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# **ASSISTED DYING : COMPARISONS BETWEEN ENGLAND AND NEW ZEALAND**

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# Abstract

If I became terminally ill and in unbearable pain it is illegal for my doctor to prescribe drugs for assisted dying or assisted suicide. The police are involved if there is evidence of assisted suicide and in England and Wales the Director of Public Prosecutions decides whether cases should be prosecuted. The judiciary have repeatedly criticised the present situation which applies the Suicide Act 1961 and requested that Parliament should change the law for assisted dying. Members of both Houses of Parliament have been reluctant to legislate unless the new law has clarity and strong safeguards to prevent coercion of vulnerable patients. The aim of this research is to make and justify new proposals for legal reform.

There have been a series of Assisted Dying Bills for the terminally ill between 2003 and 2015. This dissertation assumes that eventually the law will change and the literature review identifies the importance of comparisons with other jurisdictions. The research uses the methodology of comparative legal research to make comparisons between England and Wales and New Zealand. The two jurisdictions have similar constitutional frameworks and the courts in New Zealand have requested their Parliament should legislate. The statutes and case law in both jurisdictions are compared. There is then a comparison of recent attempts to change the law which leads to recommendations for change. The Conclusions are that more comparative research needs to be done as well as further analysis of opinion surveys to confirm whether Parliament and public opinion agree.

# Chapter 1 : Introduction

This chapter is an introduction to the problem of assisted dying for the terminally ill. It begins with a discussion of definition and terminology. These are necessary in order to understand the current legislation in England and Wales and the policy of the Director of Public Prosecutions for whether it is in the public interest to prosecute someone who has assisted in a suicide.

## 1.1 Discussion of definitions

This research considers the law of assisted suicide in England and Wales and its application to the problem of assisted dying for the terminally ill. The person who is terminally ill will be described as a patient because that is their status with their medical advisors. If the person is assisted to die then he or she is described as the victim and whoever is involved in assisting their death is the suspect. The key words used in the research are suicide, assisted suicide, physician assisted suicide, assisted dying and euthanasia. Precision on definitions and terminology is important because assisted dying and assisted suicide are different and are both different to euthanasia.

Black's Law Dictionary defines suicide: "Suicide is the willful and voluntary act of a person who understands the physical nature of the act, and intends by it to accomplish the result of self-destruction." According to the Oxford English Dictionary 'suicide' comes from the latin 'sui' meaning of oneself and 'caedere' meaning to kill and is: "The action of killing oneself intentionally". The Merriam-Webster Dictionary defines 'suicide': "the act or an instance of taking one's own life voluntarily and intentionally especially by a person of years of discretion and of sound mind".

There are several definitions of euthanasia and physician assisted suicide. Materstvedt et al (2003) of the European Association for Palliative Care Ethics Committee gave these definitions in the context of palliative care:

"Euthanasia is killing on request and is defined as A doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request.

Physician-assisted suicide is defined as A doctor intentionally helping a person to commit suicide by providing drugs for self-administration, at that person's voluntary and competent request."

The definition given by NHS Choices (2015) is:

"Euthanasia is the act of deliberately ending a person's life to relieve suffering"

Already there is controversy because the first definition of euthanasia specifies a voluntary and competent request without mention of illness or suffering and the second definition does not include mention of any request by the victim. The first definition is limited to the activity of a doctor whereas the second is not. Neither definition is satisfactory. An example of euthanasia illustrates the concept. Cartwright (in Close and Cartwright (2014, p40)) describes how King George V was injected in 1936 with lethal drugs on his deathbed by the King's physician Lord Dawson. Cartwright also reports that Lord Dawson said in debate (House of Lords, 1936) "One should make the act of dying more gentle and more peaceful even if it does involve the curtailment of the length of life; that has become the custom....If we cannot cure, for heaven's sake let us do our best to lighten the pain." This is an early example of the doctrine of double effect used to justify euthanasia for those

who are dying.

Assisted dying is different to assisted suicide. Chapter 2 describes the attempts at legal reform in England and Wales which have been through Assisted Dying Bills not Assisted Suicide Bills. The Collins Dictionary defines assisted dying as: “the suicide of a person afflicted by an incurable disease, using a lethal dose of drugs provided by a physician for this purpose.” Section 1 of the Assisted Dying (No. 2) Bill 2015-16 defines assisted dying by: “.... a person who is terminally ill may request and lawfully be provided with assistance to end his or her own life.” Terminally ill is defined in the Assisted Dying (No. 2) Bill 2015-16:

“A person is terminally ill if that person -

- (a) has been diagnosed by a registered medical practitioner as having an inevitably progressive condition which cannot be reversed by treatment (“a terminal illness”); and
- (b) as a consequence of that terminal illness, is reasonably expected to die within six months.”

Terminal illness is defined by the Department of Work and Pensions in a written Parliamentary Question (WPQ, 2015) as: “a progressive disease where death as a consequence of that disease can reasonably be expected within 6 months”. The General Medical Council (2015) states that : “Patients are ‘approaching the end of life’ when they are likely to die within the next 12 months”. The General Medical Council do not have a definition of terminally ill. There are two different timescales: 6 months for terminally ill and 12 months for approaching the end of life. This is not crucial because as reported by Frost et al (2014) estimates by medical professionals of life expectancy in terminal prognoses are wrong in over 80% of cases.

Assisted suicide involves a person who has assistance to commit suicide and it follows that physician assisted suicide is assisted suicide which is assisted by a physician. The person may be in normal health and not terminally or incurably ill. The person may be or may not be competent. In contrast assisted dying only applies to terminally ill patients who are competent. Assisted dying is a form of suicide because under the proposed rules the patient has to self-administer the drug which will kill them. During the Second Reading of the Assisted Dying Bill [HL] 2014-15 Lords Hansard (2014) records that some members of the House of Lords disagreed with the title because they said it was about suicide not dying and should be the Assisted Suicide Bill.

## 1.2 Summary of the law

The prosecution of cases of assisted dying is based on assisted suicide legislation and the published advice of the Director of Public Prosecutions (DPP) to the Crown Prosecution Service (CPS). This dissertation will not discuss all parts of the UK because the law in Northern Ireland and Scotland is different and outside the scope of this research.

### 1.2.1 Legislation

The law of assisted suicide is written in the Suicide Act 1961. The original version of Section 2(1) of the Suicide Act 1961 stated:

“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.”

On 1 February 2010 Section 2(1) of the Suicide Act 1961 was amended by Section 59 and Schedule 12 of the Coroners and Justice Act 2009 which states :

“(1)A person (“D”) commits an offence if—

(a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and

(b) D's act was intended to encourage or assist suicide or an attempt at suicide.

(1A) The person referred to in subsection (1)(a) need not be a specific person (or class of persons) known to, or identified by, D.

(1B) D may commit an offence under this section whether or not a suicide, or an attempt at suicide, occurs.

(1C) An offence under this section is triable on indictment and a person convicted of such an offence is liable to imprisonment for a term not exceeding 14 years.”

Section 2(4) of the Suicide Act 1961 states :

“No proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions”

## 1.2.2 DPP policy and guidance

The Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide was issued by the DPP on 25 February 2010 and updated on 16 October 2014 (CPS (2014a, b)). This policy was issued as a direct result of the decision in *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45; [2010] 1 AC 345 (HL) which is described in more detail in Chapter 2. In CPS (2014a) the DPP explains that where there is sufficient evidence to justify a prosecution then it must be decided whether it is in the public interest. The public interest factors tending in favour and those against prosecution are listed. For the family and friends of a terminally ill person there is the possibility that assisting suicide might lead to prosecution and it is important for them that the factors tending against prosecution have been clarified. Healthcare professionals are identified as a special case and only those who are not directly responsible for care are included within the factors tending against prosecution. Section 45 of CPS (2014a) lists the factors tending against prosecution. The first factor is that the victim had reached a voluntary, clear, settled and informed decision to commit suicide. The victim does not need to be ill or terminally ill and this is an important feature of the DPP policy because the proposals for legal reform described in Chapter 2 are all focussed on assisted dying for the terminally ill. The next five factors are about the suspect. This indicates an important balance showing that the intentions and behaviour of the suspect are more important than the situation of the victim. One factor is about the compassion of the suspect. The other factors are about discussions between the victim and the suspect and whether the actions are to try to dissuade the victim and only giving minor and reluctant encouragement or assistance when faced with a determined victim. The final factor is whether the suspect has reported the victim's suicide to the police and fully assisted them in their enquiries.

## 1.3 Justification for the Research

A YouGov survey (2014) based on 2050 responses reported 73% in favour of the legislation to allow assisted dying. If this result is representative of the views of the electorate generally then it is time for politicians to respond and to change the law. There are medical and legal reasons to justify the need for research about whether to change the law about assisted suicide and assisted dying and what these new rules should be.

### 1.3.1 Medical Technology

Frost et al (2014) assert that medical technology has developed over recent years especially for coronary heart disease and cancer treatment which is linked to increased life expectancy. This has consequences for the sufferers who might have died in the past but who instead receive expensive treatments to extend their lives. Statistics published by the UK Office for National Statistics (ONS (2014a, 2014b)) show that people are living longer and in 2013 there were over half a million people aged 90 or over. There are many social, political and economic problems as a result of this rising elderly population. For the elderly who are suffering in intense pain or vegetative or lacking in dignity through incontinence there are compassionate reasons to suggest the law should change to allow euthanasia or assisted dying.

### 1.3.2 Legal reasons for change

McLean (2007) evaluated the need for legal change with future legislation based on rights, necessity and compassion. As described in the literature review in Chapter 2 and the comparative data in Table 4.2 there is case law which shows the challenges for judges in England and Wales making convictions and sentencing. The literature review also shows that the judiciary have requested that the UK Parliament should change the law but nothing has happened. The Commission on Assisted Dying (DEMOS CoAD (2012)) conclusions were that the current legal status of assisted suicide was inadequate and incoherent and should not continue. The CoAD chairman was Lord Falconer who was subsequently the proposer of the Assisted Dying Bill [HL] 2013-14. The research was funded by members of the Dignity in Dying organisation and the CoAD could be criticised for their independence and impartiality because of their source of funding.

The case law which links assisted suicide to human rights and CPS policy has become an important influence on the law in England and Wales. Wicks (2015, p150) highlighted the importance of the House of Lords judgment in *Purdy* that the offence of assisted suicide engaged Article 8 of ECHR and identified inconsistent prosecution of the offence. The judgment in *Purdy* led to the DPP consultation which resulted in the DPP Policy document described in Section 1.2.2. The main purpose of the paper by Wicks (2015) was to explain how the Supreme Court judgment in *R (on the application of Nicklinson and Lamb) v Ministry of Justice; R (on the application of AM) (AP) v Director of Public Prosecutions* [2014] UKSC 38 was significant. The judgment of Martin's application in *Nicklinson* led to the update to the DPP Policy document clarifying the role of healthcare professionals.

