COMMENTARY ON THE TERMINALLY ILL ADULTS (END OF LIFE) BILL

The following analysis was largely prepared by a member of the CMA who is a retired Consultant physician with legal qualifications. This analysis is a commentary on the Private Members Bill of Ms Kim Leadbeater MBE MP which is currently before Parliament and passed the Second Reading on 29 November 2024 by 330 votes to 275. It was approved by the CMA council on 18 January 2025.

This analysis is a commentary of the Bill as presented to Parliament and is likely to undergo changes before the third reading. It does not constitute legal advice but will hopefully help to explain how the practice of medicine would change if the Leadbeater Bill became law.

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17.01.2025

THE TERMINALLY ILL ADULTS (END OF LIFE) BILL

Purpose of the Terminally Ill Adults (End of Life) Bill

The purpose of the Bill is *"to allow adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own life."*

The Bill concerns the deliberate and intentional killing of those considered to be within 6 months of natural death at their request. The means of killing is through assisted suicide. The issues raised are of considerable medical and judicial importance. Whilst the debate assumes that assisted suicide would only occur out of compassion for the dying, compassion is not mentioned in the Bill and the intentions of those assisting the suicide of patients is not considered specifically.

Not all crimes should be punished

There is a distinction between what should be regarded in primary statute as criminal activity and whether all crimes should be penalised through the courts. Not all crimes are punishable, or should be punished. The Crown Prosecution Service (CPS) has to determine whether to proceed with prosecution. In so deciding, the CPS considers both the available evidence and the public interest in pursuing a prosecution. The position of an isolated instance of a relative assisting in the suicide of a family member

who is unlikely to repeat such an activity, is different to the position of a healthcare professional who might be involved in hundreds of deaths within the health service. Indeed, there have been few prosecutions of family members involved in assisted suicide. Paradoxically, the Leadbeater Bill would continue to penalise relatives who assisted anyone to go to Dignitas in Switzerland for an assisted death. Such assistance would be clear evidence of trying to influence a patient to take their own life.

Instigation of a prosecution for assisted suicide

Whilst the definition of what constitutes a crime is a matter of statute law, the issue of bringing a prosecution in particular cases rests upon two central considerations. First, is there sufficient evidence to bring a prosecution and second, whether it is in the public interest.[i]

Prosecutors must apply the principles of the European Convention on Human Rights, in accordance with the Human Rights Act 1998, which include Article 2, the Right to Life.

Parliament has decided that a limited number of offences should only be taken to court with the agreement of the DPP. These are called consent cases. In such cases the DPP, or a prosecutor acting on their behalf, applies the Code in deciding whether to give consent to a prosecution.

In deciding whether there is sufficient evidence for prosecution, questions may arise concerning the type of evidence and whether it is admissible, sufficient, credible and reliable.

In considering the public interest, prosecutors should consider the seriousness of the offence and the level of culpability of the suspect. Culpability is likely to include issues around the persons involvement, premeditation, personal benefit from the conduct, the chances of repetition and the age and circumstances of the suspect including whether there was undue pressure and the risk of repetition and the vulnerability of the victim.

Prosecution is more likely if the victim was vulnerable or where the perpetrator was in a position of trust or authority or serving the public. The seriousness of the offence and its effect on the public should also be considered.

Fundamental right to life: Article 2 of the European Convention on Human Rights and the Human Rights Act 1998.

The fundamental right to life is the foundation of all other rights and without which no other right would be meaningful. If there is no right to life there is no right to any other right. The right to life is inherent by virtue of our human nature and existence and can neither be conferred nor denied by others

The six underlying foundational principles within the Declaration of Human Rights and subsequent Conventions have been described as inclusion, inherency, equality, inalienability, indivisibility and universality.

Inclusivity means that the rights refer to "everyone" and "every person" without discrimination. The rights are inherent to all living human beings by virtue of their humanity and membership of the human family. They are not conferred rights that are granted by external government. Inalienability refers to rights that cannot be removed, destroyed, transferred or renounced even by the individuals themselves, their parents or Society. Equality means that no human beings are "more equal" than others but that everyone has equal rights as members of the human family. "The notion of equality springs from the oneness of the human family and is linked to the essential dignity of the individual."[ii] Human rights cannot be predicated on the view that certain individuals are either superior or inferior to others. The act of being born does not confer rights, but rather the fact of being human. The rights are indivisible and cannot be sacrificed or denied in order to enhance the rights of others. No individual or Institution should be required to be complicit in acts that are against their right to conscience and declared mission. Finally, human rights are universal to be upheld everywhere and at all times irrespective of culture.

The inalienable rights of all human beings are respected by the World Medical Association. These fundamental human rights are inherent and derive from our human nature and membership of the human family and must be recognised and protected through the rule of law and professional codes of medical ethics.

Changes to the law on homicide.

The Bill seeks to decriminalise assisted suicide when performed by healthcare professionals, with the support of the judiciary.

Changes to the law on homicide are both difficult and rare as the right to life is regarded as sacrosanct. This is particularly true when the target population are seen to be frail, elderly, vulnerable or disabled without a voice for themselves either individually or collectively.

Capital punishment was effectively abolished by the Murder (Abolition of the Death Penalty) Act 1965 under the Labour Government and Prime Minister Harold Wilson. The last two executions had been authorised by the Conservative Home Secretary, Henry Brooke MP, in August 1964. In 1965 it was accepted that the State should not be involved in the direct taking of human life. The emphasis has now shifted from guilty criminals to innocent patients. The doctor who is able to cure, can also kill. It is perhaps ironic that the move towards assisted suicide has been sponsored by Lord

Falconer, past Lord Chancellor under Tony Blair, and is being reintroduced by Ms Kim Leadbeater shortly after the new Labour Government came into power under the new Prime Minister Sir Keir Starmer KC.

Suicide ceased to be a criminal offence with the passage of the Suicide Act in 1961. However assisting a suicide remains a criminal offence. Under section 2(1): "*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 or indictment to imprisonment for a term not exceeding fourteen years.*"

The Hippocratic Tradition

The prohibition of both active euthanasia and assisted suicide is embodied within the Hippocratic tradition and Oath:

"I shall give no deadly drug to any, nor will I counsel such."

Both euthanasia and assisted suicide involve the deliberate killing of patients. Doctors are responsible ethically and legally for the prescriptions they provide for patients. It would be no defence in negligence if the wrong drug or dose has been given to state that the doctor is not responsible because the patient self-administered the medication by ingestion and should have known what they were doing. To allow assisted suicide is to cross the Rubicon regarding the fundamental ethics of Medicine. It would also cross the Rubicon for lawyers, as High Court Judges will be required to give their "consent" and authorise the deliberate killing of the patient.

CLAUSE 1. ASSISTED DYING

A terminally ill person who—

(1) (a) has the capacity to make a decision to end their own life (see section 3),

(b) is aged 18 or over at the time the person makes a first declaration (see section 5),

(c) is ordinarily resident in England and Wales and has been so resident for at least 12 months ending with the date of the first declaration, and

(d) is registered as a patient with a general medical practice in England or Wales, may, on request, be provided with assistance to end their own life in accordance with sections 5 to 22.

(2) Sections 5 to 22, in particular, require steps to be taken to establish that the person—

(a) has a clear, settled and informed wish to end their own life, and

(b) has made the decision that they wish to end their own life voluntarily and has not been coerced or pressured by any other person into making it.

The term "assisted dying" is somewhat ambiguous. It is used as the header to Section 1, but is not specifically defined. Assisted dying is defined indirectly in the Bill as when

a patient h*as* “assistance to end their own life.*”* Would palliative medical treatment or a surgical procedure aimed at reducing pain, but which nevertheless led to the death of the patient, be classified as “assisted dying”? Would an unintended death arising from a palliative procedure or treatment be classified as “assisted dying.”? When the issues are debated many people consider palliative care as a form of assisted (or assistance in) dying.

When used colloquially it would include bona vide palliative care to relieve suffering. This is one of the core purposes of medicine which are – to cure where possible, to treat diseases, to alleviate suffering and to restore mental physical and spiritual function and wellbeing.

“Wheresoever I shall go and whosoever’s house I shall enter, there will I go for the benefit of the sick, refraining from any act of wrongdoing.” (Hippocratic Oath)

Cecily Saunders noted that those who are dying still have a lot of living to do and wished that palliative care would enable patients to live up to the point of their natural death. “You matter because you are you. You matter to the last moment of your life, and we will do all we can to help you not only to die peacefully, but to live until you die.”

During the final phase of their lives, patients may not only come to terms with the profound existential problems of their own death, but also help their loved ones to come to terms with their bereavement, even before death has occurred. We must all die and we are all confronted with this existential issue in our lives and must reflect on the meaning and significance of our lives, particularly when they are drawing to a close.

Consent.

Under section 1 (2)(a), the consent of the patient to end their own life must be a “a clear, settled and informed wish to end their own life” and under s 1(2)(b) it must be voluntary. This voluntary, clear, settled and informed wish must be agreed in the High Court under section 12.

The issue of consent is considered below in relation to mental capacity and making a free and uncoerced decision.

Decision to commit suicide.

The decision to commit suicide is familiar to psychiatrists, general physicians and emergency care doctors since attempted suicide is a common reason for hospital admission. The majority of drug overdoses and cases of deliberate self-harm are not regarded as genuine suicide attempts and are called para-suicides. A much smaller proportion are genuine suicide attempts. What is new is that healthcare professionals will be asked to be involved in the actual suicide.

The decision to commit suicide is complex, is often prolonged and usually involves patients with mental health problems including severe depression. It is difficult to understand that the law will simply assume that the patient will simply have made a "voluntary, clear, settled and informed wish" to commit assisted suicide. Those who survive a suicide or para-suicide attempt are referred for a psychiatric assessment and support. Assisted suicide under the Bill will encourage an independent doctor to give advice and provide help and assistance for a further suicide, rather than restoring mental health and wellbeing.

The four aspects of consent under section1 (2)(a& b).

Voluntary. The decision must be that of the patient and be their choice. It is unclear how this will apply to the vulnerable, depressed, socially isolated or disabled. Several studies have shown that a desire to die per se is not the top priority for those applying for assisted suicide. Paradoxically, a loss of autonomy and the ability to make decisions is often cited as one of the main reasons. Independent doctors, who are not usually involved in the routine care of the patient, will not be aware of the patient's wishes apart from what the patient has told them during their consultations.

Will consultations take place alone with the patient, or will family members be able to assist and support the patient? Will they be recorded for those who cannot attend but have been involved in the care of the patients? What evidence, if any, will be available when there are probate issues arising from the death and relatives and potential beneficiaries of the Will argue that the decision to end their lives was not voluntary? Probate issues are discussed below.

Clear. What normally establishes whether there has been clarity of decision-making in clinical practice is having a systematic approach and proper documentation of the issues discussed and how they were dealt with. For serious medical treatment, this usually involves a Multidisciplinary Team meeting (MDT meeting) so that this is not the decision of a single doctor acting in isolation. Proof of clarity in subsequent proceedings, including probate issues, is likely to require that the "independent" doctors explain and justify their actions and involvement in the case. Will the doctors be required to see the patient only once, or several times, to confirm the clarity of a voluntary and fixed decision? In palliative care, the views of the paitent are often complex and may change over time. The separation of the "independent" doctor from the "attending" doctor who is likely to be more familiar with the needs and wishes of the patient, is expressly required in the Bill.

Settled. A decision to engage in suicide is an irreversible step for anyone. It is final and cannot (usually) be reversed unless the suicide attempt fails. Where this is the case, patients often regret the decision and do not usually make a further suicide attempt.

The Centre for Disease Control in America showed that there were 49,475 deaths from suicide in 2022 out of an estimated 13.2 million adults who had seriously considered suicide. There were 3.8 million planned attempts and 1.6 million attempted suicides. Hence, actual suicides are the tip of the iceberg. In the USA for every suicide death, there were about:[iii]

- 11 emergency department visits for self-harm
- 52 self-reported suicide attempts in the past year
- 336 people who seriously considered suicide in the past year.

The Bill does not define what is meant by a settled decision to engage in assisted suicide. The demographic data above clearly show that many more patients give serious consideration to committing suicide than those who actually commit suicide. All those seeing an "independent" doctor would necessarily fall into the category of patients who were considering suicide. How would the doctor be able to determine that the decision was definitive and irreversible? The only finality is when the patient dies through suicide. A failed attempt is unlikely to be repeated.

