

What would be the possible implications for Nurses if the current United Kingdom law were changed to legalise assisted suicide?

Matthew Hartwell & Mark Gagan

Senior Lecturers at Bournemouth University.

Matthew Hartwell Programme Leader Non-Medical Prescribing.

Mark Gagan RN,LLM,(Medical Law) PGD Social Research ,RNT, Senior Lecturer Adult nursing programme

Bournemouth University

B215

17 Christchurch Road

Bournemouth

BH1 3LH

## Introduction

Assisted suicide remains a controversial topic for registered nurses, who are increasingly being requested for assistance in ending a patient's life (Kopala and Kennedy 1998, Boudreau and Somerville 2014). At least three events bring this discussion of assisted suicide to the forefront for nurses and those who are prescribers in the UK. These include on-going media attention, an increased focus on nursing involvement and the potential of emerging legislation that might legalise assisted suicide. (Richards 2014).

Suicide, was decriminalised, in England and Wales, under the terms of the Suicide Act 1961. However despite this change any form of assisted suicide still remains a criminal offence.

The European Court of Justice, implementing the Convention for the Protection of Human Rights and Fundamental Freedoms (and therefore United Kingdom (UK) legislature) insists there is a "right to life", (Article 2) under the auspices of the Human Rights Act [1998], however, there is no legal "right to die".

Some European countries e.g. Switzerland and Belgium have legalised assisted suicide which may create a sense of unreasonableness and unfairness and promotes "death tourism" as desperate families take their loved ones abroad from the UK to die in clinics in Zurich rather than at home.

Cases such as Pretty,[2001] Purdy,[2009] and Nicklinson [2012], have highlighted the attempts to reform European and UK law to allow assisted suicide, without the threat or fear of those taking part being prosecuted. These attempts have, to date, been unsuccessful.

Historically, there are several examples of medical staff being held accountable to the law for their actions concerning the death of patients, sometimes described as "mercy killings". In the cases mentioned the person or persons receiving these medications died. It was not so clear-cut whether the administration of the medications alone killed the recipients yet it might be argued that it went some way towards hastening the end of their lives.

In 1956, Dr John Bodkin Adams was charged with the murder of some patients within his care by use of narcotics. It was stated at his trial that a doctor has a right to relieve pain, even if that incidentally shortened the life of the patient. This is an example of the "doctrine of double effect" whereby, provided the intention to relieve pain was the primary focus of the practitioner, even though the effect of the medication might be such that the patient died, then no blame for murder could be attached. Dr Bodkin Adams was acquitted by the jury after 45 minutes deliberation.

Similarly in 1999, Dr David Moor, a General Practitioner, in Newcastle, was charged with the murder of one of his patients who had terminal cancer. He was acquitted. During a newspaper interview he stated, allegedly, to hastening the death of around 300 patients who he had believed wanted to be relieved of their suffering.

It reported that in 1992, Dr Nigel Cox, a consultant rheumatologist, injected a patient with potassium chloride as an attempt at pain relief. There is no obvious pharmaceutical rationale for using this medication as a pain reliever. Following her death was charged with attempted murder, rather than murder itself, as it could not be proven that the medication had solely caused her death. He was convicted of the offence and received a twelve month suspended prison sentence.

The legal defence for the doctors was that they were acting in their patients' best interests and simply doing their job as physicians.

The doctors concerned were said to be diligent in their care of patients, were well respected by patients and families alike and they had high social status in their communities. As part of the tools of their trade they had prescribing powers and access to noxious substances which if not administered appropriately could have had fatal effects on their recipients.

In essence then, three of the factors that allowed these deaths to occur were that healthcare professionals, who were accorded great public trust and respect had access to the prescribing, dispensing and administration of medications.

Since these cases and that of Dr Harold Shipman, there have been new rules and regulations regarding the recording and administration of medications. However, since 2012, the British National Formulary has been opened up to registered nurses, following appropriate education and practice and within the scope of their knowledge and experience, giving them the ability to access all medications previously limited to doctors, including opiates.

This then gives another class of persons who are trusted, highly regarded, health professionals with access to practically unlimited prescribing, dispensing and administration of medicines. It does not automatically follow that these nurse prescribers will do as their medical colleagues have done previously but it may leave a lacuna whereby a route to assisted suicide may exist if stringent measures are not enforced.

Historically, nurses have sometimes subsumed roles previously performed by doctors, into their everyday work. The development of Diabetes nurse specialists, Colo-rectal nurse specialists and nurse practitioners in GP surgeries were unheard of in the early 1970s but have developed over time into the highly skilled professionals of today. It is not unusual for a patient on a surgical ward awaiting the formation of an ileostomy or colostomy to be spoken to by specialist nurse practitioner, as well as a surgeon, regarding the procedure that will take place and how the plan of care will develop after the operation. These nurses are not "mini-surgeons" but are well-educated, skilled practitioners who bring the unique role of the nurse into the surgical process and beyond. They do not take the place of medical staff rather they compliment the role of the surgeon and the other members of the multi-disciplinary team in delivering humanised care.

In 1981, the Royal College of Nursing sought a ruling on the practice of administering an abortifacient by nurses in gynaecological situations. Under the Abortion Act (1967), the wording of the Act was open to interpretation as to who should be actually administering the drug. It was found that particularly at night-time, nurses would administer the pessary, rather than medical staff, who were mandated in the Act to give the medication. The RCN's contention was this led to the possibility of the nurses exposing themselves to the danger of a criminal offence (illegal abortion).