As Wicks (2015, p152) explains “the offence of assisting suicide is statutory and therefore this is not a topic on which Parliament has been content to leave the development of the law to the courts.” In *Nicklinson* the judges agreed that the issue should be decided by Parliament. That debate took place in the House of Lords for the Assisted Dying Bill [HL] 2014-15 and continued with the Assisted Dying Bill [HL] 2015-16 and the House of Commons Assisted Dying (No. 2) Bill 2015-16.

## 1.4 Scope of the research

### 1.4.1 Areas for research

There are many aspects of assisted suicide and assisted dying which would benefit from legal research. The areas for legal research divide into the need for legal reform expressed by the judiciary, the views of medical professionals who care for the terminally ill, and the views of the patients and their family and friends. There are many individuals and organisations who have views about whether there should be legal reform and what that should be and these views were reflected in submissions to the Commission on Assisted Dying (DEMOS CoAD (2012)). Another area of legal research is human rights and the relationship between UK legislation and the obligations on human rights as part of the European Union.

### 1.4.2 Aim and objectives

This research is not about surveying the views of politicians, patients/victims, medical professionals or other stakeholders. This research is about legal reform for assisted dying for the terminally ill and the content of new legislation in England and Wales. The scope of the dissertation is limited to a comparative evaluation between two jurisdictions of their legislation, case law and proposals for new legislation. The jurisdictions are England and Wales and New Zealand. The reasons for choosing the method of comparative legal research and the specific choice of New Zealand as comparator are given in Chapter 3.

The aim of the research is to make proposals for legal reform by considering the Assisted Dying (No. 2) Bill 2015-16. The dissertation will compare the proposed legislation and the case law in England and Wales with that in New Zealand in order to make recommendations.

To achieve this aim there are four objectives:

- (i) Evaluate the current law in England and Wales and in New Zealand dealing with assisted suicide, euthanasia and medically assisted dying.
- (ii) Compare the Death with Dignity Act in Oregon with the Assisted Dying (No. 2) Bill 2015-16 and with the New Zealand Death with Dignity Bill (2003) and the End of Life Choice Bill (2012) in order to highlight differences and similarities and make recommendations.
- (iii) Compare case law in New Zealand and in England and Wales also including published incidents of assisted suicide which were not prosecuted by the DPP. Evaluate the merits of the Assisted Dying (No. 2) Bill 2015-16 using as measure the eligibility of these victims for assisted dying.
- (iv) Combine this information to make recommendations for legal reform in England and Wales.

## 1.5 Outline of the dissertation

The following research has four main parts. Chapter 2 begins with a description of the practical problems in England and Wales. These are described in the case law and assisted suicide judgments published by the DPP. Chapter 2 also contains a literature review which includes the lessons from overseas comparisons especially Oregon USA which has been the model for ideas of legal reform. Chapter 3 considers how to choose a research method and comparative legal research is identified as the most useful methodology. New Zealand is selected as the jurisdiction for comparison and in Chapter 4 their legislation, case law and proposals for legal reform are analysed and compared with the same in England and Wales. Similarities and differences between the two jurisdictions are highlighted and this leads to conclusions in Chapter 5 which are linked to the research aim and objectives and make proposals for future research work.

# Chapter 2 : Research Definition

## 2.1 Introduction

This Chapter looks beyond the present position in terms of the statutes and the published policy of the DPP and describes the features of the situation in England and Wales which have led to the research proposal. There are practical problems involving different stakeholders. Parliament has been reluctant to change the law to allow assisted dying for the terminally or chronically ill. Families and friends of terminally or chronically ill persons who have participated in assisted dying are not always prosecuted by the DPP. The first step is for the DPP to agree there is sufficient evidence to consider prosecution and it is these cases which are compared later in Chapter 4 in Table 4.2. The literature review is not a complete review of all the literature about assisted suicide and assisted dying but it is limited to advice to Parliament and comparisons with other jurisdictions.

## 2.2 The practical problems

### 2.2.1 Parliament votes against legal reforms

There is a long history of attempts to change the law. Close and Cartwright (2014, p41) describe attempts in the House of Lords to allow euthanasia in 1935, 1936, 1950 and 1969. In 1994 the House of Lords Medical Ethics Select Committee (1994) looked at the issue of euthanasia and recommended no change to the law. The modern emphasis is now on assisted dying not euthanasia. The most recent debate in the House of Commons was for the Doctor Assisted Dying Bill on 10 December 1997 when the vote was 'no' by 89/234 (Hansard (1997)). At that time the Labour Government led the vote against euthanasia.

As described by McLean (2007, pp 147-164), Close and Cartwright (2015, pp 41, 47 and 53) and Selvalingam (2014, pp 84-97) there have been several recent unsuccessful attempts in the House of Lords to take forward assisted dying Bills. These are the Patient (Assisted Dying) Bill in 2003, the Assisted Dying for the Terminally Ill Bills of 2004 and 2005 and the Assisted Dying Bill 2013. These efforts for legal reform continue and on 18 July 2014 the UK Assisted Dying Bill [HL] 2014-15 had its Second Reading debate. It was a Private Members Bill sponsored by Lord Falconer of Thoroton who was previously Lord Chancellor in the Labour government. On 7 November it continued to be debated at the Committee Stage where an amendment was unanimously accepted which introduced the safeguard of judicial oversight. There had to be a Third Reading before it could progress to the House of Commons and this did not happen before the election. After the election it was re-introduced in the House of Lords as the UK Assisted Dying Bill [HL] 2015-16 and returned for its First Reading on 4 June 2015. In the House of Commons Labour MP Rob Marris proposed the UK Assisted Dying (No 2) Bill 2015-16 which is based on the Assisted Dying Bill [HL] 2015-16 with minor editing changes and the addition of Section 1 (3) that the High Court shall deal with applications within 14 days or soon thereafter. It had its First Reading on 24 June and at its Second Reading on 11 September was voted 'no' by 118/330. These Assisted Dying Bills are compared in Chapter 4 and in Table 4.1.

The acceptance in Parliament of the need for legal reform is changing slowly. Senior Archbishops who are members of the House of Lords oppose the bills because of their religious views about the sanctity of life. Two high-profile retired Church of England Archbishops have spoken in favour of

the Assisted Dying Bill – former Archbishop of South Africa Desmond Tutu, who described the final intensive hospitalisation of Nelson Mandela as “disgraceful” (BBC (2014)) and former Archbishop of Canterbury, Lord Carey (Daily Mail (2014a)), who announced that he had dropped his opposition to the Assisted Dying Bill “in the face of the reality of needless suffering”. At the 2015 election the former DPP, Sir Keir Starmer KCB QC, was elected Labour MP for Holborn and St Pancras. He was responsible for the DPP policy advice described in Section 1.2.2. He adds substantial legal expertise to the House of Commons as shown in his maiden speech (Guardian (2015)) which defended the Human Rights Act. He recently spoke to ITV News (ITV(2015)) about the need for changes to the law to allow assisted dying.

## 2.2.2 Assisted suicide cases

There are three important cases which have influenced the journey towards legal reform in England and Wales. The first is *Pretty v Director of Public Prosecutions and Secretary of State for the Home Department* [2001] UKHL 61 and *Pretty v United Kingdom* 2346/02 [2002] ECHR 427. Diane Pretty suffered from motor neuron disease (MND). She sought an assurance from the DPP in advance that her husband would not be prosecuted if he assisted her suicide. When her request failed she appealed unsuccessfully to the ECHR. Although she was unsuccessful her case generated media interest and academic discussion about the notion of personal autonomy, as reported by Lewis (2007, p 23)).

The second case is *Purdy* which was discussed in Chapter 1 and described in her autobiography (Purdy (2010)). Debbie Purdy had multiple sclerosis and her condition was deteriorating. Her plan was to go to Dignitas with her husband to end her life when it became unbearable. In 2008 she wrote to the DPP asking him to explain exactly “when he would prosecute people for offences under the Suicide Act 1961” (Purdy (2010, p237)). She was unsuccessful and appealed to the High Court and finally was successful on appeal to the House of Lords in 2009. Details of the published DPP policy and guidance are in Section 1.2.2.

The third case is *Nicklinson* which is mentioned in Section 1.3.2. The case involved three people: Nicklinson, Lamb and Martin. Nicklinson had locked-in syndrome following a stroke and wanted to know if he could ask a doctor to help him end his life. He lost and died by starvation shortly afterwards. The case continued to the Court of Appeal in 2014 jointly with Lamb who had been paralysed by a car accident. At the same time Martin who was paralysed by a stroke wanted to go to Dignitas for assisted suicide and needed help from his wife who was a nurse to travel there. The DPP policy stated that prosecution would be more likely if “acting in his or her capacity as a medical doctor, nurse or other healthcare professional, a professional carer (whether for payment or not), or as a person in authority” (Close and Cartwright (2014, p53)). The Nicklinson, Lamb and Martin cases were heard together at the Supreme Court as *Nicklinson* and the DPP was required to clarify what professionals could do to support assisted suicide. The result changed the DPP policy as stated in CPS (2014b).

The DPP has published (CPS (2015)) twelve decisions on assisted suicide cases between December 2008 and September 2014. These cases are summarised in Chapter 4 and compared in Table 4.2. CPS (2015) reports that “from 1 April 2009 up to 24 April 2015 there have been 110 cases referred to the CPS by the police that have been recorded as assisted suicide”. As described in CPS(2015) the decision of the DPP is divided into two consecutive parts: the first is whether there is evidence to support a prosecution; the second is whether a prosecution is in the public interest. The twelve decisions described above each had evidence which would support a prosecution and it was then the personal decision of the DPP which decided whether a prosecution should go forward. Only *R v*

*Howe (Kevin)* [2014] EWCA Crim 114; [2014] WLR (D) 77 has been successfully prosecuted. Balancing the small number of cases of assisted suicide against the regular series of unsuccessful debates in Parliament leads to the preliminary conclusion that the problem of assisted suicide is being dealt with satisfactorily by the present legal arrangements. In Chapter 4 Table 4.2 the comparison of the twelve assisted suicide cases published by the DPP shows that only a small number of victims were terminally ill and the majority would not be eligible under the rules of the Assisted Dying (No. 2) Bill 2015-16.

## 2.3 Literature Review

This literature review identifies existing knowledge about the law in England and Wales and comparisons made with other jurisdictions. There are many published comparisons between jurisdictions. Comparisons have been produced by academics and by research librarians and Select Committees to give information to Parliament about the current situation and what happens in other jurisdictions. The majority are desk-based research. Some have included fact-finding visits overseas.

