

RESPONSE TO THE CONSULTATION ON THE INTERIM POLICY FOR PROSECUTORS IN RESPECT OF CASES OF ASSISTED SUICIDE

INTRODUCTION

The National Council for Palliative Care (NCPC) is grateful to the Director of Public Prosecutions (DPP) for his invitation to respond to this consultation. This response has been discussed and approved by our Board of Trustees.

NCPC recognises the difficulty of the DPP's task. Our understanding is that it is rare, possibly unique, for the DPP to publish guidance about the circumstances in which he might decide that although there is evidence that a criminal offence has been committed he will nevertheless not prosecute the suspect. This is new and uncertain territory.

Nothing in this response should be taken as support for a change in the law to permit assisted suicide. NCPC opposed Lord Joffe's parliamentary attempts between 2003 and 2006 to change the law in relation to assisted suicide. We took the view that there was not sufficient evidence to justify so significant a change in the law, and that the proposed safeguards in the draft legislation were inadequate and unworkable.

NCPC's aims in responding to this consultation are to:

- Advise the DPP on how this policy might operate in practice
- Identify areas where greater clarity is required
- Identify areas where the policy might place vulnerable people at risk.

SCOPE OF THE INTERIM POLICY

We are concerned by the breadth of the interim policy. Our understanding is that the Court required the DPP to publish a policy setting out the factors he would take into account where the offence in question is assisting the suicide of a person who is terminally ill or severely and incurably disabled, who wishes to be helped by a friend or family member to travel to a country where assisted suicide is lawful. The policy goes much further than that relatively narrow set of circumstances, covering all cases of assisted suicide in this country.

Assisted suicide is a highly complex and controversial issue. It has recently been considered at length by a Select Committee of the House of Lords. Parliament, through the House of Lords, has twice in recent years voted against its legalisation. The Bills that were rejected were in both cases drawn significantly more tightly than this policy. We believe that the DPP

should not publish a policy that goes beyond the scope of what is required to enable him to comply with the Court's order.

As described below, members of the public, health and social care professionals, and organisations providing services to the public will all be affected by the publication of this policy. The wider it is drawn, the greater the potential impact on them will be.

PURPOSE AND USE OF THE POLICY

The policy does not state what its purpose or objectives are. Although its title says it is "for prosecutors", the court's intention was that it should inform people contemplating suicide and those contemplating assisting them. The policy must therefore be taken to be "for" members of the public as well as for prosecutors, and in particular those people referred to above. Making that explicit, and then identifying what it is intended this policy should achieve for members of the public, would be helpful.

There are a number of possible purposes for this policy, including:

- Identifying clearly the factors that prosecutors will take into account when deciding whether or not there is a public interest to prosecute
- Providing people with clear information about what is meant by "assist" (i.e. "aid, abet, counsel or procure"), what activities are capable of coming within that definition, and what activities will not come within that definition
- Protecting vulnerable people.

The policy does not achieve all of the above. Because this policy is intended in part for the public, there is a need to make sure that it is as clear and accessible as possible, and is safe and helpful for people who wish to use or rely on it, whatever decision they make.

Health and social care professionals, and organisations providing services to the public will also be affected by the publication of this policy, and need guidance about its impact on them and their activities.

IMPACT ON SERVICE PROVIDER ORGANISATIONS

Some of the charities that subscribe to us, which exist to provide services to people with life-threatening conditions, have expressed concern that this policy causes uncertainty and difficulty for their employees and volunteers (collectively, "workforce"), whose role it is to support, advise and care for people living with those conditions. They report that people already want to discuss or obtain information or guidance about this policy, whether in face to face conversations or via their help lines and websites. They need clarity about what it is permissible for their workforce to say or do in relation to this policy, and as responsible employers must be able to provide appropriate guidance to their workforce. They do not wish to break the law; they do wish to do their best to support and advise people in their client groups.

This needs to be understood in the context of practice in palliative and end of life care. A fundamental principle of good practice is the need for clear and open communication between patients and those providing care for them. Allied to that is very considerable support both amongst practitioners and as a matter of public policy (for example the government's End of Life Care Strategy, 2008), for people approaching the end of life to be able to have open discussions about their concerns, priorities and preferences for their future care. Such discussion means that a person's end of life care can be planned and delivered in a way that reflects their wishes so far as practicable.

As part of their discussions about their future, people sometimes raise the question of assisted suicide. At one level, it is possible to use this as a prompt to open a discussion about their future care. A person who raises assisted suicide is, at least, saying that they are willing to consider their future, they have concerns about it, and suicide might be an answer. It is certainly possible to use that as an opportunity to explore their concerns, fears and hopes for their future and explain what the potential impact of good care and treatment might be. Anecdotally, people sometimes use questions like "Should I book my ticket to Switzerland then?" as a means of opening up such discussions.

However, discussion and request for support may go beyond that. People may wish to talk about a number of issues including assisted suicide. The publication of this interim policy has already led to an upturn in the numbers of people asking service provider organisations for support or advice about assisted suicide.