Informed. This is not defined in the Bill. Must it include counselling and information as to the support available? Would simple signposting to suicide help groups be sufficient, or not? Would the information only apply to the individual patient, or include their families and friends who would lose a loved one? How would the "independent" doctor decide whether friends and family were trying to help and assist the patient to prevent a suicide, or actually encouraging assisted suicide? Does the "information" only apply to the patient or would it extend in a broader context to the information, help and support available to the family and other carers? Would the provision of information be satisfied simply by notification or the "signposting" of help that was available e.g. through the Samaritans, or would there need to be some actual contact with these support services?

Would the need to satisfy the requirements to inform the patient of palliative care include telling the patient that there is insufficient palliative care available or there is a lack of appropriate Hospice care? Would a patent be informed if there were insufficient medical and social care services available?

Specific aspects of the person's declaration

An application to the High Court may be made after the patient ('person') has made a declaration for assisted suicide in the presence of an independent witness who must not benefit either directly or indirectly from the patient's death. The person's declaration must also be countersigned by the attending doctor and an independent doctor.

Independent witness

The declaration must be in the presence of a witness. Is the witness a witness of fact or must the witness also be satisfied that there has been no coercion or undue influence? Whilst the Bill states that the witness must be independent and not likely to benefit from the person's death, how will this be determined? What if the person was unaware that they were at the time or were later to become a beneficiary of the person's Will? What, if any, would be the restrictions on the witness to telling other people of the declaration, e.g. other family members who might benefit from the person's will?

CLAUSE 2 TERMINAL ILLNESS

For the purposes of this Act, a person is terminally ill if—

(1) (a) the person has an inevitably progressive illness, disease or medical condition which cannot be reversed by treatment, and
(b) the person's death in consequence of that illness, disease or medical condition can reasonably be expected within 6 months.

(2) For the purposes of subsection (1), treatment which only relieves the symptoms of an inevitably progressive illness, disease or medical condition temporarily is not to be regarded as treatment which can reverse that illness, disease or condition.

(3) For the avoidance of doubt, a person is not to be considered to be terminally ill by reason only of the person having one or both of—

(a) a mental disorder, within the meaning of the Mental Health Act 1983;

(b) a disability, within the meaning of section 6 of the Equality Act 2010.

Diagnosis of terminal illness.

The criteria for deciding if a patient has a terminal illness is that the condition must be progressive, cannot be reversed by treatment and is reasonably expected that the patient will die within six months.

It is not clear as to whether the prognosis of six months treatment is with or without treatment, even if the condition cannot be reversed. Hence, insulin dependent diabetes is a progressive condition which is likely to lead to death within a short period if insulin is withdrawn. The term "reversed by treatment" is ambiguous. Insulin will alleviate symptoms and prevent death of an underlying condition which remains progressive, although the rate of progression can be significantly reduced by adequate insulin treatment. Similar considerations would apply to heart failure and other conditions which are not normally regarded as imminently life threatening unless treatment is withdrawn.

Whilst it is often argued that assisted suicide is required to prevent patients dying with uncontrolled symptoms of their underlying disease, Section 2 (2) considers that a condition may be terminal even when the symptoms are controlled. In other words the Bill is concerned with the terminal nature rather than the symptoms of the illness in addressing assisted suicide.

A condition is not terminal ”solely” by reason of a mental illness, as defined under the Mental Health Act 1983, or by reason of a disability under section 6 of the Equality Act 2010.

Section 1 (2) of the Mental Health Act 1983 defines mental disorder (not mental illness)[iv] as “any disorder or disability of the mind.” Whilst the Bill does not accept that a condition is terminal “solely” by virtue of a mental illness (disorder under the Mental Health Act 1983), it is clear that severe depression is a mental disorder which may lead to death through suicide. Indeed, the Bill would bring forward the death of patients to within 6 months.

Section 6 (1) A of the Equalities Act 2010 states:

(1) A person (P) has a disability if—
- *(a) P has a physical or mental impairment, and*
- *(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.*

According to the Bill, a person with a mental disorder or a disability will not be considered as terminally ill “solely” because of a mental disorder i.e. a disorder or disability of the mind or a disability which has a substantial effect on the patient’s ability to carry out normal activities. Debates in the media have repeatedly called for assisted suicide in those with long term disability and painful conditions. These could be long-term and irreversible. If untreated they might lead to death within 6 months. Paradoxically, assisted suicide could bring about death in a matter of weeks under this Bill.

However, under section 13 (1) of the Equalities Act, direct discrimination occurs where:

“A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others.”

Under the Bill, a person would not be considered terminally ill “solely” on the basis of a mental disorder or disability. However, it would nevertheless be unlawful under the Equalities Act to treat such a person differently from others. Clearly, assisted suicide which caused the death of the person, would unquestionably be a less favourable treatment than for those without the particular disability or mental disorder.

It is therefore very difficult, if not impossible to understand how assisted suicide, reserved for those who are terminally ill would not be discriminatory. In other words,

the Bill accepts that those who are seriously ill may be deliberately killed though assisted suicide, whereas it would still be murder to bring about the death of otherwise healthy persons.

The diagnosis of a terminal illness, unless the patient is imminently dying, is difficult. The main difficulty will be in deciding if the patient had a terminal illness after they have died. Section 2 (1) requires that the diagnosis is made by a registered medical practitioner of *"an inevitably progressive condition which cannot be reversed by treatment"* and is *"reasonably expected to die within six months."* It is not clear as to whether *"irreversibility"* refers to the natural history of the underlying condition itself if left untreated. Clearly, a patient could have a chance of surviving less than 6 months if they refused treatment when they might otherwise live for years with appropriate treatment. Would the underlying condition cease to be irreversible if treatment can reverse the underlying condition? There is no doubt that various forms of cancer treatment, chemotherapy, radiotherapy, surgery can cure cancer. However, this is not always the case and the effects of cancer treatment cannot be determined from overall group statistics in individual cases. Hence, some patients will unexpectedly survive as a result of treatment whilst others who were thought to have a good prognosis, fail to survive. A five-year survival after treatment for some cancers is regarded as a "cure" i.e. that treatment has altered what might otherwise be regarded as a progressive condition. It is therefore difficult to define a reasonable expectation of a six-month prognosis or whether the treatment will cause an irreversible change in the underlying condition. Does irreversible change mean that there cannot be a relapse in the condition, even years later, following apparently successful treatment?

According to the Bill, treatment which *"only relieves the symptoms"* is not *"to be regarded as treatment that can reverse the condition."*

Two of the most important certified causes of death today are frailty and dementia, which are currently progressive conditions without long-term effective treatment. Are frailty and dementia terminal conditions under the Bill? It has important physical implication as well as mental changes, although in the early stages of dementia, patients may retain mental capacity.

The British Geriatrics Society published a paper in May 2020 entitled *"End of Life Care in Frailty: Identification and prognostication."* Frailty is an important and necessary consideration in care of Elderly and Palliative Care. *"Proximity to death, rather than age, is the strongest driver of health care expenditure - and yet end of life experiences, for both older people with frailty and their families, are often poor."* The time trajectory for frailty in the elderly is unpredictable, even when the patient is not suffering from any clear underlying pathology, which means that *"using 'time until death' as the sole indicator of end-of-life need is unhelpful."*

The British Geriatrics Society paper notes that *"Severe frailty is an end-of-life state and should trigger a healthcare professional to identify and sensitively discuss end of life needs and preferences."* Nevertheless, under the Bill, the end-of-life needs and preferences would include the deliberate ending of the patient's life. However, the British Geriatrics Society (BGD) is *opposed to the legalisation of Assisted Dying in the UK and Crown Dependencies for the reasons outlined in this position statement.*

1. *The BGS urges parliamentarians, government and legislators to remain cognisant of the significant diversity of views on this issue for older people, and to maintain diligent focus on the needs of older people in proceeding with the legalisation of Assisted Dying in the UK and Crown Dependencies.*

2. *Many of our members are not confident that effective legal safeguards could be developed to protect older people from unwarranted harms.*

3. *In taking this position, we acknowledge that a significant minority of our members are supportive of the legalisation of Assisted Dying in the UK.*

4. *We also recognise that many of our members are undecided, and that members' attitudes may shift over time.*

5. *We recommend that any future UK law on Assisted Dying should support explicitly any healthcare professionals who object conscientiously to direct participation in Assisted Dying.*

6. *We are committed to reviewing our position statement on a regular basis, either in the event of a change in law in the UK or in three years (2027), whichever comes first.*

On a more positive note, the British Geriatrics Society emphasises the following aspect of care of the elderly towards the end of their lives:

1. ***Allowing death due to natural causes at the right time****, instead of continuing unwanted interventions aiming to prolong life. This is distinct ethically from the intentional ending of life, even when life is unquestionably coming to an end.*
2. ***Improving timely recognition of terminal decline*** *due to underlying disease processes including multimorbidity, advanced dementia and severe frailty. This is consistent with national guidance advocating the timely identification of*

patients approaching the last 12 months of life to tailor their care according to their individual preferences and wishes.[9]

3. ***Deploying effective health communication systems*** *to share information regarding individual preferences, including advance care plans incorporating advance decisions to refuse treatment and preferred place of death, also shared with individuals with valid powers of attorney for health and welfare.*
4. ***Enabling holistic, multidisciplinary care services to deliver Comprehensive Geriatric Assessment*** *focused on multimorbidity, dementia and frailty, with recognition these conditions cannot always be ameliorated.*
5. ***Providing universally accessible, high-quality supportive and palliative care services*** *making provision for those whose terminal decline is due to multimorbidity, dementia and/or frailty which enable individuals to enjoy naturally enduring life by ameliorating unpleasant physical, psychological and existential symptoms which otherwise cause end of life to be distressing and burdensome.*
6. ***Shifting societal attitudes to de-medicalise death*** *and supporting wider societal care provision to alleviate distress in terminal disease.*

CLAUSE 3. CAPACITY

3 Capacity

In this Act, references to a person having capacity are to be read in accordance with the Mental Capacity Act 2005.

Mental Capacity.

The five core principles of the Mental Capacity Act 2005 are outlined in section 1 of the Act. Mental capacity is assumed under the Mental Capacity Act 2005 unless there is a reason for believing otherwise. "*A person must be assumed to have capacity unless it is established that he/she lacks capacity.*" The fact that a person makes an unwise decision is not to be taken as evidence, per se, that the person lacks capacity. "*A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.*" Therefore, unless there is a reason to believe that the person lacks capacity, there is no requirement to perform a mental capacity assessment.

If the patient suffers from a condition that may question their capacity e.g. dementia, head injury, effects of medication, stroke, then any potentially reversible cause of incapacity, such as medication, should be addressed before a formal capacity test. Whilst mental illness may affect decision-making there are circumstances when mentally ill patients should be given treatment under the Mental Health Act 1983 which

may be contrary to their actual or presumed wishes if the treatment is necessary to treat their mental illness and its sequelae, or if it is necessary for the protection of others.

If there is an underlying condition which raises doubts about capacity, it then becomes necessary to perform a mental capacity assessment "after all practicable steps to help him/her to do so have been taken without success." (s.1 MCA 2005). It may be easy to determine that a patient lacks capacity for example if they are concussed or suffering from a head injury. Difficulties arise if the decision to be made is serious or if the patient has fluctuating capacity or there is evidence that they have changed their mind over a short period of time (i.e. that they have fluctuating capacity). Clearly, there should be a greater degree of certainty about a patient's mental capacity if a serious decision e.g. complex or dangerous surgery is being considered, whereas a lower degree of capacity is required to make a simple or safe decision.

It might be assumed that the decision to take one's own life to be serious and definitive and require a high degree of capacity. Depression and not merely tiredness but actual fatigue from sleeplessness may also cloud the patient's mental capacity as may the effects of sedative and strong opiate analgesia. When faced with the knowledge of death most patients take time to adjust to this information.

Assessment of capacity

The Bill introduces a subjective element to the assessment of capacity. If the coordinating doctor or the independent doctor has doubt about the patient's mental capacity then they must refer the patient and take into account any opinion provided. It is not clear that the second opinion provided by a psychiatrist would be definitive.

Codes of Practice (under clause 30) issued by the Health Secretary may include guidance as to *"whether the patient has a clear and settled intention to end their life."* Codes of Practice may be used in connection to "*whether the person has capacity to make such a decision.*" This may include, under s. 30 (1)(ii) *"recognising and taking account of the effects of depression or other psychological disorders that may impair a person's decision."*

A particular concern for physicians who would normally refer those who have attempted suicide to a psychiatrist is that the patient would then receive proper counselling and support to prevent a further suicide. It would be a matter of considerable concern if the referral led to the assisted suicide of the patient.

CLAUSE 4. INITIAL DISCUSSIONS WITH REGISTERED MEDICAL PRACTITIONERS

(1) No registered medical practitioner is under any duty to raise the subject of the provision of assistance in accordance with this Act with a person.