### 2.3.1 Advice to Parliament

McLean (2007, pp 148-160) describes the unsuccessful attempts at legislation in the House of Lords. The Assisted Dying for the Terminally Ill Bill [HL] (2004) would have allowed euthanasia and physician assisted suicide. It was debated in the House of Lords where it was decided to establish a Select Committee on Assisted Dying for the Terminally Ill Bill (“the Select Committee”) to consult widely on the views of individuals and organisations. The Select Committee looked at “the ethical principles underlying it ...and the realities of assisted dying” and reported that “The Assisted Dying for the Terminally Ill Bill seeks to legalise, for people who are terminally ill, who are mentally competent and who are suffering unbearably, medical assistance with suicide or, in cases where the person concerned would be physically incapable of taking the final action to end his or her life, voluntary euthanasia”. The Select Committee visited Oregon, the Netherlands and Switzerland and obtained a summary of the position in Belgium. In 2004 these were the only four jurisdictions who had legalised assisted suicide or euthanasia. The Report of the Select Committee (2005) made recommendations to Parliament about the content of any future bill. The Assisted Dying for the Terminally Ill Bill (2004) was then modified to become the Assisted Dying for the Terminally Ill Bill (2005) in two important aspects. The first was that it no longer allowed euthanasia and was limited to physician assisted suicide. The second was that the rules and procedures proposed were based on those which were successfully in use in Oregon, USA. These changes did not satisfy the House of Lords and when the vote was taken in May 2006 the majority decided to delay the bill by 6 months thus removing it from the current session.

The discussions during the case of *Purdy* in 2009 must have influenced the House of Lords to continue towards legal reforms. The next review of assisted dying for the House of Lords was by the Commission on Assisted Dying (CoAD) which was set up in 2010 with terms of reference (DEMOS CoAD (2012) p2) :

- “to investigate the circumstances under which it should be possible for people to be assisted to die
- to recommend what system, if any, should exist to allow people to be assisted to die
- to identify who should be entitled to be assisted to die
- to determine what safeguards should be put in place to ensure that vulnerable people are neither abused nor pressured to choose an assisted death

to recommend what changes in the law, if any, should be introduced.”

Members of the CoAD made visits to the Netherlands, Belgium, Oregon and Switzerland, covering the same jurisdictions as the previous Select Committee. Their conclusions (DEMOS CoAD (2012)) were that the current legal status of assisted suicide was inadequate and incoherent and should not continue. In line with the CoAD terms of reference a legal framework for assisted dying was proposed which led directly to the House of Lords Assisted Dying Bill [HL] 2014-15.

Renewed interest in assisted suicide by the House of Lords led to the publication by the House of Commons library of an information sheet on Assisted Suicide by Lipscombe and Barber (2014) which provided a factual account of the situation in England and Wales and also described the law in Switzerland, Oregon and Scotland. There are many stakeholders involved and the analysis by Lipscombe and Barber (2014, Chapter 6) identified the views of campaign groups and health professionals. It was updated by Lipscombe et al (2015) to provide briefing for the House of Commons debate on 11 September 2015. It is an adequate summary of the UK position for politicians and a good starting point for analysis and evaluation but does not include views of the other main stakeholders: the patients and their family, friends and carers.

## 2.3.2 Comparisons with other jurisdictions

ERGO (2010) reported in 2010 that there were seven countries who have enacted legislation and where international comparisons can be made. These are Switzerland, Columbia, Albania, Belgium, Netherlands, Luxembourg, and the USA (Oregon, Columbia, and Washington State). Of these Switzerland was the first country to allow assisted suicide and is unique in accepting foreigners. The Swiss law is defined in the Swiss Penal Code (SR 311.0) Art 115: 'Inciting and assisting someone to commit suicide' which has been in force since 1 January 1942. Dignitas (2014a) reports that between 1998 and 2014 273 UK residents have travelled to its office in Zurich to commit assisted suicide. Analysis of the list of twelve assisted suicide cases published by the DPP and described in Section 2.1.2 and in Table 4.2 shows that none of the family and friends who accompanied these 273 UK residents to Switzerland have been prosecuted. Brewer and Irwin (2015, pp. 63-98) write about the journey from the UK for people who have died at Dignitas. One justification for legal reform is that the victims of assisted suicide would prefer to be able to die at home in the UK and not be required to travel to Switzerland.

Steck et al (2013) published a systematic literature review which analysed data from Belgium, Luxembourg, the Netherlands, Switzerland, Oregon, Washington, and Montana. Warnock and MacDonald (2009) compared the Netherlands, Oregon and Switzerland. Dyer (2009) compared Canada, Oregon, Washington State, Montana, Belgium, Netherlands, Australia, Scotland, Luxembourg and Switzerland. Selvalingam (2014, Chapter 5) compared the Netherlands, Belgium, Switzerland, Germany, Northern Territory Australia and Oregon USA.

The legislation in Oregon USA, the Death with Dignity Act October 27 1997, is most cited as a comparator. The Select Committee and the CoAD visited Oregon and the criteria for eligibility and the procedures involving medical professionals have been used as a model for the UK Assisted Dying Bills. Hehir and Satherley (2014), writing in Close and Cartwright (2014, Chapter 6), discussed Oregon as a model for the proposed system in England and Wales.

Lewis (2007) criticises academic enthusiasm for comparison between jurisdictions by considering the legislative approaches in Netherlands, England, Canada, France, Oregon, Belgium and Northern Territories of Australia. Her research on the failure of legalization through a rights-based claim

(Lewis (2007, Chapters 2 and 3)) is contrasted with the Netherlands approach of necessity and French proposals based on compassion as other routes towards legalization. The Benelux countries (comprising Belgium, the Netherlands and Luxembourg) all use the approach of necessity in their legislation: the Belgian 'Euthanasia Act May 28 2002', the Netherlands 'Termination of Life on Request and Assisted Suicide Act 2002' and the Luxembourg 'Law on Euthanasia and Assisted Suicide 16 March 2009'. The CoAD commissioned a briefing paper (Lewis and Black (2012)) which compared legal safeguards in the Netherlands, Belgium, Oregon and Switzerland.

Since 2012 Quebec has making attempts at legal reform. The legislative approach in Quebec described in *Quebec Dying with Dignity* (2012) was similar to the UK and used a Select Committee to collect information and consult the views of individuals and organisations. Their National Assembly Select Committee *Dying with Dignity* (the “Quebec Select Committee”) organised a mission to the Netherlands and to Belgium as well as desk research on Luxembourg, Switzerland and the United States. This was all reported in *Quebec Dying with Dignity* (2012, Appendix V) but progress in legal reform was too slow and failed when faced with an election in 2014. Following the election the National Assembly voted in favour of Quebec Bill 52 (2014) “An Act respecting end-of-life care” which included medical aid in dying. Bill 52 “prescribes the criteria that must be met for a person to obtain medical aid in dying and the requirements to be complied with before a physician may administer it”. This new legislation has impact beyond Quebec. On 6 February 2015 the Supreme Court of Canada in *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 ruled that the law prohibiting physician-assisted dying (for a competent adult suffering from a grievous and irremediable medical condition which is intolerable) contravenes the Canadian Charter of Rights and Freedoms. Canada has become the latest jurisdiction to allow assisted dying and the first to do so using rights-based arguments.

### 2.3.3 Gaps in the literature review

In spite of all these visits overseas and comparisons of selected jurisdictions the UK is no closer to legal reform. Describing the different jurisdictions is not difficult but the research problem is to then make useful comparisons between them and extend that comparison to generate proposals for new laws in England and Wales. There is a lot of comparison but not enough critical analysis and evaluation in the literature. It is a difficult challenge and some of the reasons will be suggested in Chapter 3. Combining the information in the literature review has provided an ordered list of the most popular jurisdictions for comparison : Oregon, Switzerland, the Netherlands and Belgium are the most frequently described and Oregon is the most researched.

# Chapter 3 : Methods and Techniques

## 3.1 Introduction

This chapter considers research methods and techniques and explores which are suitable for this research problem. One option for legal research is to use quantitative or qualitative research methods from the social sciences. These are useful for collecting data in a structured manner in order to evaluate the gap between the needs of society and the law. Where the law is already recognised as needing reform then the problem is focussed towards the detail of the best proposal for legal reform. It is that conflict between the problem (of the need for reform) and the identification of acceptable solutions which is the topic of this research and where comparative law and the method of comparative legal research is useful.

## 3.2 Selection of the methodology

The aim of the research is to make proposals for legal reform by considering the Assisted Dying (No 2) Bill 2015-16. This comparative critical evaluation of research methods is limited to research methods which might be valid for that research project. Quantitative and qualitative socio-legal research methods are compared with the method of comparative legal research which evaluates differences and similarities between different jurisdictions. The conclusion is that a comparison between jurisdictions is the chosen methodology and that this should be formalised by using a framework for comparative legal research. New Zealand is chosen as the comparator. This decision leads to the four research objectives listed in Section 1.4.2.

### 3.2.1 Socio-legal quantitative methods

Open University (2013, Chapter 9 p13) comments that the right to die is an area where the law and changing social institutions and attitudes are not closely aligned and it is asserted that “Socio-legal research is necessary to explore these issues empirically in order to formulate informed policy for legislation to bridge this uncertainty and restore public confidence in legal and medical processes”. The research method of socio-legal research is important because it considers both the impact of law on society and society's impact on the law. It can be part of an interdisciplinary approach which combines law, social policy and politics to show how law is happening in practice.

Socio-legal research methods use a range of methods and techniques including quantitative surveys by questionnaire and qualitative methods of observation. There is no standardised approach and this has both advantages and disadvantages. The advantage is that there are a broad spectrum of possibilities for carrying out research and rigorous analysis and robust argument can influence policy through presenting the representative views of society. The disadvantage is that good results depend on experience of using social science methods and it is possible to apply the wrong approach or apply a reasonable approach incorrectly. Proposals for legal reform described in Chapter 2 have all required the involvement of physicians and psychiatrists to check the eligibility of the patient who will be assisted to die and to ensure the legal administration of the lethal drug. The participation of physicians and psychiatrists in the assisted dying process is essential. Regular quantitative surveys about the views of medical professionals to assisted dying have been carried out by their professional organisations and these have contributed to the reports of the Select Committee on Assisted Dying for the Terminally Ill (2005) and the Commission on Assisted Dying

(DEMOS CoAD (2012)). Views of medical professionals can change with time. When new legislation is agreed by Parliament then it will be important to survey the views of medical professionals again in order to assess how many are willing to participate in the assisted dying process when they can no longer use the excuse that it is illegal. Meanwhile a useful academic analysis would be to evaluate and compare past surveys and use these results to show how the views of medical professional have changed and to make future predictions of their involvement in assisted dying.