Subscribers have asked, for example, whether it is "assistance" for their workforce to help people interpret or understand the policy. They have asked what they should do if a patient or carer tells them of plans for the patient to commit suicide.

Para 21 (7) refers to actions that might be "sufficient to come within the definition of the offence". Clarity about what might or might not be sufficient would be very helpful.

We know that some of our subscribers would welcome the opportunity to discuss their concerns in details with the DPP and would be willing to help bring about such a meeting if the DPP is agreeable to that.

EQUITY: WHAT DOES THE POLICY SAY ABOUT PUBLIC INTEREST ATTITUDES TOWARDS VULNERABLE PEOPLE?

The policy identifies the factors which will influence the DPP's decision-making about where the public interest lies in relation to prosecution. Those factors should be broadly consistent with approaches to policy-making and the public interest elsewhere in the public domain.

Outside this policy, people answering to one or more of the following descriptions are often treated inequitably and consequently considered by public policy-makers to be vulnerable:

- People under the age of 18
- People with impaired mental capacity
- Older people

- People with terminal illness
- People with a severe and incurable physical disability
- People with a severe degenerative physical condition
- People who have a history of failed suicide attempts.

Within this policy, only the first two are regarded as vulnerable, in that those are identified as being factors in favour of prosecution. The policy does not mention older people at all (see further under factors for or against prosecution, below). The implication of this policy is that there is not a public interest in protecting people in the other groups listed above. This is not consistent with public policy in other areas.

Generally, public policy does not regard suicide as a good outcome and tries to discourage and prevent it.

There is understandably great public sympathy for people with life-threatening conditions and serious physical disability. We are concerned that the effect of this policy is to translate that natural sympathy into unequal treatment. There is a considerable public interest, which is the aim of palliative and end of life care services, in ensuring that everybody is valued and cared for equally.

FACTORS FOR OR AGAINST PROSECUTION

There is a risk that members of the public who read this policy will conclude that, in circumstances in which an offence will not be prosecuted, an offence has not been committed; in effect that the policy has changed the law in certain circumstances. We therefore suggest that the following should be given greater emphasis than is currently the case:

- Assisting suicide remains a criminal offence. The factors identified under the public interest stage do not have any bearing on whether an offence has been committed, only on the question whether there is a public interest in prosecuting the person suspected.
- The lists of factors are not check-lists and should not be used as such (para. 15 should be strengthened in this respect)

We also consider that greater clarity is required in relation to a number of the factors identified:

The victim's age

We agree that it should be a factor in favour of prosecution that the victim was under 18. However the policy does not recognise that older people can also be vulnerable and in need of protection. It should be emphasised that the fact that the victim is over the age of 18 is not a factor against prosecution.

There is a danger that older people can and can be made to feel that they are a burden or that they are less valued members of society. There is evidence that they are treated

inequitably in a range of different ways. For example, our research shows that older people receive disproportionately less access to specialist palliative care than younger people. This policy should not reinforce disadvantage or discrimination against older people.

Whether the victim's capacity to reach an informed decision was adversely affected by a recognised mental illness or learning difficulty

Information about what is meant by capacity to decide would be helpful. The Mental Capacity Act 2005 (MCA) defines this as a person's ability to understand, retain, use or weigh relevant information, or communicate their decision (section 3). Capacity involves a person's comprehension, memory, judgment or ability to communicate. Where a person's capacity is impaired, or "adversely affected", the MCA places a duty on those involved with that person's care and treatment to take all practicable steps to support them so that they can make decisions for themselves.

Explicit warnings should be given about depression and cognitive impairment.

The policy does not mention depression. Depression is a recognised feature for many people living with long-term or life-threatening physical illness or disability. It often goes undiagnosed. It is treatable. A person with undiagnosed depression might appear to be a person with a clear, settled and informed wish to commit suicide.

Similarly, cognitive impairment is a recognised feature in people living with a number of life-threatening conditions, including some neurological conditions and cancers. Again, it often goes undiagnosed. This is neither a "mental illness" or a "learning difficulty" so far as those phrases are generally understood.

Recognition should also be given to the fact that a person's judgement or capacity might also be affected by physical, psychological or spiritual pain. This again can be treatable.

The victim's "informed wish" or "informed decision"

Regrettably, public discussion and debate about the end of life is often characterised by misleading information and assertion. There is a need to warn people to make sure that their decisions and wishes are well-informed, and based on good information. This should include discussions with specialist doctors or other healthcare professionals about what good care and symptom control can achieve.

One example is the fear of choking to death, in relation to neurological conditions such as MS or MND. For example, in its report on the publication of the interim policy, *The Times* included a case study about an MND patient whose chief reason for choosing to end her life at Dignitas was said to be the information that she could choke to death. However, with good care in place, this happens only rarely.

The experience of many palliative care specialists as well as doctors in other specialties is that people often do change their mind over time about what they want in the future, as

they learn to live with their condition or experience what care can deliver. What may appear to be their “settled” view can and does change. The policy does not acknowledge this.