(2) But nothing in subsection (1) prevents a registered medical practitioner exercising their professional judgement to decide if, and when, it is appropriate to discuss the matter with a person.

(3) Where a person indicates to a registered medical practitioner their wish to seek assistance to end their own life in accordance with this Act, the registered medical practitioner may (but is not required to) conduct a preliminary discussion about the requirements that need to be met for such assistance to be provided.

(4) If a registered medical practitioner conducts such a preliminary discussion with a person, the practitioner must explain to and discuss with that person—

(a) the person's diagnosis and prognosis;

(b) any treatment available and the likely effect of it;

(c) any available palliative, hospice or other care, including symptom management and psychological support.

(5) A registered medical practitioner who is unwilling or unable to conduct the preliminary discussion mentioned under subsection (3) must, if requested by the person to do so, refer them to another registered medical practitioner whom the first practitioner believes is willing and able to conduct that discussion.

According to the Bill, a doctor may initiate discussions with the patient about assisted suicide, but is not required to. However, if the patient wishes to be referred to a doctor who is prepared to discuss assisted suicide and who might support assisted suicide, the doctor must refer the patient to another doctor *"whom the first practitioner believes is willing and able to conduct that discussion."*

CLAUSE 5. PROCEDURE, SAFEGUARDS AND PROTECTIONS

5 Initial request for assistance: first declaration

(1) A person who wishes to be provided with assistance to end their own life in accordance with this Act must make a declaration to that effect (a "first declaration").

(2) A first declaration must be—

(a) in the form set out in Schedule 1,

(b) signed and dated by the person making the declaration, and

(c) witnessed by—

(i) the coordinating doctor in relation to that person, and

(ii) another person,

both of whom must see the declaration being signed.

(3) In this Act, "the coordinating doctor" means a registered medical practitioner—

(a) who has such training, qualifications and experience as the Secretary of State may specify by regulations,

(b) who has indicated to the person making the declaration that they are able and willing to carry out the functions under this Act of the coordinating doctor in relation to the person,

(c) who is not a relative of the person making the declaration, and

(d) who does not know or believe that they—

(i) are a beneficiary under a will of the person, or
(ii) may otherwise benefit financially or in any other material way from the death of the person.

(4) Before making regulations under subsection (3)(a), the Secretary of State must consult such persons as they consider appropriate.
(5) A person may not witness a first declaration under subsection (2)(c)(ii) if they are disqualified under section 36 from being a witness.
(6) Regulations under subsection (3)(a) are subject to the negative procedure.

The official process starts with the first declaration of the patient that they wish to have assisted suicide. The declaration has to be made in accordance with Schedule 1 and be witnessed by the coordinating doctor and another witness. The coordinating doctor must have agreed to participate in the process and need not be the patient's usual doctor within the GP practice or the Consultant within a hospital department.

Whilst the coordinating doctor must agree to undertake this role, and is not legally required to do so, it is not clear as to whether potential coordinating doctors will be known within the GP practice of hospital or how they will be advertised. It is difficult to understand how this could be an informal process and the patient might then have to engage in "doctor shopping" in order to find a suitable Coordinating doctor. This raises two questions.

First, will actual or potential coordinating doctors be known publicly either in general practice or hospitals.

Second, and more importantly, will it be known within departments or more widely which doctors would not act as coordinating doctors.

Ms Leadbetter in a press conference on 12 November stated that doctors involved with assisted suicide would have to function within their normal NHS contracts and not for an additional fee. This would be in keeping with the Bill, in so far as doctors must not gain financially from assisted suicide (see below).

Would it be acceptable for doctors to notify their GP practice or Trust that they will abide by the Hippocratic maxim and will *"not give a deadly drug to anyone, nor counsel such?"* Would it be acceptable for them to have such a statement in the reception or doctor's surgery or clinic? This would obviate the need for a formal discussion but begs the question as to whether patients would wish to see doctors who would be prepared to end their lives.

It should be noted that after the preliminary discussion and the initial declaration of the patient, the later requirements of the Bill have to be overseen by the coordinating and independent doctors.

Roles of the coordinating and independent doctors.

It is clear that the coordinating doctor need not be a doctor who is familiar with the patient or is their usual doctor, either in the GP practice or hospital. It is possible that the person's usual doctor has a conscientious objection to the assisted dying for whatever reason, and has been bypassed. If assisted suicide becomes available, it is possible that only doctors who are in favour of the process will become involved either as coordinating or independent doctors.

There is no provision for any statement as to why the person's usual GP or Consultant was not involved. The only requirement is that two doctors agree with the procedure, irrespective of any doctors who may know the patient and their condition who would not consider assisted suicide as the appropriate option. Whilst there is a requirement for doctors to agree with the process, there is no provision for other medical practitioners or witnesses to indicate why assisted suicide may not be appropriate, or indicated, or for any declaration that the requirements for a free and independent decision were not fulfilled.

When it comes to judicial approval of the declaration it is not clear that the process will remain largely secret or will be held in court at an open hearing when additional practitioners, witnesses and interested parties may be called.

The test of *"a clear and settled intention*" of the person to end their own life is essentially subjective. It is based upon the opinion of the doctor after having *"in-depth discussions*" with the person, who is *"acting on their own free will"* without undue *"influence, coercion, or duress."* It is difficult to understand how discussions between the two doctors, who are acting independently, and with evidence which was only required to be based on *"in depth discussions"* (undefined) with the person and without external collaborative evidence from other individuals or sources could safely lead to a clear view that the person was acting on their own free will, without any undue influence or coercion.

CLAUSE 6. REQUIREMENT FOR PROOF OF IDENTITY

(1) This section applies where a person makes a first declaration.

(2)The person must, at the same time as that declaration is made, provide two forms of proof of identity to the coordinating doctor and the witness mentioned in section 5(2)(c)(ii).

(3) The Secretary of State may, by regulations, make provision about the forms of proof of identity that are acceptable for the purposes of subsection (2).

(4)Regulations under subsection (3) are subject to the negative procedure.

The identity of the patient as a resident in England and Wales and as a patient registered with a GP practice are requirements for assisted suicide and would normally be easily established. Exceptions would be homeless or disabled persons who are not registered with a GP, asylum seekers and illegal immigrants.

It is important to stress at this point that the issue before doctors and the judiciary is whether certain other requirements of the Bill are fulfilled, then assisted suicide will be lawful. This could become a "tick box" exercise. The first assessment by a doctor is described under clause 7.

CLAUSE 7. FIRST DOCTOR'S ASSESSMENT (COORDINATING DOCTOR)

(1) The coordinating doctor must, as soon as reasonably practicable after a first declaration is made by a person, carry out the first assessment.

(2) "The first assessment" is an assessment to ascertain whether, in the opinion of the coordinating doctor, the person—

- *(a) is terminally ill,*
- *(b) has capacity to make the decision to end their own life,*
- *(c) was aged 18 or over at the time the first declaration was made,*
- *(d) is ordinarily resident in England and Wales and has been so resident for at least 12 months ending with the date of the first declaration,*
- *(e) is registered as a patient with a general medical practice in England or Wales,*
- *(f) has a clear, settled and informed wish to end their own life, and*
- *(g) made the first declaration voluntarily and has not been coerced or pressured by any other person into making it.*

(3) If, having carried out the first assessment, the coordinating doctor is satisfied that the requirements of subsection (2)(a) to (g) are satisfied, the coordinating doctor must—

- *(a) make a statement to that effect in the form set out in Schedule 2, and sign and date it,*
- *(b) provide the person who was assessed with a copy of the statement, and*
- *(c) refer that person, as soon as practicable, to another registered medical practitioner who meets the requirements of section 8(6) and is able and willing to carry out the second assessment ("the independent doctor").*

There is no timing requirement before the first assessment is made in relation to when the patient first became aware of their terminal illness. The only requirement is that the first assessment is triggered by the patient's declaration to have assisted suicide.

Denial. Anger. Bargaining. Depression. Acceptance.

When faced with the knowledge of death most patient take time to adjust to this information, as described by Dr Elizabeth Kubler-Ross.[v] She described five stages in the process of adapting to a terminal illness - to denial, anger, bargaining depression and acceptance. Hence there may be including initial denial and anger, refusal to accept the diagnosis and blame on doctors and others for not making an earlier diagnosis. Patients may become depressed before acceptance and recognition of the fact of dying. Dr Kubler-Ross then described a period of adaptation to the knowledge and circumstances before final acceptance. These phases may not all occur with any given

patient and take time. The exact responses vary between patients for what Dr Kubler-Ross described as the *“coping mechanisms to deal with extremely difficult situations.”* She wanted death and dying to be discussed more widely and openly and to help the terminally ill to come to terms with their diagnosis and to encourage everyone to live life to the full, especially when they know that their time on earth is limited. As she said in 1983 “*Terminally ill people can teach us everything - not just about dying, but about living.”*

Nevertheless, the Bill does not require any consideration of the reasons why the patient has sought suicide, nor does it recognise that it takes time to adapt to the existential problem of impending mortality which must eventually affect us all. However, if the wishes of the patient are sought early after diagnosis they may be angry, frustrated and depressed and express a wish to die. However, with time their views often involve. In short, there are as many experiences of dying, which we must all face, as there are individuals. Depression and not merely tiredness but fatigue from sleeplessness may also cloud the patient’s mental capacity as may the effects of sedative and strong opiate analgesia. Of all the areas of medical practice, the care of the dying is one which experienced clinicians and nurses do not find easy. Many of us find dealing with patients who are facing death difficult and for which there is no easy and universal answer. All patients are different and experience death in unique and individual ways.

Under section 7(1) the coordinating doctor must carry out a first assessment, as soon as possible after the patients first declaration. This initial assessment may therefore occur when the patient has recently been told of their diagnosis and are in a negative state of denial, anger or frustration.

Will the opinion of the coordinating doctor be judged objectively or subjectively?

The initial assessment is to be *judged “in the opinion of the coordinating doctor”* who has been selected as someone who is not opposed to assisted suicide. The opinion of another doctor, including in some cases , the patient’s usual doctor, is not to be taken into account. A doctor who has a conscientious objection to assisting in a patient’s suicide is specifically excluded from being a coordinating or independent doctor.

The opinion of the coordinating doctor is required to determine if the patient is terminally ill, has capacity to decide to end their own life, is aged over 18, normally resident and is registered with a GP in England and Wales. The coordinating doctor must then decide that the patient has a clear, settled and informed wish to end their own life and has made a first declaration voluntarily and without coercion or pressure from any other person.

The first issue that arises is whether the legal test for the coordinating doctor is either subjective or objective. In other words, must the doctor provide objective evidence for their opinion which could stand the test of reasonableness i.e. from an opinion with

which any reasonable or responsible doctor would concur? Or, conversely, is the legal test subjective, based upon the practitioner's own views?

It is clear from the Bill that the assessment of the coordinating doctor is to be judged subjectively. Hence, the only legal requirement is that the doctor has made an assessment which is correct *"in the opinion of the coordinating doctor"*. The pupil is allowed to mark their own homework. For the avoidance of doubt, the practitioner under s. (3) must be satisfied that the requirements of subsection (2) (a) to (g) are satisfied, before making a declaration in Schedule 2 and refer the patient to "*the independent doctor"* who is "*willing and able"* to carry out the second assessment.

This begs the question as to how the coordinating doctor would know that the independent doctor was willing and able to make the second assessment? What happens if the independent doctor has an undeclared conscientious objection to assisted suicide? How would this be known unless the coordinating doctor knew the independent doctor, or a list of doctors who did not object to assisted suicide, was available publicly or to medical professionals? With the passage of time, would independent doctors become known through Court appearances, or through being involved in cases within particular GP practices or hospital departments?

CLAUSE 8. SECOND DOCTOR'S ASSESSMENT (INDEPENDENT DOCTOR)

(1) Where a referral is made under section 7(3)(c), the independent doctor must carry out the second assessment of the person as soon as reasonably practicable after the first period for reflection has ended.

(2) "The second assessment" is an assessment to ascertain whether, in the opinion of the independent doctor, the person who made the first declaration—

- *(a) is terminally ill,*
- *(b) has capacity to make the decision to end their own life,*
- *(c) was aged 18 years or over at the time the first declaration was made,*
- *(d) has a clear, settled and informed wish to end their own life, and*
- *(e) made the first declaration voluntarily and has not been coerced or pressured by any other person into making it.*

(3) In subsection (1) "the first period for reflection" means the period of 7 days beginning with the day the coordinating doctor made the statement under section 7(3).

(4) The independent doctor must carry out the second assessment independently of the coordinating doctor (subject to section 9(4) (sharing of specialists' opinions)).