### 3.2.2 Ethnography and observation

Ethnography is “the systematic study of everyday life and practice of a particular group or culture”. (Open University (2013, Chapter 7 p21)). The method is useful for observation of contributions to meetings where decisions are to be made and negotiations to agree the way forward are required. It is not necessary for the researcher to be present at the meetings but an accurate record of the discussions is essential. For new legislation in progress in either the House of Commons or House of Lords the contributions by members are available verbatim from Hansard and can often be seen live on television. Hansard is a good accurate record from which to draw conclusions and the television material can be watched over and over again. This research method is therefore useful to analyse the participation of those members of the House of Commons and the House of Lords who are contributing to current debates on the UK Assisted Dying (No 2) Bill 2015-16 and the UK Assisted Dying Bill [HL] 2015-16. It shows how policy is influenced and why policy decisions are made. Observation of the debates will identify the reasons members spoke against legal reform and provide suggestions for how a future bill should be modified.

### 3.2.3 Comparative legal research

Comparative legal research is not new. Modern comparative law begun in 1900 at the International Congress of Comparative Law held in Paris where the first attempts were made to formulate the functions and aims of comparative law (Ehrmann (1976, p15)). Zweigert and Kotz (1977, p2) defined it as “an intellectual activity with law as its object and comparison as its process”.

Bogdan (1994, p29) proposes transplanting ideas from other jurisdictions for creating new legislation: “Instead of guessing and risking less appropriate results, it would be better to use the enormous wealth of experience that is found in the foreign legal systems ... Perhaps another country has already tried something that is being considered for adoption in one's own country. What experience has been obtained ? Perhaps there are alternatives, maybe simpler and less expensive solutions, which in a foreign state have shown themselves to function well. “

De Cruz (2007, p20) states that comparative law aids law reform because “Statute law requires the English Law Commission to procure information from other legal systems whenever this is seen as facilitating the performance of its function of systematically developing and reforming the law”. Monateri (2012, p26) agrees that “the complexity of decision-making has heightened the importance of knowing how other jurisdictions have dealt with similar problems ... comparative methods have thus become a source of law.” Bussani and Mattei (2012) assert that “We can only claim to understand another legal system when we know the context...we must go beyond judicial decisions, doctrinal writings and the black-letter law of codes and statutes and probe the 'deeper structures' where law meets cultural, political, socio-economic factors.”

Comparative legal research is not easy and De Cruz (2007, p239) describes the main problems. The

first and most obvious are language and terminology. In spite of the Internet there is the problem of access to overseas information. Ideally the researcher should be fluent in the local languages or have access to good quality translation. Different legal systems also incorporate cultural differences and may be based on common law, civil law or religious law. This diversity of culture and language is highlighted in European law and the problems of harmonisation and standardisation. It is a challenge when comparing civil and common law jurisdictions. There is also a tendency to impose one's own legal conceptions and expectations on the systems being compared. Finally it is difficult to achieve true comparability between jurisdictions. It is much easier to contrast different jurisdictions without any analysis or critical evaluation. Awareness of the challenges of a comparative approach means that research not only identifies similarities but must also explore the reasons for differences.

## 3.3 Justification

### 3.3.1 Choice of methodology

The two socio-legal methods described in Section 3.1 are useful to research the views of the two key stakeholder groups involved in legal reform which are the medical professionals and the politicians but neither research method will generate ideas for new legislation to restore public confidence. New ideas can result from using a comparative approach to legal research which goes beyond the simple list of comparisons between jurisdictions. The distinction between comparisons and comparative legal research is important. Reitz (1998, p619) explains that “to claim the benefits of the comparative method, one cannot leave the act of comparison to the reader”. Comparative legal research can be used to identify alternative legislation in other jurisdictions and show whether other ideas can be transplanted from one jurisdiction to another. Selvalingam (2014) came to similar conclusions for her choice of methodology when she compared three methods: socio-legal approach, doctrinal research and comparative law. Her research focussed on legislation in the Northern Territories of Australia and in Oregon USA in order to provide recommendations for reform in England and Wales.

### 3.3.2 Choice of jurisdiction for comparison

The success of a comparative approach depends crucially on the choice of jurisdictions which are used for the comparisons. This can be a disadvantage if the wrong choice is made and after much research nothing useful has been learned. This research starts with England and Wales as one jurisdiction and the assumption that its legal system is well-known. It is essential to have sufficient knowledge of the alternative legal system or systems in order to make a valid comparison. Menski (2006 p67) warns “It requires extensive practical research in those countries, not just exotic trips to a leading university library or a brief discussion with some lawyers who may tell researchers what they want to hear”.

References to comparisons of different jurisdictions are included in the literature review in Chapter 2. Covering these same jurisdictions again would build on these comparisons but where there have been no significant changes to statutes or case law then there will be no significant new ideas. The choice of comparator here is deliberately different to those already described and is New Zealand. New Zealand was chosen from those countries which have English as the main language and a common law legal system which has historic linkages with the UK. It is a country I know well. My first official visit was in 1995 and I now spend 3 months there each year with access to library

facilities at the Victoria University of Wellington. Australia and Canada are also common law jurisdictions and could be used as comparators. They were not considered here because they have a mixed federal and regional system of legislation. In such a mixed system legal reform depends on the topic and Acts will be passed by Parliament or by provincial legislators. Monateri (2012, p31) mentioned the important influence of New Zealand “For some 30 years many important English cases have included detailed discussions of the case law of a number of the most influential common law jurisdictions, in particular Australia and New Zealand.” There are some differences between England and New Zealand. Husa (2015, p223) explains “There are features in the New Zealand system that differ from the common law because even at a reasonably early stage fairness as a kind of meta-principle of law rose to the level of the common law of English origin. It was considered as a more flexible aim that built on general principles more clearly than did the English common law as such.....In New Zealand courts have for a long time applied the principle of fairness and the common law in interaction. They are seen as complementary parallel systems with the common law having the upper hand.”

Direct comparison between two jurisdictions is not always easy and one useful method is that of the 'tertium comparationis' which translates as the third comparison (Smits (2012, p561)). The comparison is about using an ideal with common characteristics which can be described as a common denominator. Reitz (1998, p622) also describes it: “This imposing bit of jargon refers to nothing more than the common point of departure for the comparison”. Although not strictly a third comparison according to this definition, my research will also include comparison with the Death with Dignity Act (1997) in Oregon USA.

## 3.4 Research Procedures

### 3.4.1 How to do comparative legal research

Zweigert and Kotz (1998, Chapter 3) describe the traditional method of comparative law and explain that the established method of research is to compile reports on the different legal systems to be compared and then investigate the reasons for differences and similarities. Siems (2014, pp.14-27) describes the comparative method in four steps : preliminary description of the research question; description of the laws in the chosen countries; comparison which explores the reasons for similarities and differences; and critical evaluation leading to policy recommendations. Reitz (1998) also explains how to do comparative law beginning with the analysis of how the chosen legal systems are similar or different then finding the reasons and any gaps between the law in the statute books and the law in action which is applied in the courts. I agree with Reitz on the importance of researching beyond the law in the statute books and to look at cases and the commentary of scholars.

De Cruz (2007, Chapter 7) proposes a detailed framework for his comparative law methodology which was produced as a guide for his postgraduate students. His framework has eight Steps, numbered 1 to 8. Steps 1, 2, 3 and 4 are information gathering about the 'home' jurisdiction and the foreign jurisdiction. In my research the information about England and Wales is in Chapters 1 and 2. The information about New Zealand is in Chapter 4. Chapter 4 also includes Step 5 which organises the information to set out the differences and similarities between the two systems. This leads in Chapter 4 to the important Step 6 synthesis whereby ideas are brought together to identify possible answers to the problem and Step 7 which critically analyses the legal principles for future legal reform. Chapter 5 uses the remaining headings in Step 8 to set out the conclusions. The advantage of this staged approach to the technique of comparative law is that it is well-defined,

organised, structured and logical. It has also worked for other students.

### 3.4.2 Literature review of comparative law applied to assisted dying

The literature review in Chapter 2 has shown that there are many comparisons of the law in different jurisdictions. The Select Committee on Assisted Dying for the Terminally Ill (2005) and the Commission on Assisted Dying (DEMOS CoAD (2012)) have both assembled information from other jurisdictions which were then used to influence the drafting of the subsequent Bills. The dissertations of Mathieson (2013) and Selvalingam (2014) have looked beyond comparisons and have used the method of comparative legal research in order to make recommendations based on the similarities and differences between the law in different jurisdictions.

## 3.5 Ethical considerations

Some aspects of research on assisted dying would lead to ethical considerations. Any research which includes interviews or questionnaires must be conducted in an ethical manner and approval must be given by the Open University Ethics Committee. The relationship between the researcher and the participants must be clearly defined and the data used in a way which does not cause harm. Participants have rights concerning confidentiality and are able to withdraw from the project at any time. Collecting the views of politicians and medical professionals about changes to the law on assisted dying would require special ethical approval. Terminally ill and incurably ill people and their families are vulnerable and permission would be needed to make sure that any research which involves direct questioning of them is carried out in a sensitive and caring manner.

This research is desk-based comparative legal research and does not involve any direct contact with stakeholders and therefore does not require special ethical considerations.

# Chapter 4 - Analysis and Interpretation

## 4.1 Introduction

The legal situation in England and Wales comprising law, case law and attempts at legal reform has been described in Chapters 1 and 2. This Chapter describes the legislative process in New Zealand, their law on suicide and assisted dying, case law and attempts at legal reform. There is then a comparison between England and Wales and New Zealand which identifies their similarities and differences and then leads to recommendations for legal reform.

## 4.2 New Zealand information collection for comparative law

### 4.2.1 Collecting the information

The second jurisdiction of this comparative research is New Zealand. I have previously worked with officials from New Zealand on policy comparisons between the UK and New Zealand. Some researchers attempt to do policy research without visiting overseas but my experience in policy development is that spending time over many years immersed in the culture leads to a better understanding of the social, economic and political features. This experience was carried forward to desk research for my information collection which was carried out in New Zealand between January and March 2015. One benefit of visiting overseas is to find local publications and case law not available in legal search databases. Further research continued on LexisNexis and through visiting the New Zealand collection at the Oxford Law Library. This mixture of approaches to information collection is effective and used by other scholars. Selvalingam (2014) travelled to Australia to complete her research on assisted suicide and incorporated their ideas into her recommendations for legal reform in England and Wales.

