefore required the Director to promulgate an offence-specific policy identifying the facts and circumstances which he will take into account in deciding whether or not to consent to a prosecution under Section 2(1) of the 1961 Act.

Implications for clinicians

The case of Debbie Purdy demonstrates how the Suicide Act 1961 is implemented and in particular the central importance of Article 8 of the Human Rights Act. Although rare in occurrence, in the UK knowledge of case law and the Human Rights Act aspects could be of benefit should a psychiatrist become involved in a case whereby a person wishes to end their life, with assistance, in a country where it is lawful to do so. Psychiatric assessment would in effect be two-pronged. First, to ensure any treatable psychiatric disorder, such as depression or psychosis, was not contributing to the decision to end the person's life (depression rates of 20% have been found in people requesting physician-assisted suicides).[11,12] Second, and naturally flowing from this, would be the issue of assessing the capacity of the person to make the decision (an aspect that is important to consider since the advent of the Mental Capacity Act 2005). There could conceivably be a scenario,

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although highly unlikely ever to be sanctioned by any legislation, whereby an individual with a severe and enduring treatment-resistant mental disorder requests a physician-assisted suicide on that ground alone. It is possible that prior to the terminal event a person may need a psychiatric assessment.

There is growing literature relating to attitudes of clinicians participating in physician-assisted suicides.[13] A review of Oregon psychiatrists (where the Death with Dignity Act has been enacted from 1998) found they were divided in their belief about ethical permissibility of assisted suicide and that their moral beliefs may influence how they might evaluate a patient requesting assisted suicide.[14] The study also found that psychiatrists' confidence in their ability to determine whether a psychiatric disorder such as depression was impairing the judgement of a patient requesting assisted suicide was low. A survey of forensic psychiatrists found that 58% believed the presence of a major depressive disorder should result in an automatic finding of incapacity, and psychiatrists with ethical objections to assisted suicide advocated a higher threshold for capacity and more extensive review of a decision.[15] Physicians who provided assistance with suicide in Oregon reported perceived problems, including unwanted publicity and difficulty understanding the requirements of the law itself (there was also concern that inadequate social support or lack of access to healthcare may provoke some people to request an assisted suicide).

The future of the Suicide Act 1961

So can the UK learn from overseas legislation for possible future amendments? Worldwide, assisted suicide is legal in The Netherlands (accounting for 2.7% of all deaths),[14] Switzerland, Luxembourg and the USA state of Oregon (accounting for 0.14 % of all deaths),[14] and was legalised in Australia's Northern Territory for a short period in 1996. Legislation is of two distinct types, according to the scope of the 'assistance' that is permitted. In Switzerland and Oregon, it is limited to a strict definition of assisted suicide, under which the patient himself performs the fatal act and the role of the physician is to provide the means to this act through the prescribing or preparation of medication. In The Netherlands and Luxembourg, legislation is broader and includes physician-administered acts of suicide, essentially voluntary euthanasia. Belgium is unique in that it permits euthanasia but does not legislate for assisted suicide. The UK has resisted recent attempts to legalise assisted dying, as evidenced by the failing of the Assisted Dying for the Terminally Ill Bill, which sought to legalise both the provision of a terminally ill patient with the means to end their own life and, where a patient was incapable of doing so himself, the termination of the patient's life by a physician.[16]

International legislation as a whole has in common several qualifying conditions, including the involvement of a physician, the need for repeated requests, the need for referral to additional clinicians and the importance of informed consent with associated assessment of capacity. The Assisted Dying Bill similarly offered equivalent safeguards, with the addition of other qualifying conditions such as that a declaration be made in the presence of two witnesses and, in circumstances in which the patient's capacity was in doubt, the patient should be referred to a psychiatrist for further assessment (interestingly, in Oregon in 2007 none of the 49 people who died by lethal ingestion had been evaluated by a psychiatrist or psychologist and hence there was concern that the legislation may not adequately protect all mentally ill patients[14]). A survey of Dutch psychiatrists[17] found psychiatric consultation for patients requesting physician-assisted suicide was also rare, estimated at about 4% of all such physician-assisted death requests annually (approximately 400 consultations in total). It has been suggested that a psychiatric assessment should be mandatory as part of any assisted dying legislation.[18]

The UK government has recently commented on proposed changes to the Suicide Act 1961. The Parliamentary Under-Secretary for Justice noted the growing concern about whether current law was adequate to also deal with misuse of the internet to promote suicide and suicide methods.[19] The minister noted the unusual nature of the offence in Section 2 of the Suicide Act which provides for 'accessory liability in respect of something that is not of itself criminal'. She also noted the practical application of this law was complicated and was 'difficult both to understand and to explain'. The minister concluded that the scope of the current law would not be extended but that the existing statutory language of Section 2 should be 'simplified and modernised'. The Law Commission proffered the suggestion that Section 2 would be more easily understood if it used the words 'assists or encourages' rather than 'aids, abets, counsels or procures'.[20]

In the case of Debbie Purdy and her husband, the High Court and the Court of Appeal both accepted that being able to go abroad to end their suffering by assisted suicide was an issue that 'many would regard as something that the law should permit' but that this would necessitate a change in the law by Parliament. The government has made clear its intention to update the Suicide Act as soon as Parliamentary time allows,[19] and Lord Joffe intends to again bring before Parliament another Assisted Dying for the Terminally Ill Bill.[21]

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Spirituality and religion in psychiatric practice: why all the fuss?†

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Summary In this article we suggest that controversy over interventions such as prayer in psychiatric practice distracts attention from a serious consideration of the role of spirituality in our society. There is abundant evidence that spiritual belief, experience and practice gives meaning to many people and thus whatever they think of its truth value, psychiatrists cannot ignore it.

Declaration of interest None.

An historical perspective

In Western societies psychiatric and psychotherapeutic practice emerged out of a secular age that was eager to slough, like so much dead skin, the 'enchantment' of spirituality.[2] Spirits were less often considered responsible for madness while rational, natural and humane treatments of illness became the accepted healing modalities. Thus it is not surprising that by the late 20th century most UK psychiatrists looked askance at spirituality.[3] But how did secularism become our modern professional paradigm? One popular view is that our secular age arose as science progressed and superstitious thinking fell away; however, as Taylor[2] and others have argued, its origins are more complex.

The current assumption in Western societies that disengaged reason is all we need to understand our world, and flourish in it, seems to have progressed through a number of steps. Briefly, these may be characterised as: (1) ever greater demands by the Christian church from at least the 12th century for lay people to seek moral perfection and not simply participate in religious practice; (2) stripping the natural world of magic and rejection of superstition; (3) the development of Reformation ideas that men and women

†See commentary, pp. 193–195, this issue.