(5) If, having carried out the second assessment, the independent doctor is satisfied as to the matters mentioned in subsection (2)(a) to (e), the independent doctor—

- *(a) must make a statement to that effect in the form set out in Schedule 3 and sign and date it, and*
- *(b) provide each of the coordinating doctor and the person who was assessed with a copy of the statement.*

(6) A registered medical practitioner may carry out the functions of the independent doctor under this Act only if that practitioner—

(a) has such training, qualifications and experience as the Secretary of State may by regulations specify,
(b) has not provided treatment or care for the person being assessed in relation to that person's terminal illness,
(c) is not a relative of the person being assessed,
(d) is not a partner or colleague in the same practice or clinical team as the coordinating doctor,
(e) did not witness the first declaration made by the person being assessed, and
(f) does not know or believe that they—
(i) are a beneficiary under a will of the person, or
(ii) may otherwise benefit financially or in any other material way from the death of the person.

(7) In subsection (6)(b) the reference to "terminal illness" means the illness, disease or medical condition mentioned in section 2(1)(a).

(8) Before making regulations under subsection (6)(a), the Secretary of State must consult such persons as the Secretary of State considers appropriate.

(9) Regulations under subsection (6)(a) are subject to the negative procedure.

The assessment of the independent doctor is similar to that of the coordinating doctor and covers the same issues. The patient can only be assessed after the *"first period for reflection"* of 7 days from the first statement of the coordinating doctor. This could therefore be only a short time after the initial diagnosis for some patients who will still be coming to terms with the diagnosis of a terminal illness. As outlined above this could be a time when the patient is still in denial or suffering anger or frustration at the diagnosis.

The legal test for an adequate assessment is again subjective and relies on the independent doctors being *"satisfied"* in their opinion regarding the issues outlined in subsection (2)(a) to (e). In addition, the independent doctor must be independent of the coordinating doctor and have the necessary training, qualifications and experiences as specified by the Secretary of State, must not have provided care for the terminal illness of the patient and not benefit financially, or in any other material way, from the death of the person. This implies that the independent doctor must not be acting for a fee or be acting as a non-NHS practitioner from the private sector.

The way the assessments must be made is dealt with in clause 9.

CLAUSE 9. DOCTOR'S ASSESSMENTS: FURTHER PROVISION (1)

(1) In this section "assessing doctor" means—
(a) the coordinating doctor carrying out the first assessment;
(b) the independent doctor carrying out the second assessment.

(2) The assessing doctor must—
(a) examine the person and their medical records and make such other enquiries as the assessing doctor considers appropriate;
(b) explain to and discuss with the person being assessed—
(i) the person's diagnosis and prognosis;
(ii) any treatment available and the likely effect of it;

(iii) any available palliative, hospice or other care, including symptom management and psychological support;

(iv) the nature of the substance that might be provided to assist the person to end their own life (including how it will bring about death);

(c) discuss with the person their wishes in the event of complications arising in connection with the self-administration of an approved substance under section 18;

(d) inform the person—

(i) of the further steps that must be taken before assistance can be provided to the person to end their own life in accordance with this Act;

(ii) that the person may decide at any time not to take any of those steps (and of how to cancel the first declaration and any of those further steps);

(e) advise the person to inform a registered medical practitioner from the person's GP practice that the person is requesting assistance to end their own life (unless the assessing doctor is themselves a practitioner from that practice);

(f) in so far as the assessing doctor considers it appropriate, advise the person to consider discussing the request with their next of kin and other persons they are close to.

(3) To inform their assessment, the assessing doctor—

(a) must, if they have doubt as to whether the person being assessed is terminally ill, refer the person for assessment by a registered medical practitioner who holds qualifications in or has experience of the diagnosis and management of the illness, disease or condition in question;

(b) may, if they have doubt as to the capacity of the person being assessed, refer the person for assessment by a registered medical practitioner who is registered in the specialism of psychiatry in the Specialist Register kept by the General Medical Council or who otherwise holds qualifications in or has experience of the assessment of capability;

(c) must, if they make a referral under paragraph (a) or (b), take account of any opinion provided by that other registered medical practitioner.

(4) An opinion provided to one assessing doctor under subsection (3)(a) or (b) must be shared with the other assessing doctor.

(5) Where the independent doctor is required to obtain an opinion under subsection (3)(a)—

(a) that duty may be discharged by an opinion obtained under that provision by the coordinating doctor, or

(b) the independent doctor may make their own referral under that provision.

Clause 9 describes how the assessing doctors must examine the person and their medical records and make any other enquiries as deemed appropriate. The assessing doctors must explain and discuss the diagnosis and prognosis, any likely treatment and its effects, the availability of palliative care and psychological support, the nature of the approved substance to end the person's life and any complications that might arise and how they would be dealt with. The assessing doctor must also inform the patient of the process of assisted suicide and inform them of how that may decide to cancel the first declaration. The assessing doctor must refer the patient for an opinion as to whether the patient is terminally ill if there is any doubt and may refer to a psychiatrist if there is doubt about their mental capacity. If further opinions are sought regarding the person's terminal illness or mental capacity, these opinions must be taken into account. Any further opinion must also be shared with the other assessing doctor.

Whilst the patient should inform the GP practice, it is up to the assessing doctor to advise the person to consider discussing the request with their next of kin or others close to the patient.

The consequence of a refusal of the independent doctor to agree that the patient's wish for assisted suicide should go ahead, is not answered by clause 10. This may be because there is no provision in the Schedule 3 declaration of the independent doctor to refuse the patient's request for assisted suicide. What happens if the independent doctor refuses to make a Schedule 3 declaration and approve of the patient's wish for assisted suicide? This is answered in Clause 10.

CLAUSE 10. ANOTHER INDEPENDENT DOCTOR: SECOND OPINION

(1) If, following the second assessment, the independent doctor refuses to make the statement mentioned in section 8(5), the coordinating doctor may, if requested to do so by the person who made the first declaration, refer that person to a different registered medical practitioner who meets the requirements of section 8(6) and is able and willing to carry out a further assessment of the kind mentioned in section 8(2).

(2) Where a referral is made to a registered medical practitioner under subsection (1), that referral is treated as a referral under section 7(3)(c), the practitioner becomes the independent doctor (replacing the registered medical practitioner to whom a referral was originally made) and sections 8 and 9 apply accordingly.

(3) In consequence of a particular first declaration made by a person, the coordinating doctor may make only one referral for a second opinion under subsection (1).

A refusal by the independent doctor to make a Schedule 3 declaration, means that the coordinating doctor may refer to a second independent doctor and the first will be ignored. It is unclear as to whether or not this first refusal will later be taken into account by the High Court. There is no requirement to ask why no assessment has been made by the independent doctor, which might include the view of the independent doctor that the assisted suicide should not go ahead.

Clearly, there is bias towards accepting the patient's declaration in favour of assisted suicide. It is far from clear if the second independent doctor would know that the first independent doctor had refused to make a Schedule 3 declaration. At all events, if the second independent doctor refuses the application or does not issue a Schedule 3 declaration, a third independent doctor cannot be requested as "the coordinating doctor may make only one referral for a second opinion."

The circumstances under which the coordinating doctor can be replaced are defined in clause 11. Can the coordinating doctor be replaced?

CLAUSE 11. REPLACING THE COORDINATING DOCTOR ON DEATH etc

(1) The Secretary of State may, by regulations, make provision about cases where, after a first declaration has been witnessed by the coordinating doctor, that doctor dies or through illness or otherwise is unable or unwilling to continue to carry out the functions of the coordinating doctor.

(2) Regulations under subsection (1) may, in particular, make provision—

(a) relating to the appointment, with the agreement of the person who made the declaration, of a replacement coordinating doctor who meets the requirements of section 5(3) and is able and willing to carry out the functions of the coordinating doctor;

(b) to ensure continuity of care for that person despite the change in the coordinating doctor.

(3) Regulations under subsection (1) are subject to the negative procedure.

If the co-ordinating doctor, *"through illness or otherwise is unable or unwilling to continue to carry out the functions of the coordinating doctor,"* a second coordinating doctor may be appointed according to regulations set out by the Secretary of State. These conditions are therefore not outlined in the Bill. However, the implication is that another coordinating doctor would be appointed unless the patient no longer wanted assisted suicide.

The role of the judiciary is given in clause 12.

CLAUSE 12. COURT APPROVAL

(1) Where—

(a) a person has made a first declaration under section 5 which has not been cancelled,

(b) the coordinating doctor has made the statement mentioned in section 7(3), and

(c) the independent doctor has made the statement mentioned in section 8(5),

that person may apply to the High Court for a declaration that the requirements of this Act have been met in relation to the first declaration.

(2) On an application under this section, the High Court—

(a) must make the declaration if it is satisfied of all the matters listed in subsection (3), and

(b) in any other case, must refuse to make the declaration.

(3) The matters referred to in subsection (2)(a) are that—

(a) the requirements of sections 5 to 9 have been met in relation to the person who made the application,

(b) the person is terminally ill,

(c) the person has capacity to make the decision to end their own life,

(d) the person was aged 18 or over at the time the first declaration was made,

(e) the person is ordinarily resident in England and Wales and has been so resident for at least 12 months ending with the date of the first declaration,

(f) the person is registered as a patient with a general medical practice in England or Wales,

(g) the person has a clear, settled and informed wish to end their own life, and

(h) the person made the first declaration and the application under this section voluntarily and has not been coerced or pressured by any other person into making that declaration or application.

(4) Subject to the following provisions of this section and to any provision made by Rules of Court, the High Court may follow such procedure as it deems appropriate for each application under this section.

(5) The High Court—

(a) may hear from and question, in person, the person who made the application for the declaration;

(b) must hear from and may question, in person, the coordinating doctor or the independent doctor (or both);

(c) for the purposes of paragraph (b), may require the coordinating doctor or the independent doctor (or both) to appear before the court.

(6) For the purposes of determining whether it is satisfied of the matters mentioned in subsection (3)(g) and (h), the High Court may also—

(a) hear from and question any other person;

(b) ask a person to report to the court on such matters relating to the person who has applied for the declaration as it considers appropriate.

(7) In subsection (5)—

(a) in paragraph (a), the reference to the person who made the application includes, in a case where the person's first declaration was signed by a proxy under section 15, that proxy, and

(b) "in person" includes by means of a live video link or a live audio link.

(8) Where, on an application made by a person under this section, the High Court refuses to make the declaration, that person may appeal to the Court of Appeal against that decision.

(9) The Court of Appeal must—

(a) if it is satisfied of the matters mentioned in paragraphs (a) to (h) of subsection (3), make a declaration that the requirements of this Act have been met in relation to the first declaration, and

(b) in any other case, confirm the High Court's decision.

(10) Subsections (4) to (7) apply in relation to the Court of Appeal as they apply in relation to the High Court.

(11) No appeal lies from a decision of the High Court to make a declaration under this section.

Under section 12 (2) the High Court must make a declaration that if it is satisfied on all the matters raised in subsection 3, otherwise it must refuse to make a declaration. The judge must confirm that the person has a voluntary, clear and informed wish to end

their life and is over the age of 18, has mental capacity to decide to end their own life, has a terminal illness and has been a resident in England and Wales for a year.

The High Court may hear from and question the person who made the application but must hear from the coordinating or independent doctor (or both). There is no mention as to whether these doctors are the original practitioners or have been replaced, especially in relation to the independent doctor, as noted above. The High Court may also ask a person to report on matters concerning the patient as it considers appropriate. If the High Court refuses the application for assisted suicide, the patient may appeal to the Court of Appeal. The Court of Appeal must decide on the issues which had been before the High Court and decide if the requirement of the Act were met. However, there can be no appeal against a High Court decision to grant a declaration for an assisted suicide.

Role of the judiciary.

Having abolished the death penalty in 1969, the Bill, if enacted, would permit judges to authorise the death of innocent people who had not been convicted of any serious crime.

This is to cross the judicial Rubicon. It would lead to the death of countless patients whose lives were considered as no longer worth living by virtue of terminal illness and its sequelae. The remedy would be suicide authorised by the Court.

Would the judge be deciding a fundamental issue of law, ethics or simply be rubber stamping a decision made by the patient and doctors? It appears that the judge would only be confirming that the conditions of the Bill were satisfied, namely that the person was eligible for assisted suicide by virtue of being an adult over 18, resident in England and Wales and registered with a general practice. The declaration made for assisted suicide would be authorised if the decision of the patient was deemed to be voluntary, uncoerced and fixed in which case the High Court must grant the declaration of the patient.