### 4.2.2 Legislative process in New Zealand

Information about the system of government is published in New Zealand House of Representatives Parliament Briefs (2010a, 2010b and 2010c). Until 1950 the system of government was a smaller version of that in the UK with a Legislative Council as upper house and described as the Westminster model. The system is different now and there is only the House of Representatives. Since 1996 members are democratically elected using a system of mixed member proportional (MMP) representation so that there are elected local MPs and also MPs chosen to produce a balance of political parties. Without the delays involved with an upper house this means that Bills can be dealt with more quickly than in the UK and MMP delivers a balance of political views. As in the UK, each Bill has three readings where it is debated. After passing its first reading a Bill is referred to the most relevant of the 13 subject-specific committees. The Select Committee system is similar to that in the UK and includes examining Bills and assembling the views of organisations and people with an interest. A modified Bill is then debated at the second reading and if successful then a committee of the whole house considers the Bill in detail; it then proceeds to the third reading debate and vote.

The UK and New Zealand legislative systems converge with the Queen, represented in New Zealand by the Governor-General, giving the Royal Assent to sign a Bill into law. There has been no discussion of the personal views of the Queen about Physician Assisted Suicide and euthanasia and Royal Assent has always been a formality. There will be no conflict between the role of the Queen as Head of the Church of England which is against legal reform and her constitutional role.

### 4.2.3 New Zealand statutes

Suicide is not a crime in New Zealand but assisting suicide is a criminal offence. Assisting suicide is a crime prosecuted under the Crimes Act 1961. Section 179 of the Crimes Act 1961 states : “Every one is liable to imprisonment for a term not exceeding 14 years who – (a) incites, counsels, or procures any person to commit suicide, if that person commits or attempts to commit suicide in consequence thereof; or (b) aids or abets any person in the commission of suicide.” The crime of an unsuccessful suicide pact is covered separately, in Section 180, with a maximum sentence of 5 years imprisonment. For comparison, Section 2 of the Suicide Act 1961 was described in Chapter 1. The laws in England and New Zealand are similar with the same penalty. In *Seales v Attorney General* [2015] NZHC 12 [87] Justice Collins describes the differences in legislative origins:

“The legislative origins of the provisions of the Crimes Act 1961..... can be traced to the Criminal Code Act 1893. That statute was the product of a series of steps taken in England dating back to 1833 to codify that jurisdiction’s criminal law.... culminated in the appointment of the Criminal Code Commission in 1878 ..... The draft code which was developed is usually referred to as “Stephen’s Code”. Stephen’s Code was never adopted in England. As a consequence, the criminal law of England and Wales is an amalgam of common law and specific legislative provisions. Stephen’s Code was, however, adopted in New Zealand in 1893”.

In New Zealand the Criminal Justice Act 1985 and Section 411 of the Criminal Procedure Act 2011 set out the procedure for the conduct of criminal proceedings. It defines four categories of crimes. Category four is the most serious and includes murder and manslaughter with a jury trial in the High Court (in either Auckland, Wellington or Christchurch). As is seen in the discussion of case law in Section 4.2.4 if the suspect pleads guilty or is found guilty by the jury there is not always a conviction or imprisonment. Sentencing is determined by the Sentencing Act 2002 as well as considering sentences from similar crimes.

The conduct of criminal proceedings is different in England and Wales and Section 2(4) of the Suicide Act 1961 states that “no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions”. The DPP has personal control of whether to prosecute. This has the advantage of a standard opinion across all cases of assisted suicide, but reaching a decision takes time. The DPP is only in post for five years and there is the possibility of inconsistencies between different DPPs.

### 4.2.4 New Zealand case law

New Zealand case law from 1991 to 2014 shows the changes in sentencing policy for assisted suicide. There have been ten cases of assisted suicide prosecuted in New Zealand between 1991 and 2014 where the judgments were reported and had been used to influence future decisions and sentencing. These are : *R v Stead* (1991) 7 CRNZ 291 CA, *R v Ruscoe* (1992) 8 CRNZ 68 CA, *R v Karnon* (1999) HC Auckland S 14/99, *R v Simpson* (2001) HC Auckland T010609, *R v Law* (2002) 19 CRNZ 500, *R v Bell* (2002) HC Wanganui S011886, *R v Martin* (2005) BCL 224 CA

199/04, *R v Crutchley* (2007) HC Hamilton CRI-2007-069-83, *R v Davison* (2010) HC Dunedin CRI-2010-012-4876 and *R v Mott* (2012) HC Auckland NZHC 2366.

In *Stead* the defendant had deliberately killed his mother at her behest after her suicide attempt had failed. He had made several unsuccessful attempts to kill her before finally succeeding by stabbing. This case in 1991 applied the sanctity principle so that a custodial sentence was appropriate for aiding suicide or mercy killing, and the Court of Appeal confirmed the sentence of three and a half years imprisonment for manslaughter.

In *Ruscoe* the defendant had pleaded guilty to aiding and abetting suicide. The deceased was a tetraplegic in constant pain who had expressed a frequent desire to commit suicide and was a close friend. The offending was motivated by compassion. A sentence of one year's supervision was substituted for nine months' imprisonment.

In *Karnon* the defendant pleaded guilty to manslaughter over the death of his ill wife. He was sentenced to two years supervision.

In *Simpson* the defendant was convicted of the manslaughter of his mother who was suffering from bowel cancer and being treated at home. Dr Simpson used his medical kit to give two potentially lethal injections then tried to suffocate her. He finally strangled her. The charge of murder was reduced to manslaughter by the jury. Sentencing was 3 years imprisonment.

In *Law* the defendant, aged 77, killed his elderly wife. They had been married for 50 years. She was in the advanced stages of Alzheimer's disease. They had previously agreed to "do each other in" if either fell victim to Alzheimer's disease. He was sentenced to 18-month jail with the option of home detention and served 9 months in prison.

In *Bell* the defendant pleaded guilty to attempted murder. The defendant had known the victim for 15 years and visited her in hospital. She could not feed herself, could not talk, did not recognise people and was incontinent. The defendant took a pillow and unsuccessfully attempted to suffocate her. He was sentenced to 12 months imprisonment with no leave to apply for home detention.

In *Martin* the defendant, a registered nurse, was convicted of the attempted murder of her mother by injection of morphine while she was unconscious. The defendant had written and published a book (Martin (2002)) describing her actions, linking them to euthanasia. She was sentenced to 15 months' imprisonment and served 9 months. She wrote a second book about her experiences (Martin (2007)).

In *Crutchley* the defendant was found guilty of attempted murder of his mother who was dying from terminal cancer. She had inadequate palliative care and was denied further pain relief by rest home staff, and pleaded for help. In panic he overrode the medicating pump and emptied the complete dose of painkillers and she then lapsed into unconsciousness. Imprisonment should be imposed but the jury recommended mercy. In sentencing the court took account of his work and instead of four months home detention he was given six months community detention and 150 hours community work.

In *Davison* the defendant was charged with attempted murder but pleaded guilty to counselling and procuring the suicide of his terminally ill mother, a retired GP aged 85

years. He left his work and family in South Africa to be with his mother as she was dying. He saved morphine tablets which had been prescribed in order to give her an overdose. Although there was pre-meditation, he acted out of compassion and love and not for any personal gain. The starting point for sentencing was 21 to 24 months' imprisonment. The judge described the mitigating factors which were his good character, 20 per cent discount, and his guilty plea, 25 per cent discount. None of the previous judgments had given this arithmetic justification for reducing the sentence which resulted in an indicative sentence of 13 to 14 months' imprisonment. Instead 5 months home detention (in New Zealand) was imposed after which he returned to South Africa. He wrote a book about his experience (Davison (2013)).

In *Mott* the defendant pleaded guilty to assisting his wife to commit suicide. She was suffering from primary progressive multiple sclerosis and committed suicide using nitrogen gas while he was away. He admitted discussing how the equipment would work but did not provide direct assistance. Discharge without conviction was sought and agreed. In *Mott* the factors listed by the judge which influenced sentencing were: the defendant acted out of love; there was no personal gain; he was old and of good character and with no previous convictions; there was remorse and no appreciable risk of re-offending; the defendant was open and fully cooperative with Police and made an early plea of guilty.

These are individual cases but linked in a sequence in time and the courts were able to build their judgments on those of previous similar cases. Some general principles are clear from the court summaries and the sentencing. As time progresses the public view of euthanasia and assisted suicide in New Zealand has changed, as seen by the jury verdicts and their requests for leniency. Sentencing becomes lighter. The starting point in the Crimes Act 1961 is a maximum of 14 years which is then reduced down. The maximum sentencing is 3.5 years which is only one quarter of the maximum sentence. The doctor and nurse both earn imprisonment whereas children and spouses are treated with sympathy and compassion. Where there is imprisonment it is justified because of the sanctity principle with respect for human life, and for deterrence. Where a lighter sentence is made and imprisonment replaced by home detention or community service then it is not because of any features of the victim. Sentencing is about the defendant. *Mott* is an example where the defendant pleaded guilty but was discharged without conviction.

The judiciary in New Zealand does not seem to be limited by the lack of law, and is quoted (Steward, 2012) as “applying common sense” in the judgment of *Mott*. The examples in New Zealand of assisted dying or assisted suicide have become known when they reached the courts for prosecution after the event. In 2015 Lecretia Seales sought permissions in advance. She was a senior lawyer working in the Law Commission in Wellington and had a brain tumour and was terminally ill. She asked that her doctor be allowed to aid her by either administering a fatal drug (euthanasia) or provide a fatal drug to enable her to end her life by herself (assisted suicide). Judgment at the High Court in June 2015 (*Seales v Attorney General* [2015] NZHC 1239) was that her doctor would be prosecuted if she assisted suicide and that only Parliament can change the law. The UK and New Zealand have now reached the same opinion: the law needs to be changed and only Parliament can change the law.

## 4.2.5 Attempts at legal reform in New Zealand

Attempts to legalise voluntary euthanasia commenced in 1995 and were influenced by new legislation in Australia Northern Territories, the Rights of the Terminally Ill Act 1995 which was overturned in 1997, and the Oregon Death with Dignity Act 1994 (ODDA) which became law in

1997. The elected Government of New Zealand has not had a policy on euthanasia so legal reform was not government policy. Any euthanasia bill had to be drafted and proposed by an MP and submitted to the ballot as a Private Members Bill. The first Death with Dignity Bill 1995 (DWDB 1995) was introduced on 2 August 1995 by Michael Laws then MP for Hawkes Bay. He had held a referendum in his constituency in June 1995 which included asking their views on euthanasia. 79% voted “Yes” for euthanasia for the terminally ill who have given prior consent. He proposed in the DWDB 1995 that “This Bill is about giving an individual who may be terminally or incurably ill, or who has made an advanced directive (Living Will) should certain mental incapacity occur, the final and only choice about his or her life and death”. Two physicians and one psychiatrist would be involved and the request for assistance to die must be made in writing. The DWDB 1995 was defeated by 61/29 votes and did not proceed to the Select Committee stage. If it had eventually been approved by Parliament then it would not become law until after a national referendum.