There is evidence to support this. For example research shows that a high proportion of people with heart failure change their minds in relation to a decision not to be actively treated. Heart failure is a chronic progressive and eventually fatal condition at least as burdensome as cancer in terms of symptoms:

- *Changing preferences for survival after hospitalization with advanced heart failure* Stevenson et al. J Am Coll Cardiol 2008, 52(21): 1702-8
- *Resuscitation preferences among patients with severe congestive heart failure: results from the Support Project (1998)* Krumholz et al

An additional point is that it should be recognised that people can change their minds in different directions. If, after experiencing care or treatment, a person decides that they want to end their life and does so, to what extent are the health and social care professionals potentially culpable as agents of change?

The extent to which the victim had considered and pursued recognised treatment and care options

This is linked to issues about the extent to which the victim had made an informed choice (see above). However it also places the responsibility for this entirely on the victim. We believe that people should be entitled to receive good information about palliative and end of life care, as well as other care and treatment that might be available to them, as well as access to care and treatment that meets their needs. In practice this would mean that a formal palliative care assessment has been undertaken by a recognised and registered medical specialist.

Ensuring access to care is a responsibility and function of society, and should not be left to individual people.

The victim had/did not have a terminal illness; or a severe and incurable physical disability; or a severe physical degenerative condition from which there was no possibility of recovery

Clarity is needed about some of this language:

- “Terminal” Many conditions have the potential to end life, but do not inevitably do so. Cancer prognosis can vary considerably, for example. Even where people have a condition that will inevitably result in their death, they might still have a long period of life ahead of them. What does “a terminal illness” mean?
- “Severe” is highly personal; what might be severe to one person may not be to another. Is diabetes “severe”? Is this to be assessed subjectively or objectively?

The suspect’s employment/the victim’s place of care

Para 19 (14) states that a factor in favour of prosecution is “the suspect was paid to care for the victim in a care/nursing home environment”. Protection should not depend on where the victim was being cared for, or where the suspect happens to work. Care homes and nursing homes should not be singled out from other settings of care, such as hospitals, hospices, and other “home” settings (eg a person’s private home, or sheltered or extra care housing). This should be a relevant factor for paid employees in all healthcare settings.

Para 20 (7) states that it is a factor against prosecution if “the assistance which the suspect provided was as a consequence of his or her usual lawful employment.” Clarity is needed about what this permissive factor means, and what its relationship is to the prohibitive factor above in para 19 (14). If assisting suicide is a crime, how can an act of assistance be within somebody’s lawful employment (wherever they happen to work)? What happens if the act of assistance was within somebody’s lawful employment, in a healthcare setting? These factors are confusing. Health and social care professionals need clarity about this.

The reference in para 21 (7) to acts that were “of only minor assistance or influence” is similarly confusing and in urgent need of clarification.

Our view is that health and social care professionals should not do acts to assist suicide because it is a criminal activity, whether or not it might be prosecuted. The policy should make that explicit. We believe this also reflects the DPP’s intentions when drafting the policy. Certainly there is a need for absolute clarity amongst all health and social care professionals about what is and is not permissible for them as a result of this policy.

Was the suspect “wholly motivated by compassion”?

The DPP emphasised the importance of this factor in interviews accompanying the publication of the interim policy: *“The key is motivation. Is the motivation that of a compassionate spouse or other relative, or that of someone who stands to gain from the death of another person?”*

Discerning a person’s motivation is not straightforward. Very often, people do not have a single motivation, but are motivated by a number of different factors. A spouse, partner or relative providing care might be significantly, but not wholly, motivated by compassion. Similarly “gain” is not merely financial. The prospect of no longer having to tend to somebody with considerable care needs, be that through exhaustion, weariness or some other cause, is capable of being a motivation and a gain. Human relationships are nuanced and complicated. Financial gain may not simply arise from the victim’s estate, but because meeting people’s care needs is often highly expensive. Compassion can be used to disguise coercion. The policy risks over-simplifying complex issues.

ADDITIONAL COMMENTS

- **Para 12:** The warning in this paragraph that acting to take another person’s life is murder or manslaughter should not be included under the heading “evidential stage” but form part of a clear statement at the beginning of the policy that both acts to assist suicide and to take another’s life are serious criminal offences.

- **Para 13:** The phrase “It is possible in law to attempt to assist a suicide” is ambiguous, being capable of meaning either that such an attempt is permissible or that it is illegal.

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NOTES

About palliative care and the National Council for Palliative Care

- Palliative Care has been defined as follows:

Palliative care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.

This is NCPC’s definition, which was accepted by The National Institute for Clinical Excellence (NICE) in its 2004 guidance on *Improving Supportive and Palliative Care for Adults with Cancer*.

- NCPC is the umbrella charitable organisation for all those who are involved in providing, commissioning and using palliative and end of life care services in England, Wales & Northern Ireland. NCPC promotes the extension and improvement of palliative care services for all people with life-threatening and life-limiting conditions. NCPC promotes palliative care in health and social care settings across all sectors to government, national and local policy makers.

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