Would there be a right of conscientious objection for lawyers and judges not to be involved in such decision? In the Falconer Bill (July 2024) the right of conscientious objection was stated but on reflection Lord Falconer said that any suggestion that it applied to lawyers was not intended. In the Leadbeater Bill this issue is not addressed at all, implying that judges would be expected to be involved. The bias in the system is also shown in the fact that a positive decision by the High Court cannot be appealed before the Court of Appeal. The question of whether there could be an appeal to the

European Court of Human Rights in Strasbourg for a breach of Article 2 of the European Convention on Human Rights "right to life" is not addressed in the Bill.

What is the constitutional basis for allowing the Judiciary to oversee and authorise the deliberate killing of innocent persons who are not guilty of any crime? Paradoxically the reason for decriminalising suicide in 1961 was to avoid the issue of potentially convicting a person who had made a failed suicide attempt. Prior to 1961 those who had failed to take their own life but recovered from a drug overdose could be arrested by the police the next day! The law needed to change when it was recognised that suicide attempts were clinical evidence of profound mental health issues which needed medical support and not a criminal record. Of course, if the person died, there could be no punishment for the crime of suicide for that patient.

Does the Judiciary and Parliament now accept through this Bill that Society may take the lives of innocent subjects? Would there be implications for the individual judges who knew when they woke up that the previous day they had authorised the death of an innocent person?

Prior to the decision of the High Court, regarding whether her young daughter Tafida should have her ventilator turned off and whether she could be allowed to travel to Italy, her mother, Shelena Begum, stated that she felt as if the judge was about to pass sentence of death on her daughter. If the Bill is passed, judges will pass sentence on many thousands of patients in England and Wales. This will be the responsibility of those in Parliament who have passed the law and of judges who have applied it.

Declaration by the High Court

Assisted suicide will be decriminalised under the Bill but will require a declaration by the High Court (Family Division).

Assisted dying involves the intentional killing of patients at their request with the "consent" of a judge. The consent or agreement of the victim has never before been a mitigating factor for any form of homicide. The Bill goes further than mitigation to decriminalise killing if it is the wish of the victim.

The Rubicon was crossed in the case of Bland [1990] in the House of Lords. It was acknowledged that the withdrawal of hydration and nutrition from Tony Bland who was in a persistent vegetative state following the Hillsborough disaster in 1989, had the *mens rea* (guilty mind) to bring about his death through dehydration but not the *actus reus* (guilty act) as the withdrawal of hydration and nutrition was an omission and not an act.

Assisted suicide, if approved by Parliament, will authorise both the judiciary and the medical and nursing professions to deliberately cause the death of innocent patients.

This would be a fundamental denial of the right to life. Under the European Convention on Human Rights Article 2 states that *"everyone's right to life shall be protected by law."* There is a general duty to protect life, a procedural duty to investigate deaths and an operational duty to ensure personal safety.

The general duty has a negative aspect, not to take life and a positive duty to take measures to preserve life, as described in Middleton at paragraph 2[vi]

> *"The European Court of Human Rights has repeatedly interpreted article 2 of the European Convention as imposing on member states substantive obligations not to take life without justification and also to establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life. See, for example, LCB v United Kingdom (1998) 27 EHRR 212, para 36; Osman v United Kingdom (1998) 29 EHRR 245; Powell v United Kingdom (App No 45305/99, unreported 4 May 2000), 16-17; Keenan v United Kingdom (2001) 33 EHRR 913, paras 88-90; Edwards v United Kingdom (2002) 35 EHRR 487, para 54; Calvelli and Ciglio v Italy (App No 32967/96, unreported, 17 January 2002); Öneryildiz v Turkey (App No 48939/99, unreported, 18 June 2002).*

In *Jordan v United Kingdom* in the European Court of Human Rights, it was made clear that the purpose of Article 2 was to protect the right to life and hence the rights and freedoms of the convention:

> *"105. The obligation to protect the right to life under Article 2 of the Convention, read in conjunction with the State's general duty under Article 1 of the Convention to 'secure to everyone within [its] jurisdiction the rights and freedoms defined in [the] Convention', also requires by implication that there should be some form of effective official investigation when individuals have been killed as a result of the use of force."*

The role of the judicial system is to uphold basic human rights and to investigate and take action when Article 2 has been infringed. This raises very serious issues in relation to the involvement of the judiciary in the case of assisted suicide.

Judicial involvement

The issue of judicial involvement was recently addressed by Sir James Munby, Former President of the Family Division in October 2024 in relation to the Falconer [Assisted Dying] Bill, which is similar in content and context to the Leadbeater Bill. He raised a number of issues. Presuming that only a High Court Judge or the President of the Family Division would be involved, Sir James raised the issue as to the matters to be determined and the discretion of the judge. For example, *"If the judge is satisfied as to each of the matters referred to in clause 1(2), is the judge nonetheless entitled to refuse*

to make an order?" Sir James then raised a number of questions that have not been addressed in the Falconer [Assisted Dying HL] Bill:

- *Who can apply to the court and who should be joined as parties?*
- *Is there to be a hearing, or is the application to be dealt with 'on the papers' and without a hearing?*
- *If there is to be a hearing, is this to be in public or in private? Are there to be reporting restrictions? Are the identities of any of the participants, in particular the patient, the witness and the countersigning doctors, to be anonymised?*
- *Given that many, or even most, applications are likely to be unopposed, what procedures are to be adopted for testing and, if need be, challenging the evidence? Who should exercise that function?*
- *Should the judge be required to give a judgment in every case (clause 9(2) of the Falconer Bill seems to assume there will be a judgment if the application is refused, but what if the application is granted?) and be required to publish the judgment?*
- *How are appeals to be incorporated in the process?*
- *What public funding arrangements will there be?*

Reflecting on the end-of-life case which dates back to the 1990s, Sir James offered the following possible solutions:

> *"For my own part, I am strongly of the view that the integrity of the process and the maintenance of public confidence demand that there be a hearing in public in every case, and with an absolute minimum of reporting restrictions; that there should be no anonymisation of any of the participants (except, perhaps, for the patient during his or her lifetime); that there must be a rigorous procedure in every case for testing and if need be challenging the evidence; and that the judge must be required to give and publish a judgment in every case. This, after all, was the approach adopted in end-of-life cases as long ago as the 1990s."*

In summary, Sir James concludes that:

> *"But it is fundamental that the court cannot authorise the administration of treatment intended to kill. Specifically, a judge cannot authorise the administration to a patient of a drug intended to bring about the patient's death. The Falconer Bill, and it would seem also the Leadbeater Bill, stand this fundamental and unchallenged principle on its head. What is proposed is that a*

judge by court order should facilitate the administration to a patient of a drug intended to bring about the patient's death."

The case of Tafida Raqeeb.

The clash between medicine and the law was brought into sharp contrast by the case of Tafida Raqeeb. At the age of 5 years in February 2019 she had suffered a catastrophic intracerebral bleed from an arteriovenous malformation.. She was rushed to hospital and had an evacuation of the haemorrhage at King's Neurosurgical Unit some hours later. She remained on a ventilator with profound brain injury and transferred to the London Hospital where a decision was made to stop her ventilation. This decision was challenged by her family in the High Court in September 2019. Her mother, Shalena Begum resisted and eventually won her case, saved the life of her daughter who was transferred to Italy for further treatment. She has since come off ventilation and remains in Italy, despite a prognosis at the hearing that she would not recover. On the day of the court decision by Mr Justice MacDonald, Shelina Begum said the following outside the High Court, which summarises the profound difficulties of the Court in deciding the fate of patients, especially when the prognosis turns out to be wrong:

> *"Our beautiful daughter Tafida is not dying and we are continuously seeing small but important signs that she is gradually improving. We have always been hopeful that she might make something of a recovery if she is given the time and the right treatment continues. We have always had Tafida's best interests at heart and we have never wanted to come to court to argue for our rights to seek continued care in a world class hospital willing to give her the treatment she needs. The entire experience of having to fight for our daughter's life over the last three months has been exhausting and traumatic for all of my family members and we are glad that this is now finally over."*

Ms Shelina Begum. 3.10.19

Cost of judicial involvement

There are over 600,000 deaths in England and Wales each year. Assuming that there are 10,000 deaths per week in England and Wales and an assisted dying rate of 1% of all deaths, this would mean 100 assisted death each week or 20 referrals to the High Court working each day. How many High Court judges would be involved and how much time would be devoted to these hearings? What would be the cost of hearings, how many would there be each year? Who would bear the costs both in terms of legal fees and time spent by doctors at the hearings?

CLAUSE 13. CONFIRMATION OF REQUEST FOR ASSISTANCE: SECOND DECLARATION

(1) Where—

(a) the High Court or Court of Appeal has made a declaration in respect of a person under section 12, and

(b) the second period for reflection has come to an end,

if the person wishes to be provided with assistance to end their own life in accordance with this Act, the person must make a further declaration to that effect (the "second declaration").

(2) In subsection (1) "the second period for reflection" means—

(a) the period of 14 days beginning with the day on which the declaration was made by the High Court or, as the case may be, Court of Appeal, or

(b) where the coordinating doctor reasonably believes that the person's death is likely to occur before the end of the period of one month beginning with the day that declaration was made, the period of 48 hours beginning with that day.

(3) A second declaration must be—

(a) in the form set out in Schedule 4,

(b) signed and dated by the person making the declaration,

(c) witnessed by—

(i) the coordinating doctor, and

(ii) a person other than the coordinating doctor or the independent doctor,

both of whom must see the declaration being signed.

(4) (4)

The coordinating doctor may witness a second declaration only if, at the time the second declaration is made, the coordinating doctor is still satisfied that the person making the declaration—

(a) is terminally ill,

(b) has the capacity to make the decision to end their own life,

(c)

has a clear, settled and informed wish to end their own life, and

(d) is making the declaration voluntarily and has not been coerced or pressured by any other person into making it.

(5) If the coordinating doctor is so satisfied, they must make a statement to that effect.

(6) The statement under subsection (5) must be—

(a) in the form set out in Schedule 5,

(b) signed and dated by the coordinating doctor, and

(c) witnessed by the same person who witnessed the second declaration under subsection (3)(c)(ii).

(7) A person may not witness a declaration under subsection (3)(c)(ii) if they are disqualified under section 36 from being a witness.

There must be a second declaration by the patient of their wish to have an assisted suicide at least 14 days after a declaration by the High Court or Court of Appeal, unless it was reasonably believed that the person might die within one month of the first declaration in which case the period of reflection is reduced from 14 days to 48 hours. The second declaration by the patient must be in the form set out in Schedule 4, witnessed by the coordinating doctor who must be satisfied that the conditions underlying the wish for assisted suicide remain and by another witness. The coordinating doctor must sign a form under Schedule 5 which must also be witnessed by the witness to the second declaration made by the patient.

CLAUSE 14. CANCELLATION OF DECLARATIONS

(1) A person who has made a first declaration or a second declaration may cancel it by giving oral or written notice of the cancellation (or otherwise indicating their decision to cancel in a manner of communication known to be used by the person) to—

(a) the coordinating doctor, or

(b) any registered medical practitioner from the person's GP practice.

(2) Where notice or an indication is given to a registered medical practitioner under subsection (1)(b), the practitioner must, as soon as practicable, notify the coordinating doctor of the cancellation.

(3) A cancellation under subsection (1) has effect from the time the notice or indication is given.

(4) From the time a first declaration is cancelled, any duty or power of the coordinating doctor or the independent doctor under sections 7 to 9 (assessments, statements and referrals) that arose in consequence of that declaration ceases to have effect A person who has made the first and second declarations may cancel it orally, in writing or through a proxy.

A person who has made a first or second declaration may withdraw it either orally or in writing or through a proxy, who may also have signed the original declarations under clause 15.

CLAUSE 15. SIGNING BY PROXY

(1) This section applies where a person intending to make a first declaration or a second declaration—

(a) declares to a proxy that they are unable to sign their own name (by reason of physical impairment, being unable to read or for any other reason), and

(b) authorises the proxy to sign the declaration on their behalf.

(2) A declaration signed by a proxy—

(a) in the presence of the person, and

(b) in accordance with subsection (3),

has the same effect as if signed by the person themselves.

(3) Where a proxy signs a declaration, the proxy is to add, after their signature—

(a) their full name and address,

(b) the capacity in which they qualify as a proxy, and

(c) a statement that they have signed in that capacity as a proxy.

(4) A proxy may not sign a declaration—

(a) unless satisfied that the person understands the nature and effect of the making of the declaration,

(b) if disqualified under section 36 from being a proxy, or

(c) if it is a second declaration and the proxy signed the first declaration as a witness.

(5) In this section "proxy" means—

(a) a person who has known the person making the declaration personally for at least 2 years, or

(b) a person who is of good standing in the community.