The Death with Dignity Bill (2003) (DWDB 2003) was introduced into Parliament as a Private Members Bill by Peter Brown on 6 March 2003. The aim of the DWDB 2003 was “to legalise voluntary euthanasia under certain circumstances”. The purpose of the DWDB 2003 was stated: “to allow persons who are terminally and/or incurably ill the opportunity of requesting assistance from a medically qualified person to end their lives in a humane and dignified way and to provide for that to occur after medical confirmation, a psychiatric assessment, counselling and personal reflection”. On voting it was defeated by 60/58 and thus narrowly failed to proceed to Select Committee for detailed scrutiny and public debate.

The next and most recent attempt was the End of Life Choice Bill (2012) (ELCB 2012): “The purpose of this Bill is to provide individuals with a choice to end their lives and to receive medical assistance to die under certain circumstances”. ELCB 2012 limited eligibility to adult New Zealand citizens and residents who suffered from an unbearable and irreversible condition or were terminally ill with prognosis of less than 12 months; two physicians and a psychiatrist were involved and two written requests must be made for assistance to die. ELCB 2012 also proposed “end of life directives” to enable people to make a prior request for assisted dying while they were mentally competent. ELCB 2012 was withdrawn in September 2013 prior to the 2014 election. It therefore suffered the same timing problem as the UK Assisted Dying Bill [HL] 2014-15 which failed to progress because of the imminent election.

## 4.3 Analysis

### 4.3.1 Comparison of attempts at legal reform

The method of comparative legal research requires comparisons but does not specify how that should be done, only that there should be analysis of similarities and differences between the jurisdictions. The similarities and differences between the proposed legal reforms in the UK and New Zealand are compared in Table 4.1 below. My comparison includes the Oregon Death with Dignity Act, the UK Assisted Dying for the Terminally Ill Bill [HL] 2005, the UK Assisted Dying Bill [HL] 2014-15/Assisted Dying Bill [HL] 2015-16/Assisted Dying (No. 2) Bill 2015-16, the Policy of the UK DPP on assisted suicide 2014, the New Zealand Death with Dignity Bill (1995), the New Zealand Death with Dignity Bill (2003) and the New Zealand End of Life Choice Bill (2012).

	<u>Oregon Death with Dignity Act 1997</u>	<u>UK Assisted Dying for the Terminally Ill Bill 2005 [HL]</u>	<u>UK Assisted Dying Bill [HL] 2014-15 and Assisted Dying Bill [HL] 2015-16 Assisted Dying (No.2) Bill 2015-16</u>	<u>DPP Policy 2014 (Public interest checklist)</u>	<u>NZ Death with Dignity Bill 1995</u>	<u>NZ Death with Dignity Bill 2003</u>	<u>NZ End of Life Choice Bill 2012</u>
<u>Patient Eligibility</u>							
Terminally Ill	Yes, 6 months	Yes, 6 months	Yes, 6 months	No	Yes	Yes	Yes, 12 months
Incurably Ill	No	No	No	No	Yes	Yes	Yes
Pain, suffering distress	No	Yes		Recognises crucial importance of compassion		Yes	Irreversible condition which makes life unbearable
Competent	Yes	Yes	Yes, in accordance with Mental Capacity Act 2005	Yes, in accordance with Mental Capacity Act 2005	Yes	Yes	Yes or has registered End of Life Directive
Advanced Directive or Living Will					Yes, if brain disease or accident ( PVS)	Advanced Directive	End of Life Directive, refreshed every 5 years
Local Resident	Yes		Yes, one year	Yes, also includes deaths overseas			Citizen or resident
<u>Professional involvement</u>							
Attending physician	Two Oral and a written witnessed request. Second oral request after 15 days	Written, witnessed declaration	Written, witnessed, declaration, countersigned by attending doctor	Help prohibited if in their care	Written request	Written request, witnessed by 2 individuals	Yes
Consulting physician	Yes	Yes	Also countersigns declaration	No	Second opinion	Second opinion	Second opinion
Psychiatrist	Only if lacks capacity	Only if lacks capacity		No	Yes	Yes, provides written report	Yes
Counsellor/advisors	Compassion and Choices volunteers			Decision must be communicated.		Yes	Advisory
Judicial		One witness must be solicitor or public notary	In advance judicial oversight by Family Division of HC	DPP policy : intent and public interest			
Cooling off period for reflection	48 hours	14 days	14 days after declaration		48 hours	48 hours	7 days
<u>Method of deliverance</u>							
Oral drugs	Yes	Prescription provided	Delivered by attending doctor or other authorised health professional for immediate use		Yes	Prescription provided	Yes
Injection or PEG (gastric tube)		Doctor provides means for self-administration	Doctor provides means for self-administration		Yes	Yes, administered by doctor	Yes, by attending physician
Self-administered	Yes	Yes	Yes	Yes	Yes	Taken under supervision	Yes
Medically assisted	Doctor provides prescription only			No if cares for patient	Yes	Yes, on nominated day	Yes
Family/friend assisted				Yes if not beneficiaries	No	No	Yes, if delegated by attending physician
<u>Reporting</u>							
Data collection	Data is collected on prescriptions issued and people who commit suicide	Doctor sends documentation to Monitoring Commission		Publishes list of assisted suicides and judgements		Medical records sent to local Coroner	Register of End of Life Directives and Medically Assisted Deaths
Parliament oversight	Annual report by Oregon District Health Services	Secretary of State to publish report annually	Chief Medical Officer to monitor and report annually to Secretary of State and Parliament	CPS and DPP reports to Parliament		Coroners advise Attorney General who reports to Parliament	Review body to report to House of Representatives

TABLE 4.1 Comparison of Legal Reforms in England and Wales and New Zealand

The key feature of both the UK and New Zealand proposals for legal reform is that both were derived from the ODDA which states : “ [it] allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.” The ODDA is only about assisted suicide for the terminally ill and not about euthanasia and does not involve medical involvement beyond the provision of the prescription for the lethal drugs. The New Zealand ELCB 2012 is different and includes those who are not terminally ill and is about euthanasia. In England and Wales the Assisted Dying (No. 2) Bill 2015-16 is limited to the terminally ill and is about assisted suicide under medical supervision.

Comparative law requires deeper research into the reasons for these differences in approach and whether lessons can be learned. The line between assisting suicide and murder and manslaughter is a thin line. The need for safeguards explains why the series of Assisted Dying Bills in England and Wales described in Chapter 2 have become increasingly complex and the latest version proposes a framework of judicial oversight with three medical professionals and witnessed written declarations requesting medically assisted suicide and only allowing supervised self-ingestion of the drugs. My opinion is that simplification not complexity is needed and the ODDA is the simplest in Table 4.1. One important feature from the comparisons is that only the DPP policy advice does not require the patient/victim to be terminally or incurably ill. The latest proposal in the Assisted Dying (No. 2) Bill 2015-16 is that judicial permission for safeguarded assisted suicide should be given in advance and this removes the need for the cause of death to be verified after the event by looking at the evidence.

### 4.3.2 Comparisons of case law and links to eligibility

There are many reasons why an individual who is ill might consider requesting assisted dying. Some illnesses have a known progression with unpleasant end-of-life symptoms. Cancer and AIDS are two diseases where end-of-life care is usually in hospital or in a hospice. Motor Neuron Disease, of which the most famous living example is Professor Stephen Hawking, leads to the inability to talk, eat and breathe unaided. Multiple Sclerosis (MS) and the Permanent or Persistent Vegetative State (PVS) are serious illnesses but victims may not be terminally ill. Brain diseases including Alzheimer's and senile dementia mean that people become confused and lose memory. The old-old, which I define as over 85 years old, can be tired of life although not terminally ill. I have anecdotal evidence in that both my mother aged 97 and her elder sister aged 98 complained about wanting to die but were kept alive in hospitals and care homes. Assisted suicide could be an option for many people who are incurably ill or chronically ill or with no prospect of improvement or who just are tired of life and want to die. None of these are necessarily terminally ill and expected to die from an incurable illness within 6 months. So the ODDA and the Assisted Dying Bills in the UK do not deal with the actual problem which is dealing with those who are chronically ill or suffering unbearable conditions or just elderly, frail and suffering all the indignities of needing help with personal care.

Situation can be an important comparator and there are two aspects. Firstly in England and Wales there must be residence as part of eligibility in the Assisted Dying Bills. Secondly the DPP can pursue UK citizens for assisted suicide committed overseas and did so in the case of Daniel James (DPP, 2008). This potentially affects the rules for family, friends and doctors who assist travel to Switzerland to take advantage of their system for assisted suicide which permits overseas tourism.

The End of Life Choice Bill (2012) required New Zealand residence or citizenship whereas previous New Zealand Death with Dignity Bills did not. The Dignitas organisation produces statistics of numbers of assisted suicides since 1998 by nationality (Dignitas (2014a)) and states that there has been one assisted suicide at Dignitas of someone from New Zealand and 273 assisted

suicides from the UK. Dignitas also produces statistics of membership by nationality (Dignitas (2014b)) and there are currently 9 members from New Zealand and 828 members from the UK. Membership is a pre-requisite to asking for assisted suicide.

Location of the patient/victim is important too. There is a difference in whether he/she is at home or in a care home, hospice or hospital. Assisted suicide is more difficult in an institution where drugs are carefully monitored and sufficient amount for an overdose is hard to acquire and the culture of the organisation is that of trying hard to keep people alive. Lack of medical knowledge for the best drugs and the right dosage has resulted in several cases (*Stead, Simpson, Martin and Bell*) where a failed suicide by overdose was followed by other attempts at killing. The role of medical professionals is therefore important to ensure that if assisted suicide takes place then the patient/victim dies peacefully and with dignity.

The next step in data analysis is to identify to what extent the cases in the UK would have been eligible for assisted suicide if the Bill was already law. A similar analysis is done for case law in New Zealand. Assisted Dying Bills have become increasingly complex and the latest version proposes a framework of judicial oversight with three medical professionals and witnessed written declarations requesting medically assisted suicide and only allowing supervised self-ingestion of the drugs. Table 4.2 compares the decisions of the DPP on cases from 2008 to 2014 (CPS, 2015) where “the policy on Assisted Suicide has applied or in cases that are otherwise relevant”. Table 4.2 also includes other examples from Close and Cartwright (2014). Table 4.3 compares the case law on assisted suicide from 1991 to 2015 for New Zealand. The final column in both tables is headed “Assisted Dying Bill Eligibility”.

Date	Case or victim	Age	Disease	Terminally ill ?	Situation	Mental capacity	Self-administration	Outcome	Assisted Dying Bill Eligibility
2014	<i>R v Amelia Caller</i>	21			Amelia was friend of Emma Crossman who committed suicide		Yes. Suicide using equipment	DPP: Prosecuted but not guilty at Lincoln Crown Court	
2014	Dr and Mrs Arnold	60+	Both ill. Mrs Arnold had dementia	Yes	Daughter assisted joint suicide. Compassion	Yes		DPP: Evidence but not in the public interest to prosecute.	Yes, but dementia not eligible
2013	<i>Howe</i>	18+	Suicidal	No	Friend wanted to set fire to himself	No	Yes, after petrol and lighter were provided	DPP : Prosecuted and guilty of assisted attempted suicide	No
2013	<i>Nicklinson:</i> Tony Nicklinson	58	Locked-in syndrome	No	At home with wife	Yes	Died by refusing food and drink.	Sought permission for doctors help for voluntary euthanasia.	No
	Paul Lamb		Paralysed after car accident	No		Yes	Wanted to travel to Switzerland for suicide	DPP forced to modify assisted suicide policy document to explain what medical professionals are permitted to do	No
	AM also referred to as Martin	46	Paralysed after stroke	No	At home with wife	Yes	Wanted to travel to Switzerland for suicide		No
2011	Dr Ann McPherson	60+	Pancreatic cancer and secondaries	Yes	At home with GP support and family care	Yes	Died naturally – not suicide	Painful, hopeless, gasping death.	Yes
2010	Jane Hodge	91			Four people were with her when she committed suicide at home	Yes	Yes	DPP: No evidence that the people present assisted.	
2010	Caroline Loder	48	Multiple Sclerosis		Dr Elisabeth Wilson (aged 83) and two men were with her at her home			DPP: some evidence of assisting suicide but not in the public interest to prosecute.	
2010	Raymond Cutkelvin	58	Pancreatic cancer	Not at time of suicide	Accompanied to Switzerland by his civil partner, Dr Irwin and another friend	Yes	Died at Dignitas in 2007	DPP: evidence of assisting suicide but not in the public interest to prosecute	Yes, in due course
2010	Margaret Bateman	62	Chronic pain for decades	No	Husband cared for her at home		Death by inhaling gas at home	DPP: evidence of assisting suicide but not in the public interest to prosecute	
2010	Sir Edward and Lady Downes	85+ old	He was blind and deaf. She had terminal cancer.		Son assisted by organising the trip to Switzerland. Compassion		Died together at Dignitas	Suicide pact. First case applying Public Interest factors.	Yes for her. Not for him.
2010	<i>R v Gilderdale</i>	31	ME		Provided morphine to daughter for assisted suicide, then injected more drugs and introduced air embolism.		Yes. Morphine	DPP: prosecuted but then found Not Guilty of attempted murder	
2009	<i>Purdy</i>	45	Multiple Sclerosis		At home with husband			Sought clarity from DPP on policy for prosecution if went to Dignitas, Switzerland	Yes
2008	Daniel James	23	Paralysed	No. Incurable illness		Yes	Died at Dignitas, Switzerland		No
2004	Don Smith	60+	Terminal cancer	Yes	In hospice with home visits	Yes	Yes. Unsuccessful overdose then plastic bag in hospice and final sedation		Yes
2003	Neil Love	60+	Asperger's syndrome and brain cyst	Yes. Post-mortem found only months to live	At home with wife	Yes	Yes. Milk, drugs then plastic bag	Verdict of suicide.	Yes
2002	<i>Pretty</i>	43	Motor neurone disease	Terminally ill	At home with husband	Yes	Not suicide - died in hospice	Plea for permission for husband to help with assisted suicide.	Yes
1995	Barbara Smith	60+	Dementia	Incurable and tired of life.	At home with husband Don (who committed suicide in 2004)	No	Yes. Unsuccessful overdose then died of blood clot in hospital	Verdict of liver failure after paracetamol overdose	No

Table 4.2 Data Analysis – England and Wales

Date	Case	Age	Disease	Terminally ill ?	Situation	Mental capacity	Self-administration	Outcome	Assisted Dying Bill Eligibility
2015	<i>Seales</i>	42	Brain tumour	Yes	Bright lawyer in Wellington. Hospice care	Yes		Asked for doctor to be allowed to supply fatal drugs. Not allowed.	Yes
2012	<i>Mott</i>	60+	Multiple Sclerosis	Chronically ill	Wife at home. Husband assisted with equipment	Yes	Yes. Nitrogen gas	Pleaded guilty. Discharged without conviction	
2010	<i>Davison</i>	85	Terminal cancer – colon then secondaries	Yes	Mother retired GP living at home. Son lived in South Africa.	Yes	Yes, overdose	Pleaded guilty to counselling and procuring suicide. 5 months home detention in NZ	Yes
2007	<i>Crutchley</i>	60+	Terminal cancer	Yes	Mother in rest home	Maybe	No. He overrode the morphine pump.	Guilty of attempted murder. 6 months community detention and 150 hours community work	Yes
2005	<i>Martin</i>	60+	Bowel cancer	Yes	Mother at home under hospice care. Daughter was nurse	Maybe	No. Daughter injected morphine then tried suffocation.	Pleaded guilty to attempted murder. 15 months imprisonment	Yes
2002	<i>Bell</i>	18+	Undefined but unable to speak, eat, recognise people and incontinent	Maybe. Chronically ill	Friend. Victim in hospital	No	No. Attempted suffocation but friend survived	Pleaded guilty to attempted murder.	
2002	<i>Law</i>	60+	Alzheimer's	Chronically ill	Murdered wife, as he had promised her	Yes		18 months imprisonment and served 9 months	
2001	<i>Simpson</i>	60+	Bowel cancer	Yes	Mother at home. Son was doctor.		No. Injection, suffocation then strangling	Tried for murder and convicted of manslaughter. 3 years imprisonment	Yes
1999	<i>Karnon</i>		Ill	Maybe	Wife			Admitted manslaughter. 2 years supervision.	
1992	<i>Ruscoe</i>	18+	Tetraplegic in constant pain	Chronically ill	Close friend			Pleaded guilty to aiding and abetting suicide. One year supervision	
1991	<i>Stead</i>	Maybe 50+			Mother		No. Stabbing followed unsuccessful suicide attempt	3.5 years imprisonment for manslaughter	

Table 4.3 Data Analysis – New Zealand

Table 4.2 and Table 4.3 show a number of similarities and differences. The similarities are the range of illnesses which the patients/victims are suffering. Many of these illnesses are not considered to satisfy the definition of terminally ill with less than 6 months to live. The data for New Zealand is limited to those published situations where a prosecution has been made and the case has been considered by the appropriate Court. In England and Wales the role of the DPP to make the decision whether to prosecute and the publication of that decision means that there are many examples which are in the public domain but have not been prosecuted. All these examples are suitable for use to evaluate whether the proposed legal reforms in England and Wales are helpful. If the proposed new law does not reduce the decision making of the DPP or allow individuals who are contemplating suicide to be assisted by friends and family with medical support, then it has little practical merit. The final column in Table 4.2 shows that there are some suitable past cases of assisted suicide for which the victim/patient would be eligible for an attending doctor to prescribe drugs under the Assisted Dying (No.2) Bill 2015-16 if it had become law. However a bill which was similar to the End of Life Choice Bill (2012) would have included everyone listed in Table 4.2 and Table 4.3 because its scope was for the terminally ill, the incurably ill and made arrangements for those who were no longer mentally competent.

## 4.4 Linking to objectives and research aims

### 4.4.1 Data collection and analysis linking with research aim

The research aims and objectives from Section 1.4.2 specify in detail the four objectives which underpin the research aim. These include comparisons of the current law in (i), comparisons of the Bills put forward in England and Wales and New Zealand in (ii) and comparison of case law and incidents of assisted suicide in (iii). The data collection has been designed to match exactly the first three objectives and the analysis leads to the recommendations which satisfy objective (iv).

### 4.4.2 Using comparisons as part of the comparative method

Analysis of these results used the comparative law methodology referenced in Section 3.4.1 which uses the 8-Step framework of De Cruz (2007, pp 242-245). Step 4 has a useful check-list for gathering and assembling material from primary and secondary sources of law in the jurisdiction being examined. This check-list includes textbooks, bibliographies from current texts and law and socio-legal journals, material dealing with comparative law and the chosen topic area, and the important use of the Internet to find recent and supplementary material. Step 5 suggests the use of tables to organise the material and to identify similarities and differences. These research ideas have both proved very useful.

Step 6 looks at factors which may have influenced the current legal position and begins to map out the possible solutions to the problem addressing the question: how does the rule (of assisted dying) really operate in practice? Step 7 is a critical analysis of the legal principles and the practical effects of the rule. These influences and practical effects are seen in the analysis of the case law which justifies legal reform. The Assisted Dying (No. 2) Bill 2015-16 and the End of Life Choice Bill (2012) have many common features, as noted in Table 4.1, and the following recommendations are limited to features which are different and where ideas could be transplanted between jurisdictions.

### (a) The Title

The latest proposals in England and Wales have all been Assisted Dying Bills whereas in New Zealand their latest proposal was the End of Life Choice Bill.

Conclusions : Getting the right title is important because it is at the front of the bill and sets the tone for the text which follows. Assisted dying is not a good title because as described in Hansard (2014) and Hansard (2015) it has caused political controversy between whether it should be assisted dying or assisted suicide. The title “End of Life Choice” might suffer from the same arguments. The UK Government emphasis on end of life care for adults (NICE, 2013) matches the Quebec Bill 52 (2014) which has title “End of Life Care”. Although not a consequence of the comparison with New Zealand one proposal for future new legislation in England and Wales is for an End of Life Care Bill which includes assisted dying for the terminally ill.

### (b) Judicial Consent

The Assisted Dying (No. 2) Bill 2015-16 begins “Subject to the consent of the High Court (Family Division) .... a person who is terminally ill may request and lawfully be provided with assistance to end his or her own life.”