There are limited circumstances in which a proxy may sign a declaration on behalf of the patient. A proxy may not sign a declaration unless they are satisfied that the person understands the nature and effect of making the declaration. The proxy must have known the person for at least 2 years, or be of good standing within the community.

CLAUSE 16. RECORDING OF DECLARATIONS AND STATEMENTS etc.

Information in medical records

(1) This section applies where—

(a) a first declaration is made by a person;

(b) a statement is made under section 7(3), or the coordinating doctor refuses to make such a statement, in relation to a person;

(c) a statement is made under section 8(5), or the independent doctor refuses to make such a statement, in relation to a person;

(d) the High Court or Court of Appeal has made a declaration under section 12 in relation to a person or has refused to make such a declaration;

(e) a second declaration is made by a person;

(f) a statement is made under section 13(5), or the coordinating doctor refuses to make such a statement, in relation to a person.

(2) Where the coordinating doctor is a practitioner with the person's GP practice, the coordinating doctor must, as soon as practicable, record the making of the declaration or statement, or, as the case may be, the refusal to make the declaration or statement, in the person's medical records.

(3) In any other case—

(a) the coordinating doctor must, as soon as practicable, give a registered medical practitioner with that practice notice of the making of the declaration or statement or, as the case may be, the refusal to make the declaration or statement, and

(b) that practitioner must, as soon as practicable, record the making of the declaration or statement or the refusal to make the declaration or statement in the person's medical records.

(4) A record made under subsection (2) or (3) of a statement or declaration within subsection (1)(a), (b), (c), (e) or (f) must include the original statement or declaration.

The declarations of the patient and statements of the coordinating and independent doctors must be recorded in the medical notes which must also include any withdrawals of declarations by the patient or refusals to sign statements by either of the doctors. It is not clear if the notes would be available to the High Court.

CLAUSE 17 RECORDING OF CANCELLATIONS

This section applies where a person cancels a first declaration or a second declaration under section 14.

(2) If the notice or indication under that section is given to a registered medical practitioner at the person's GP practice, that practitioner must, as soon as practicable, record the cancellation in the person's medical records.

(3) In any other case—

(a) the registered medical practitioner to whom notice or indication of the cancellation is given must, as soon as practicable, notify a registered medical practitioner with that practice of the cancellation, and

(b) the practitioner notified under paragraph (a) must, as soon as practicable, record the cancellation in the person's medical records.

Following a cancellation of the first or second declaration of the patient their GP practice must be informed and the cancellation recorded in the medical records.

CLAUSE 18. PROVISION OF ASSISTANCE

(1) This section applies where—
- *(a) the High Court or Court of Appeal has made a declaration in respect of a person under section 12,*
- *(b) the second period for reflection (within the meaning of section 13(2)) has ended,*
- *(c) that person has made a second declaration which has not been cancelled, and*
- *(d) the coordinating doctor has made the statement under section 13(5).*

(2) The coordinating doctor may, in accordance with this section, provide that person with an approved substance (see section 20) with which the person may end their own life.

(3) The approved substance must be provided directly and in person by the coordinating doctor to that person.

(4) The coordinating doctor must be satisfied, at the time the approved substance is provided, that the person to whom it is provided—
- *(a) has capacity to make the decision to end their own life,*
- *(b) has a clear, settled and informed wish to end their own life, and*
- *(c) is requesting provision of that assistance voluntarily and has not been coerced or pressured by any other person into doing so.*

(5) The coordinating doctor may be accompanied by such other health professionals as the coordinating doctor thinks necessary.

(6) In respect of an approved substance which is provided to the person under subsection (2), the coordinating doctor may—
- *(a) prepare that substance for self-administration by that person,*
- *(b) prepare a medical device which will enable that person to self-administer the substance, and*
- *(c) assist that person to ingest or otherwise self-administer the substance.*

(7) But the decision to self-administer the approved substance and the final act of doing so must be taken by the person to whom the substance has been provided.

(8) Subsection (6) does not authorise the coordinating doctor to administer an approved substance to another person with the intention of causing that person's death.

(9) The coordinating doctor must remain with the person until—
- *(a) the person has self-administered the approved substance and—*
  - *(i) the person has died, or*
  - *(ii) it is determined by the coordinating doctor that the procedure has failed, or*
- *(b) the person has decided not to self-administer the approved substance.*

(10) For the purposes of subsection (9), the coordinating doctor need not be in the same room as the person to whom the assistance is provided.

(11) Where the person decides not to self-administer the approved substance, or there is any other reason that the substance is not used, the coordinating doctor must remove it immediately from that person.

Clause 18 is the most important aspect of the Bill. It permits the deliberate killing of terminally ill patients by means of an approved lethal substance. It places the responsibility for the death on healthcare professionals, lawyers, judges and Members of Parliament who have approved the legislation. It denies the right to life and is totally opposed to Article 2 of the Right to Life of the European Convention on Human Rights

and the Human Rights Act. It denies the Hippocratic tradition and crosses the Rubicon for reasons already stated. If assisted suicide follows the practice in other countries then between 1-5% of all deaths with be through assisted suicide. Even taking the lower estimate, of 1% it would account for around 6,000 deaths per year. Once legislation is passed, the experience of other countries indicates that the numbers of deaths increases and the threshold for assisted suicide falls. Voting on the Leadbeater Bill on 29 November 2024 has been regarded as a matter of conscience for members of Parliament. This is correct and the killing of innocent members of society should remain on their consciences if this legislation is passed. The killing of the innocent should never occur in a civilised society.

For healthcare professionals who have been involved in assisted suicide, they will have been directly involved in deliberately killing patients. This will have a profound and long-lasting effect on the trust and confidence of the public in the medical and nursing professions. The memory of relatives and friends of the deceased will remain with them and their trust in the individual clinicians involved will be deeply affected in the long-term. It is difficult to comprehend the impression that will be left regarding their deliberate killing of patients.

Potential negligence claims if assisted suicide failed.

If assisted suicide becomes lawful, would doctors ever be held negligent in failing to prevent suicides which were not inevitable, or in failing to deal with severe depression which did lead to suicide, but which might have been prevented? If there was a preventable suicide attempt which led to serious and permanent harm to the patient, could the doctor be held negligent in not trying to prevent it? Conversely, could a doctor be held negligent, legally or professionally, in not facilitating assisted suicide or be held negligent for "allowing" a difficult or distressing life to continue? Would there be a sense of "injustice" if the Court did not authorise the death of the patient? Having abolished capital punishment for crime, should the Judiciary now turn to death as a remedy for terminal illness?

Safeguards

The Bill removes the right to life of innocent members of society who have a terminal illness. Consent of the victim has never been a mitigating factor for homicide. The Bill would mean that the person can forgo their right to life which is the basis of all fundamental freedoms. The right to life would no longer be recognised in law as inherent and inalienable but could be withdrawn with the consent of the person.

There are no safeguards for the following reasons.

First, the right to life has been abolished for the terminally ill. If the right to life is denied then all other rights must cease to have any meaning or purpose.

Second, the primary victim is dead. How can they be compensated? Who will speak up for them?

Third, Parliament will have decriminalised assisted suicide for the terminally ill, provided certain criteria are fulfilled, therefore there can be no criminal sanction.

Fourth, the only offences, once the patient has died would be a civil matter in relation to a failure to follow due process. However, how can the primary victim receive compensation once they are dead?

Fifth, any further legal action would be by those who knew the deceased and may well have been party to the proceedings.

Sixth, the High Court decision to allow the declaration of the patient indicating their wish for assisted suicide cannot be overturned on appeal. Therefore, in the unlikely event of further legal action it could be blocked by the High Court decision to allow assisted suicide. Only a refusal by the High Court to allow assisted suicide could be subject to appeal.

Seven, although there is no disclaimer in the Bill regarding Human Rights, assisted suicide is clearly contrary to the right to life under in Article 2 of the European convention and the Human Rights Act 1998:

> *"Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law"*

CLAUSE 19. AUTHORISING ANOTHER DOCTOR TO PROVIDE ASSISTANCE.

(1)Subject to subsection (2), the coordinating doctor may authorise, in writing, a named registered medical practitioner to carry out the coordinating doctor's functions under section 18.

(2) A registered medical practitioner may be authorised under subsection (1) only if—

(a) the person to whom the assistance is being provided has consented, in writing, to the authorisation of that practitioner, and

(b) that practitioner has completed such training, and gained such qualifications and experience, as the Secretary of State may specify by regulations.

(3) Where a registered medical practitioner is authorised under subsection (1), section 18 applies as if references to the coordinating doctor were to that registered medical practitioner.

(4) Section 15 (signing by proxy) applies in relation to a consent under subsection (2)(a) as it applies in relation to a first or second declaration, except that, for these purposes, section 15(4) has effect as if for paragraph (c) there were substituted—

(c) if the proxy signed the first or second declaration as a witness.

(5) Before making regulations under subsection (2)(b), the Secretary of State must consult such persons as the Secretary of State considers appropriate.

(6) Regulations under subsection (2)(b) are subject to the negative procedure.

Clause 19 permits the coordinating doctor, with the agreement of the patient, to "authorise" another suitably trained doctor to assist in the suicide of the patient.

CLAUSE 20. MEANING OF "APPROVED SUBSTANCE"

(1) The Secretary of State must, by regulations, specify one or more drugs or other substances for the purposes of this Act.

(2) In this Act "approved substance" means a drug or other substance specified in regulations under subsection (1).

(3) Regulations under subsection (1) are subject to the negative procedure.

(4) See section 28 for provision about prescribing, dispensing, transporting, storing, handling and disposing of approved substances.

It will be for the Secretary of State for Health to specify through regulations the "approved substance" used to kill the patient. It is of interest that drug firms have indications and contraindications for the use of medication in the treatment of disease. No drugs are currently licensed to end the lives of patients. In America there is a similar concern about the use of drugs for capital punishment. It is difficult to imagine that any pharmaceutical company would license a drug for assisted suicide or want to be seen to be making a profit from such a prescription. Furthermore, no drugs used in this context would ever be subject to clinical trials to establish the "correct" lethal dosage. The need for approval by the Secretary of State would directly implicate a government minister in facilitating assisted suicide.

CLAUSE 21. FINAL STATEMENT

The coordinating doctor must complete a statement to the effect that the person has been provided with assistance to end their own life. This is known as the "final statement" which should be kept in the person's medical records.

(1) This section applies where a person has been provided with assistance to end their own life in accordance with this Act and has died as a result.

(2) The coordinating doctor must complete a statement to that effect (a "final statement").

(3) The statement mentioned in subsection (2) must be—

(a) in the form set out in Schedule 6, and

(b) signed and dated by the coordinating doctor.

(4) Where the coordinating doctor is a practitioner with the person's GP practice, the coordinating doctor must, as soon as practicable, record the making of the statement in the person's medical records.

(5) In any other case—

(a) the coordinating doctor must, as soon as practicable, inform a registered medical practitioner with that practice of the making of the statement, and

(b) the practitioner so informed must, as soon as practicable, record the statement in the person's medical records.

(6) A record made under subsection (4) or (5) must include the original statement.

CLAUSE 22. OTHER MATTERS TO BE RECORDED IN MEDICAL RECORDS

(1) This section applies where a person is provided with assistance to end their own life in accordance with this Act and either—

(a) the person decides not to take the substance, or

(b) the procedure fails.

(2) Where the coordinating doctor is a practitioner with the person's GP practice, the coordinating doctor must, as soon as practicable, record that this has happened in the person's medical records.

(3) In any other case—

(a) the coordinating doctor must, as soon as practicable, inform a registered medical practitioner with that practice that this has happened, and

(b) the practitioner so informed must, as soon as practicable, record that fact in the person's medical records.

The coordinating doctors must provide a "final statement" in a Schedule 6 form which will be recorded in the medical records. There is no indication as to who would have access to these medical records, or whether they would be in a manual and/or electronic form. It is practically important to know if the next of kin would have access or whether they would be available at an Inquest. It is also unclear as to whether they would be accessible to the Chief Medical Officer for the annual report or to the Secretary of State for the 5-year review. There is now good evidence that assisted suicide and active euthanasia cases are underreported in countries where they are legally permitted. The deliberate killing of the innocent in any civilised society is a matter of serious public importance and interest.

CLAUSE 23. PROTECTION FOR HEALTH PROFESSIONALS

23 No obligation to provide assistance etc

(1) No registered medical practitioner or other health professional is under any duty (whether arising from any contract, statute or otherwise) to participate in the provision of assistance in accordance with this Act.

(2) An employer must not subject an employee to any detriment for exercising their right under subsection (1) not to participate in the provision of assistance in accordance with this Act or for participating in the provision of assistance to a person in accordance with this Act.

Healthcare professionals will not be required to participate in providing assisted suicide and their employers must not penalise them for exercising this right. The Bill does not make any provision for conscientious objection for lawyers or judges who might be involved in supporting or authorising assisted suicide in the Courts.

CLAUSE 24. CRIMINAL LIABILITY FOR PROVIDING ASSISTANCE

(1) A person is not guilty of an offence by virtue of providing assistance to a person in accordance with this Act.

(2) Subsection (1) does not limit the circumstances in which a court can otherwise find that a person who has assisted another to end their own life (or to attempt to do so) has not committed an offence.

(3) In the Suicide Act 1961, after section 2A (acts capable of encouraging or assisting suicide) insert—

2AA Assistance provided under Terminally Ill Adults (End of Life) Act 2024

(1) In sections 2(1) and 2A(1), a reference to an act that is capable of encouraging or assisting suicide or attempted suicide does not include the provision of assistance to a person to end their own life in accordance with the Terminally Ill Adults (End of Life) Act 2024.

(2) It is a defence for a person charged with an offence under section 2 to prove that they—

(a) reasonably believed they were acting in accordance with the Terminally Ill Adults (End of Life) Act 2024, and

(b) took all reasonable precautions and exercised all due diligence to avoid the commission of the offence.

Whilst the Bill would not decriminalise all assisted suicide, it makes provision for the decriminalisation of assisted suicide for the terminally ill at their own request. This breaches the norm that the consent of the victim does not justify homicide and sets a new and unique exception. It remains for the accused simply to prove that they reasonably believed that they were acting in accordance with the Terminally Ill Adults Bill and acted with due diligence to avoid the commission of an offence.

CLAUSE 25. CIVIL LIABILITY FOR PROVIDING ASSISTANCE.

(1) Providing assistance to a person to end their own life in accordance with this Act does not give rise to any civil liability.

(2) Subsection (1) does not limit the circumstances in which a court can otherwise find that a person who has assisted another person to end their own life is not subject to civil liability.

(3) The references in subsections (1) and (2) to providing assistance to or assisting a person to end their own life include references to providing assistance to or, as the case may be, assisting the person in an attempt to do so.

There is no civil liability for assisting a patient in their voluntary suicide, however this does not apply to providing assistance to the suicide of another person who is not terminally ill.

CLAUSE 26. OFFENCES. DISHONESTY, COERCION OR PRESSURE.

(1) A person who, by dishonesty, coercion or pressure, induces another person to make a first or second declaration, or not to cancel such a declaration, commits an offence.

(2) A person who, by dishonesty, coercion or pressure, induces another person to self-administer an approved substance provided in accordance with this Act commits an offence.

(3) A person who commits an offence under subsection (1) or (2) is liable on conviction on indictment to imprisonment for a term not exceeding 14 years.

CLAUSE 27. FALSIFICATION OR DESTRUCTION OF DOCUMENTATION

(1) A person commits an offence if they—
- *(a) make or knowingly use a false instrument which purports to be—*
  - *(i) a first declaration,*
  - *(ii) a second declaration, or*
  - *(iii) a declaration by the High Court or the Court of Appeal under section 12, or*
- *(b) wilfully conceal or destroy a first declaration or a second declaration by another person.*

(2) A person commits an offence if, in relation to another person who has made a first declaration under this Act, they knowingly or recklessly provide a medical or other professional opinion in respect of that person which is false or misleading in a material particular.

(3) A person ("A") commits an offence if, in relation to another person ("B") who has cancelled a first or second declaration made and signed by B in accordance with this Act, A wilfully ignores or otherwise conceals knowledge of that cancellation.

(4) A person guilty of an offence under subsection (1)(a), (2) or (3) which was committed with the intention of causing the death of another person is liable, on conviction on indictment, to imprisonment for life.

(5) Unless subsection (4) applies, a person convicted of an offence under this section is liable—
- *(a) on summary conviction, to imprisonment for a term not exceeding the general limit in a magistrates' court or a fine, or both;*
- *(b) on conviction on indictment to imprisonment for a term not exceeding 5 years or a fine, or both.*

Offences may be committed where there has been dishonesty, coercion or pressure to make, or not to cancel, a declaration for assisted suicide or io induce the self-administration of an approved substance for an assisted suicide. If this is done with the intention of causing death, the person is liable, on conviction, to imprisonment for life. Other lesser offences include providing false or misleading information in relation to assisted suicide, or concealing information concerning a cancellation by the patient.

CLAUSE 28. REGULATORY REGIME FOR APPROVED SUBSTANCES

28 Prescribing, dispensing, transporting etc of approved substances

(1) The Secretary of State may, by regulations, make provision—

(a) about the prescribing and dispensing of approved substances;

(b) about the transportation, storage, handling and disposal of approved substances;

(c) about the records to be kept in relation to the prescribing, dispensing, transportation, storage, handling and disposal of approved substances.

(2) Regulations under subsection (1) may make provision about enforcement, including provision imposing civil penalties.

(1) Regulations under subsection (1) are subject to the negative procedure

The Secretary of State may be responsible for approving the use of "approved substances" for assisted suicide, by regulations. These regulations may impose civil penalties. Hence, the Secretary of State may become directly involved in the use and regulation of approved substances for assisted suicide.

CLAUSE 29. INVESTIGATION AND REGISTRATION OF DEATHS.

(1) A person is not to be regarded as having died in circumstances to which section 1(2)(a) or (b) of the Coroners and Justice Act 2009 (duty to investigate certain deaths) applies only because the person died as a consequence of the provision of assistance to that person in accordance with this Act.

(2) In the Births and Deaths Registration Act 1953, after section 39A, insert— 39B Regulations: assisted dying (1)

The Secretary of State may by regulations—

(a) provide for any provision made by or under this Act relating to the registration of deaths to apply in respect of deaths which arise from the provision of assistance in accordance with the Terminally Ill Adults (End of Life) Act 2024 with such modifications as may be prescribed in respect of—

(i) the information which is to be provided concerning such deaths,

(ii) the form and manner in which the cause of such deaths is to be certified, and

(iii) the form and manner in which such deaths are to be registered, and

(b) make such incidental, supplemental and transitional provisions as the Secretary of State considers appropriate.

(2) Any regulations made under subsection (1)(a)(ii) must provide for the cause of death to be recorded as "assisted death" along with a record of the person's terminal illness by reason of which they were entitled to be provided with assistance to end their own life in accordance with the Terminally Ill Adults (End of Life) Act 2024.

(3) In subsection (2) "terminal illness" means the illness, disease or medical condition mentioned in section 2(1)(a) of that Act.

(4) The power of the Secretary of State to make regulations under subsection (1) is exercisable by statutory instrument.

(5) Regulations may not be made under subsection (1) unless a draft of the statutory instrument containing them has been laid before and approved by a resolution of each House of Parliament.

(3) The Registrar General for England and Wales must, at least once each year, prepare and lay before Parliament a report providing a statistical analysis of deaths which have arisen from the provision of assistance to persons in accordance with this Act.

The certification of death after assisted suicide is somewhat unclear from Clause 29. The Secretary of State may, by regulations, provide for any provision under the Act in relation to the registration of such deaths and information which is to be provided concerning such deaths and the form and manner in which such deaths are to be certified and registered. On the other hand, any regulations must provide for the cause of death as "assisted death" along with a record of the person's terminal illness.

In death certification the immediate cause of death is stated in Part I and other conditions or diseases which the person suffered and contributed to the death but which were not the immediate cause of death are recorded in Part II. In the case of assisted suicide the immediate cause of death would be the "approved substances" used to cause the death or "assisted suicide." The requirement to use the term "assisted death" is misleading.

Clause 29 makes it clear that assisted suicide is not a reason for referral to a Coroner under the Coroners and Justice Act 2009 which relates to the investigation of certain deaths. Therefore there is no automatic duty to investigate assisted suicides. The relevant section of the Coroners and Justice Act 2009 referred to in the Bill where either *"(a) the deceased died a violent or unnatural death, [or] (b) the cause of death is unknown."* Hence, *"assisted suicide"* or *"assisted death"* would not be construed as an *"unnatural death."*

Clause 29 removes the need to have a public inquiry as to particular types of death and leaves a presumption that assisted suicide deaths will not be routinely investigated at an Inquest. This would require an amendment to the Coroners and Justice Act 2009 to the effect that an *"assisted death"* or *"assisted suicide"* is not an unnatural death. On the other hand, the Secretary of State could, through regulations, make provision for the information which should be provided for such death and the *"form and manner in which the cause of such deaths is to be certified."* This presumably means that the Secretary of State could indicate that an *"assisted death"* is indeed meant to mean *"assisted suicide."*

Furthermore under *"39B Regulations; assisted dying"* the Secretary of State may make regulations to make provisions in respect *of "the information which is to be provided concerning such deaths, the form and manner in which such deaths are to be certified ....and registered."* Nevertheless, any regulations must "*provide for the cause of death to be recorded as "assisted death."* The use of the term "assisted suicide" is not required and indeed, the Secretary of State is not required to make regulations which would have to be through a statutory instrument which has been laid before Parliament and approved by a resolution of each House of Parliament. This means that the Secretary of

State may not actually make regulations requiring "assisted suicide" to be stated on a death certificate.

Further difficulties would arise if such deaths were not to be reported to the Coroner because they were excluded, per se, through the amendment of the Coroners and Justice Act 2009 and because they had been authorised as legal by the High Court in a way that cannot be appealed to the Court of Appeal. This strongly implies that a Coroner would not be entitled to investigate such deaths as unnatural deaths. There would also be difficulties in reporting such deaths to the Coroner where there were other genuine concerns about the care of the patient, for example, in cases of otherwise negligent treatment of the underlying terminal illness. Whilst a failure to follow due process within the terms of the Bill would mean that the assisted suicide could still be held to be unlawful as a punishable criminal assisted suicide, it appears that this would not normally be reported to the Coroner, if at all. Furthermore, the role of the Medical Examiner within Trusts is likely to create a further barrier to reporting such cases to the Coroner. Clearly, there would be very significant and largely insurmountable barriers to presenting such deaths to the Coroner for public scrutiny through an inquest.

Nevertheless, the Registrar General must lay before Parliament a report in relation to how deaths have occurred in relation to *"the provision of assistance in accordance with this Act."*

It has always been important that there is objectivity in the certification of deaths. Death certificates are divided into two parts. The first gives the immediate cause of death and Part 2 outlines other conditions which though not directly leading to death, nevertheless, were significant contributory factors. This fundamental principle will be overturned if assisted suicide is not certified as the immediate, or direct cause of death, in favour of a less accurate term "assisted death" or if there is no mention of assisted suicide at all. In other jurisdictions there is evidence of significant underreporting of deliberate killing of patients through assisted suicide or euthanasia.

CLAUSE 30. CODES OF PRACTICE

(1) The Secretary of State may issue one or more codes of practice in connection with—

- *(a) the assessment of whether a person has a clear and settled intention to end their own life, including—*
  - *i) assessing whether the person has capacity to make such a decision;*
  - *ii) recognising and taking account of the effects of depression or other mental disorders (within the meaning of the Mental Health Act 1983) that may impair a person's decision-making;*
- *(b) the information which is made available as mentioned in sections 4 and 9 on treatment or palliative, hospice or other care available to the person and under section 9 on the consequences of deciding to end their own life;*
- *(c) the arrangements for ensuring effective communication in connection with the provision of assistance to persons in accordance with this Act, including the use of interpreters;*

(d) *the arrangements for providing approved substances to the person for whom they have been prescribed, and the assistance which such a person may be given to ingest or self-administer them;*
(e) *such other matters relating to the operation of this Act as the Secretary of State considers appropriate.*

(2) *Before issuing a code under this section the Secretary of State must consult such persons as the Secretary of State considers appropriate.*
(3) *A code issued under subsection (1) does not come into force until the Secretary of State by regulations so provides.*
(4) *Regulations bringing a code into force are subject to the affirmative procedure.*
(5) *When draft regulations are laid before Parliament in accordance with that procedure, the code to which they relate must also be laid before Parliament.*
(6) *A person performing any function under this Act must have regard to any relevant provision of a code.*
(7) *A failure to do so does not of itself render a person liable to any criminal or civil proceedings but may be taken into account in any proceedings*

The Secretary of State may, but need not, issue Codes of Practice regarding most aspects of assisted suicide. Any person performing any function under the proposed legislation must have regard to the Codes of Practice which must be taken into account in any criminal or civil proceedings. It is however clear that once the Rubicon has been crossed to allow the direct killing of patients through assisted suicide, that the Secretary of State and Government of the day will remain directly responsible for these deaths. Assuming it would apply to 1% of just under 600,000 deaths in England and Wales annually (581,363 in 2023 and 577,160 in 2022) this would amount to over 100 deaths each week.