Conclusions : The Assisted Dying Bill [HL] 2013-14 did not propose judicial consent in advance so the suggestion in the Assisted Dying (No. 2) Bill 2015-16 is a very important change for two reasons. Firstly the problem with the DPP guidance (CPS, 2014a) is that it is only used after death and then it is impossible to discuss the reasons for assisted dying with the victim or be confident of the motives of the suspect(s). Permission in advance to carry out the process of assisted dying within an approved legal framework means that the family, friends and carers of the victim are not afraid of the risk of prosecution and doctors know that their assistance is permitted. Secondly in New Zealand the doctors would be trusted to carry out the rules of the proposed End of Life Choice Bill (2012) without judicial consent in advance whereas that is not true in England and Wales. Whether UK medical professionals do not want to participate in assisted dying because it is presently illegal or whether they really are against the idea in principle even if it becomes legal will have to be seen.

### (c) Patient/victim eligibility

The proposed eligibility rules in England and Wales are that the person must have mental capacity and be terminally ill with less than 6 months to live. The first step is to make a declaration requesting assisted dying which uses a standard form which is signed by a witness and countersigned by two doctors.

The New Zealand proposal is that the person makes a request in writing which is confirmed in writing 7 days or more later. Eligibility in New Zealand is that the person is terminally ill and has less than 12 months to live, or has an irreversible physical or mental condition that is unbearable. If the person has implemented a registered End of Life Directive then he or she does not need to be mentally competent at the time of requesting assisted dying. So the law could be used by people with Alzheimer's disease or dementia or other mental conditions if their End of Life Directive was written while still competent. The End of Life Directive is valid for 5 years then can be renewed if the person remains mentally competent.

Conclusions : (i) a standard form is better than a request in writing because the official administrative process will work better if the paperwork is standardised. Both countries have similar administrative processes and a common approach is more efficient.

(ii) The timescale for illness in the UK should be lengthened to allow assisted dying for people who are terminally ill and have less than 12 months to live. Doctors are not accurate when asked for prognosis for the terminally ill but in the UK they already accept the idea that 12 months is approaching the end of life (Section 1.1) and that is the same timescale proposed in NZ. The timescale also needs to be extended to allow for the extra time needed to find and fund legal representation to go to the High Court.

(iii) Only a small number of cases referred to the DPP and listed in Table 4.2 are for those who are terminally ill. In order to reduce the burden on the DPP to deal with cases where it is later decided not to prosecute because of public interest the criteria should be extended so that eligibility is for those who are terminally ill or have an irreversible physical condition that is unbearable. In order to take account of the concerns of the disabled it must be made very clear that to be eligible does not mean that there is a duty to have assisted dying.

(iv) More research and debate is needed to consider whether those who are mentally competent but whose mental capacity is deteriorating irreversibly should be allowed to make an End of Life Directive similar to that proposed in NZ. Assisted dying for those who are no longer mentally competent is a more difficult concept for UK politicians and none of the Assisted Dying Bills have proposed this extension to eligibility.

#### (d) Assistance from medical professionals

Both proposals are based on the participation of two registered medical practitioners.

In England and Wales the “attending doctor” may delegate delivery of the lethal drugs to an “assisting health professional” who may be either a doctor or a nurse. There is a distinction in the New Zealand proposal so that medical procedures (injections etc.) must be performed by a doctor; oral ingestion can be delegated as in UK.

Conclusions: both jurisdictions have limited the assistance to health professionals who are medical professionals or registered nurses. There are good reasons for having someone with medical experience close at hand so that if the initial lethal dose does not work then there is expert help to deal with the situation. In Oregon the victim is given the prescription for the lethal drugs and then takes them without supervision which seems a mistake because of the risks of failure and there is also the risk of dangerous drugs unsecured for long periods in private houses. The possibility that the health professional is available in an adjacent room so that the family and friends can offer comfort at the moment of death is a compassionate proposal.

#### (e) Reporting

Conclusions: Different reporting and review processes are included in the two jurisdictions and that demonstrates the different approaches in the two countries. The common features are that all instances of assisted dying must be reported to a central administration which is responsible for publishing statistics annually. In the UK that has to be done separately in England and Wales and then aggregated.

### 4.4.3 Conclusions of using the comparative method

The comparative law methodology has provided an excellent framework within which different jurisdictions can be compared and the comparisons between England and Wales and New Zealand

have been interesting and relevant. In De Cruz (2007, p 245) Step 8 of his comparative law methodology addresses the question “What does this mean for the future development of this area of law in the context of the legal development of this topic, in this particular jurisdiction?” It has been difficult to capture the similarities and differences between the two jurisdictions for the topic of assisted dying because the proposals for legal reform are changing quickly. During the collection of information for this research there have been two Assisted Dying Bills in the House of Lords and a new Assisted Dying (No. 2) Bill in the House of Commons and renewed media discussion in New Zealand about the End of Life Choice Bill (2012) as a consequence of the judgment in *Seales*.

When immersed in my research I did not expect there to be a debate on assisted dying in the House of Commons so soon after the election. On 11 September 2015 the House of Commons rejected the Assisted Dying (No.2) Bill 2015-16. Over half of the elected membership of 650 voted against the Bill with many concerns (Hansard (2015)) about the lack of safeguards and the risks of the slippery slope to euthanasia and possible coercion of disabled and vulnerable people. Much more work will need to be done to satisfy these concerns if a bill is to be proposed in the future. Many members had personal stories about death and dying and they had all been lobbied by religious groups, local hospices and medical professionals; Paul Flynn (Hansard (2015, col 687)) read a moving letter from a member of his constituency, Sir Edward Leigh (Hansard (2015, col 687-688)) spoke about the need for 'natural dying' and palliative care, Lucy Allen (Hansard (2015, col712)) asserted that “A vote against the Bill will not stop assisted dying, it will simply send the message that we in Parliament will not debate the issue further”.

In England and Wales there are now two distinct options for future development of the topic: the first is that there will be continued efforts by the minority in Parliament to propose and debate changes to the legislation; the second is that the emphasis changes to address the inadequacies in the published policy of the DPP for assisted suicide.

# Chapter 5 : Conclusions

## 5.1 Introduction

The main aim of the research was to make proposals for legal reform and this has been achieved through the use of the comparative method which compared England and Wales with New Zealand. As part of that analysis the similarities and differences between the two jurisdictions were evaluated. There are already conclusions in Sections 4.4.1 and 4.4.3 about the success of the comparative law methodology and the framework which was used for the practical comparative work. These conclusions linked together the results from the analysis in Chapter 4 with the research aim and objectives and led to recommendations for changes to the Assisted Dying (No. 2) Bill 2015-16 in Section 4.4.2. These recommendations and the reasons for them will be forwarded into the policy-making process by sending copies of this dissertation to the House of Commons library and the VUW Law library in Wellington and emailing those academics whose work has influenced the analysis and conclusions. My extensive bibliography will be useful for legislators and academics who need to learn more about the situation in England and Wales and New Zealand.

## 5.2 Further work

The comparison of two jurisdictions where neither have achieved legal reform and both face similar challenges did allow the similarities and differences to be identified. Recommendations were made for small changes by transplanting ideas from one jurisdiction to the other. It has been useful to look at other jurisdictions even if there has been only limited success in identifying practical new ideas. The problem with using New Zealand as comparator is that they are no closer to legal reform than England and Wales. I was disappointed there were so few new ideas from the comparisons with New Zealand. For both jurisdictions the political issue is whether to legislate or not on a topic where there is no government policy. The major problem is whether new legislation should be for assisted dying or for euthanasia. Further work is needed to monitor future case law and judicial decisions for both jurisdictions. This will update the evaluation of the gap between the law and the actions of dying patients and their family.

More comparative legal research needs to be done with other common law jurisdictions. It is proposed that a similar project of comparative legal research should evaluate and update published research on the jurisdictions of Canada and Australia and this will include discussions with influential academics and policy makers. The research can then be used to extend the analysis in Chapter 4 which compared England and Wales and New Zealand. The tables used for comparison of the statutes in Table 4.1 and for the comparison of the case law in Table 4.2 and Table 4.3 are easily adapted to incorporate data from other jurisdictions. As described in Section 2.3.2 Canada is close to implementing new legislation. The title of the legislation in Quebec is “end of life care” and this gives an important distinction in philosophy from the conflict on terminology in England and Wales about whether it is assisted dying or assisted suicide. It is more difficult to criticise new Government proposals for end of life care than it is to resist the idea of a slippery slope of assisted dying which potentially leads to euthanasia. Selvalingam (2014) transplanted ideas from the ROTTI (1995) in Australia in her recommendations for legal reform. Unfortunately she did not foresee the debate in the House of Lords which insisted that prior judicial consent to assisted dying should be incorporated into the Assisted Dying Bill [HL] 2015-16.

As described in Section 2.2.1 and from Hansard (2015) the votes to reject the Assisted Dying (No. 2) Bill 2015-16 were based on MPs personal experience and letters from members of their constituencies. In contrast the organisations and individuals who are enthusiastic for legal reform repeatedly assert from the results of independent surveys that a large proportion of the population is in favour of an Assisted Dying Bill. Is this really true or does Parliament represent the views of the electorate ? Only a referendum would give the answer but that is very unlikely to take place in the current Parliament. There is justification for more research to include a quantitative analysis of existing surveys of views of people to identify the extent to which the views of the electorate are really changing. This may identify a gap in the scope of existing surveys and more thorough survey work will then need to be done.

## 5.3 Implications of the research

This research has captured the latest information about the legal situation in England and Wales on assisted dying and assisted suicide and has added new comparative research to influence future debates in both England and Wales and New Zealand. Much more research needs to be done to understand the reasons behind the failure to legislate in England and Wales and how the wording of the Assisted Dying (No. 2) Bill 2015-16 needs to be changed to address the concerns of Parliament. The current research assumed that there should be legal reform in England and Wales as has been requested by the House of Lords in *Purdy* and by the Supreme Court in *Nicklinson*. This assumption was wrong and solving the decision-making problems of the judiciary when presented with cases of assisted dying or assisted suicide is not a priority for Parliament. Parliament showed that it was much more interested in the views of medical professionals and of those constituency members who made the effort to write or email with their views.

It is the responsibility of Parliament on behalf of the electorate to debate the issue and then vote in favour or against legislation which would allow assisted dying. Parliament is able to decide that the law should not be changed and has done so with an enormous majority vote. This policy decision must be respected, at least until the next election when the climate for change may be different.

My personal opinion has changed during the research for this dissertation. I now appreciate the alternative view about end-of-life care which Sir Edward Leigh proposed (Hansard (2015, column 688)) :

“ we do not need an assisted suicide or an assisted dying Bill; we need a movement for natural dying. We have to come to terms with death as a society and recognise that it is a journey we are all going to take. We have to promote the hospice movement and palliative care, put much more resources into them and be honest with people that increasingly intrusive, difficult, painful operations and medications may not be the way.”

Written 27 September 2015

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