CLAUSE 31. GUIDANCE FROM CHIEF MEDICAL OFFICERS.

(1) *The relevant Chief Medical Officer must prepare and publish guidance relating to the operation of this Act.*
(2) *Before preparing guidance under this section, the relevant Chief Medical Officer must consult such persons as that Chief Medical Officer considers appropriate.*
(3) *When preparing that guidance, the relevant Chief Medical Officer must have regard to the need to provide practical and accessible information, advice and guidance to—*
    (a) *persons requesting or considering requesting assistance to end their own lives;*
    (b) *next of kin and families of such persons;*
    (c) *the general public.*
(4) *In this section "relevant Chief Medical Officer" means—*
    (a) *in relation to England, the Chief Medical Officer for England;*
    (b) *in relation to Wales, the Chief Medical Officer for Wales.*
(5) *Provision through NHS etc*

The Chief Medical Officers will be responsible for preparing and publishing guidance for persons requesting or considering assisted suicide, their next of kin and the general public.

CLAUSE 32. SECRETARY OF STATE'S POWERS TO ENSURE ASSISTANCE IS AVAILABLE.

(1) The Secretary of State may, by regulations, make provision—
  (a) to secure that arrangements are made, by the Secretary of State or other persons, for the provision of assistance to persons in accordance with this Act, and
  (b) for related matters.
(2) Regulations under subsection (1) may, in particular, enable the provision of such assistance as part of the health service in England and the health service in Wales.
(3) The power to make regulations under subsection (1) includes power to amend, repeal or revoke any provision made by an enactment passed or made before the end of the Session in which this Act is passed.
(4) Regulations under subsection (1) are subject to the affirmative procedure

The language of clause 32 is ambiguous but appears to allow the Secretary of State to make regulations that would enable assistance to be given to persons in accordance with the Act in relation to providing the means to have assisted suicide. However, if this is the case it would require healthcare professionals to assist in the suicide of patients. It is difficult to understand how this would come about especially as there is likely to be a strong resistance from clinicians to be directly involved in deliberately causing the death of patients. Where assisted suicide and euthanasia are practiced in other jurisdictions it is only a small proportion of healthcare professionals who wish to be directly involved. Clause 32 does however admit that assisted suicide would become part of the National Health Service in England and Wales.

CLAUSES 33 AND 34. MONITORING AND REVIEW

CLAUSE 33. Notifications to Chief Medical Officers

(1) The Secretary of State may, by regulations, require any registered medical practitioner to notify the relevant Chief Medical Officer of any notifiable event.
(2) The following are notifiable events in relation to a registered medical practitioner—
  (a) the practitioner witnessing a first declaration under section 5 as the coordinating doctor;
  (b) the practitioner, having carried out the first assessment, providing or refusing to provide the statement mentioned in section 7(3);
  (c) the practitioner, having carried out the second assessment, providing or refusing to provide the statement mentioned in section 8(5);
  (d) the practitioner witnessing a second declaration under section 13;
  (e) the practitioner making or refusing to make a statement under section 13(5);
  (f) the practitioner making a final statement under section 21;
  (g) the practitioner making a record in a person's medical records in accordance with section 17 or 22 or notifying another practitioner to enable such a record to be made;
  (h) such other events as may be specified by the Secretary of State by regulations.
(3) Regulations under subsection (1) may—
  (a) specify the information which must be contained in the notification;
  (b) specify the manner in which the notification must be given;
  (c) make provision about enforcement of the regulations.

(4) In this section "relevant Chief Medical Officer" has the meaning given by section 31(4).
(5) Regulations under this section are subject to the negative procedure.

CLAUSE 34. MONITORING BY CHIEF MEDICAL OFFICERS

(1)The relevant Chief Medical Officer must—

(a) monitor the operation of the Act, including compliance with its provisions and any regulations or code of practice made under it,

(b) investigate, and report to the relevant national authority on, any matter connected with the operation of the Act which the relevant national authority refers to the relevant Chief Medical Officer, and

(c) submit an annual report to the relevant national authority on the operation of the Act.

(2) The relevant Chief Medical Officer's report must include information about the occasions when—

(a) the coordinating doctor has refused to make a statement under section 7(3);

(b) the independent doctor has refused to make a statement under section 8(5);

(c) the High Court or Court of Appeal has refused to make a declaration under section 12;

(d) the coordinating doctor has refused to make a statement under section 13(5).

(3) The relevant Chief Medical Officers may combine their annual reports for the same year in a single document ("a combined report") in such manner as they consider appropriate.

(4) The relevant national authority must publish each annual report or combined report it receives under this section and—

(a) the Secretary of State must lay a copy of each report they receive before Parliament, and

(b) the Welsh Ministers must—

(i) lay a copy of each report they receive before Senedd Cymru, and

(ii) send a copy of each report (other than a combined report) they receive to the Secretary of State.

(5)The Secretary of State must—

(a)prepare and publish a written response to any report received under this section,

(b)lay a copy of any written response before Parliament, and

(c)if the written response is to a report from the Chief Medical Officer for Wales or a combined report, send a copy of the response to the Welsh Ministers.

(6)The Welsh Ministers must lay a copy of any written response they receive under subsection (5)(c) before Senedd Cymru.

(7)In this section—

relevant Chief Medical Officer has the meaning given by section 31(4);

relevant national authority means—

(a)in relation to the Chief Medical Officer for England, the Secretary of State, and

(b)in relation to the Chief Medical Officer for Wales, the Welsh Ministers.

CLAUSE 35. REVIEW OF THE ACT

(1) The Secretary of State must, during the period of 12 months beginning at the end of the initial 5-year period—

(a) undertake a review of the operation of this Act,

(b) prepare a report on that review, and

(c) as soon as reasonably practicable, publish and lay the report before Parliament.

(2) "The initial 5-year period" means the period of 5 years beginning with the day on which this Act is passed.

(3) The report must, in particular, set out—

(a) the extent to which the Act has successfully met its aim of allowing adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own lives;

(b) an assessment of the availability, quality and distribution of appropriate health services to persons with palliative care needs, including—

(i) pain and symptom management;

(ii) psychological support for those persons and their families;

(iii)information about palliative care and how to access it;

(c) any concerns with the operation of this Act which have been raised; and

(d) the Secretary of State's response to any such concerns, including any recommendations for changes to codes of practice, guidance or any enactment (including this Act).

There has been considerable emphasis on the safeguards within the proposed legislation. This necessitates monitoring and review of the application of the proposed legislation. It is already clear that decisions by the High Court in favour of a patient's first declaration for assistance in suicide cannot be appealed. It is only refusals to grant the declaration that can go before the Court of Appeal. It appears that death certification would report assisted suicide as an assisted death which would not be reported to the Coroner as an unnatural death. The process of arranging an assisted suicide would not necessarily involve other members of the patient's family and healthcare workers involved in assisted suicide would only involve those who had no conscientious objection. It was made clear by the Health Secretary on 12 November 224 that there is a need for considerable investment to improve palliative care services within the NHS. At present over two thirds of palliative care provision is funded through charities, rather than the NHS. Assisted suicide, especially if performed in Hospices, would seriously undermine the public support for palliative care. It is difficult to understand how it would improve charitable contributions to support our palliative care and hospices. The Health Secretary, who has stated that he will oppose the proposed legislation, has emphasised the need to support palliative care services for those who are dying, rather than bring about their deaths.

The monitoring process is usually predicated on the basis that the Secretary of State or Chief Medical Officers may take action. The exceptions are that the Chief Medical Officer must prepare guidance relating to the operation of this Act (s.31(1)) and must monitor the operation of the Act, including compliance with its provisions and regulations or code of practice made under it (s.34 (1)(a)); the Chief Medical Officer must provide information on the occasions when the coordinating doctor or independent doctor have refused to make a statement (s.34 (2)(a & b)); the Secretary of State must by regulations specify one or more drugs or other substances as "approved substances" (s. 20(1)), must lay before Parliament the report of the Chief Medical Officers (s.34(4 & 5)); the Secretary of State must also undertake a 5-year review of the operation of the Act (s.35(1),(2) & (3))

Notwithstanding the requirements for reports from the Chief Medical Officers and Secretary of State, there is little in the legislation which indicates what these reports should contain and how these reports will be acted upon. In particular, there is no clear channel for healthcare professionals or friends or relatives of the deceased to raise concerns. The route via the Coroner has been blocked and it is unlikely that civil action would be taken on behalf of the patient once they have died, considering the considerable expense they would incur from legal fees. There is little in the legislation to indicate how relatives of the deceased would (or could) be compensated or how those involved in the assisted suicide would apply for redress or even an explanation of what has happened. A failure to meet the concerns of relatives after the assisted suicide of a loved one will have a significant impact on the trust and confidence of the public in the care of the dying. The deliberate killing of patients must not be taken as a proper avenue of care for the dying.

CLAUSE 36. GENERAL AND FINAL

36 Disqualification from being witness or proxy

(1) The individuals specified in subsection (2) are disqualified from—

(a)witnessing a first declaration by a person under section 5(2)(c)(ii);

(b)witnessing a second declaration by a person under section 13(3)(c)(ii);

(c)being a proxy for a person intending to have a document signed by proxy under section 15.

(2)Those individuals are—

(a)any relative of the person;

(b)anyone who knows or believes that they—

(i) are a beneficiary under a will of the person, or

(ii)may otherwise benefit financially or in any other material way from the death of the person;

(c)any health professional who has provided treatment or care for the person in relation to that person's terminal illness;

(d)any person who has not attained the age of 18.

(3) In subsection (2)(c), the reference to "terminal illness" means the illness, disease or medical condition mentioned in section 2(1)(a).

It is clear that as a final consideration relatives, including those who may be beneficiaries in the patient's will, shall be excluded from being witnesses to the patient's assisted suicide. Clause 36 therefore excludes close family members and friends from being involved in the assisted suicide process. it is precisely these people who know the patient who would be able to raise concerns about what was happening. They are excluded by the Act.

CLAUSE 37. MODIFICATION OF FORM OF DECLARATIONS AND STATEMENTS

(1) The Secretary of State may by regulations amend or replace any of Schedules 1 to 6.

(2) Regulations under subsection (1) are subject to the negative procedure.

CLAUSE 38. POWER TO MAKE CONSEQUENTIAL AND TRANSITIONAL PROVISION etc.

(1) The Secretary of State may by regulations make—

(a) such supplementary, incidental or consequential provision, or

(b) such transitory, transitional or saving provision,

as the Secretary of State considers appropriate for the purposes or in consequence of any provision made by this Act.

(2) Regulations under subsection (1) are subject to the negative procedure.

CLAUSE 39. REGULATIONS

(1) A power to make regulations under any provision of this Act includes power to make different provision for different purposes.

(2) Regulations under this Act are to be made by statutory instrument.

(3) Where regulations under this Act are subject to "the affirmative procedure", the regulations may not be made unless a draft of the statutory instrument containing them has been laid before, and approved by a resolution of, each House of Parliament.

(4) Where regulations under this Act are subject to "the negative procedure", the statutory instrument containing them is subject to annulment in pursuance of a resolution of either House of Parliament.

(5) Any provision that may be made by regulations under this Act subject to the negative procedure may be made by regulations subject to the affirmative procedure.

(6) This section does not apply to regulations under section 42 (commencement).

Clauses 37 to 40 allow the Secretary of State to make regulations, including significant changes to Schedules 1 to 6, including amendments or replacements. One important issue would be whether either a coordinating doctor or independent doctor who refused to agree a suicide or was of the opinion that it was not appropriate in a given case should have their view recorded in the Schedules and/or should make their views known in the High Court. It appears that without such regulations, the views of any dissenting doctor would be ignored by a High Court judge.

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[i] The Code for Crown Prosecutors. 26 October 2018. (Issued under section 10 of the Prosecution of Offences Act 1985).

[ii] Inter-American Court of Human Rights. Proposed Amendments to the Naturalization Provisions of the Constitution of Costa Rica, Advisory Opinion OC-4/84 of January 19, 1984, Series A, No. 4, p. 104, para. 55.

[iii] See: CDC National Center for Health Statistics (NCHS), National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database CDC WONDER

**CDC WISQARS (2022); Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH) https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables .

[iv] "Mental illness" was previously defined in relation to "mental disorders." However in the new definition of mental disorder and removal of an explicit mention of mental illness in the definition came through the Mental Health Act 2007.

[v] The Swiss psychiatrist Dr Elizabeth Kubler-Ross wrote a book called On Death and Dying in 1969 which had a profound effect on the emerging palliative care movement.

[vi] *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182.Middleton para 2 also endorsed in the case of *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2 at para. 93