There was no illegal intent in the nurses giving the pessary, it was possibly done for benefit of the patient being minimally disturbed or so that a doctor could have a better chance of uninterrupted sleep but it became part of the normal routine.

Perhaps, if nurses took on the role of administering the final dose of medication, in an assisted suicide situation, this too would become "normal practice"?

Legally, however, there is no “escape provision” for nursing staff to be complicit in the prescribing, dispensing or administration of a medication that deliberately and intentionally assists in the suicide of a patient.

The Director of Public Prosecutions, in 2010, following the cases of *Pretty (R (Pretty) v DPP [2001]* and *Purdy (R (on the application of Purdy) v DPP [2009]*, published guidance regarding the prosecution of persons (including family members, medical and nursing staff) who assisted a person to commit suicide, stating that the involvement of healthcare practitioners would be a major factor in seeking to prosecute the healthcare professional on a charge of murder or manslaughter, even if the patient sought their own death by assisted suicide. (CPS 2010)

Whilst families are less likely to be prosecuted for assisting a family member to commit suicide, healthcare staff were warned most stringently, that the consequences of their involvement in assisted suicide endangered both their liberty and their professional careers.

This had been previously stated by the NMC (2009) “... It is the NMC’s statutory duty to remind nurses and midwives that they must practice within their code of conduct and within the context of national laws. The law on assisted suicide has not changed” (NMC statement on the RCN “neutral position” regarding assisted suicide in July 2009)

This discussion is not simply a legal debate, ethical considerations need to be addressed when considering issues of such importance.

Ethically speaking humans have rights, including the right to health. The right to health paradigm is an entitlement which is a very different concept from the notion of health being a commodity (Tschudin 2003). If health is a right then individuals can lay claim to it regardless of economic or political status.

Since 1946 (and via the Ottawa declaration (1986), the Jakarta declaration (1997) the Millennium Development Goals (2000) and the 2030 Agenda for Sustainable Development (2015) ) the World Health Organisation (WHO) and the United Nations (UN) have accepted as a fundamental human right, the enjoyment of the highest attainable standards of health.

In relation to the UK, it is enshrined in Article 8 of the Human Rights Act whereby there is an entitlement to respect one’s private life and family life (Human Rights Act 1998). This is respect for autonomy which is considered to be the highest moral principle (Edwards 2009).

This supports the belief that everybody has a right to define their own destiny and make their own decisions. Usually actions that affect the interests of others are regarded as problematic. If a person were to commit suicide and it had no effect on others, it could be deemed acceptable. However this is rarely the case. Suicide often does harm another for example if there were children, or parents to consider, then suicide could be seen as morally reprehensible. It is not the taking of life itself, rather, it is the potential neglect of duties to others; if these are not present then morally suicide cannot be wrong.

In relation to suicide this has often been condemned as it acts against morality and the sanctity of life (Schramme 2013). However he also states that the moral condemnation of suicide has lost its

credibility because the value put on the individual's right to self-determine (autonomy) is predominant in the modern era.

There are many arguments for and against assisted suicide and the idea of the sanctity of life principle appears foremost in the debate. Hume (1998) put forward the argument that if determining the time of death were entirely up to God, then it is also wrong to intervene and lengthen our lives, for example, by using medicine to retard the progress of disease. Patterson (2008) suggests the ending of life and, the continuance of life can therefore be said to interfere with God's will. Since humanity is constantly interfering in natural laws then why the question of life and death should be viewed any differently? If a patient were to ingest prescribed lethal medication is this dissimilar from refusal of life sustaining treatment which every person has a legal and ethical right to do (Lachman 2015). Is this not an act of suicide, rather respect for autonomy being held as the highest principle (Edwards 2008)?

Currently in the UK people can refuse lifesaving treatment and hence they may die. If requested it is the practitioner's duty to inform the patient of options that, incidentally, may legally permit a hastened death. (*Hills v Potter* [1983]) These include voluntarily stopping eating and drinking, withdrawing life sustaining interventions and sedation to unconsciousness for relief of intractable suffering (Berry 2009).

All three of these options must meet the tests for informed consent, patient capacity, voluntariness and full understanding of the implications (Mental Capacity Act 2005). The NMC (2015) also highlight that a nurse needs to balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment.

Requests from patients and families for information and practical assistance with assisted suicide pose a challenge to the professional nurse. After receiving a request it is the nurse's duty notwithstanding the nurses own personal ethics to carry out an assessment. Are there underlying reasons for this request and if so these can be addressed or ameliorated? Requests are often as a result of pain, depression or feeling isolated. Richards (2014) suggests that historically medical and nursing communities have not been consistent in relieving pain and suffering. It is therefore easy to understand why a patient who is suffering unmanaged pain can feel that the benefit of assisted suicide far outweigh the benefits of continued living and suffering.

If attempts at amelioration are unsuccessful and the patient is judged to have capacity the nurse may face some very emotionally charged decisions. Before making these decisions reflection will undoubtedly take place over some key questions. Do professional obligations to relieve pain and suffering extend to assisting in suicide, how far do autonomy rights extend, is this an act of beneficence, and does the act of assisted suicide violate the respect for persons, harm society or harm the nurse (Kopala and Kennedy 1998)?

When reflecting on these they cannot be viewed in isolation and legal considerations need to be considered. However, Edwards (2009) suggests that this is not always harmonious and often morality does not mirror the legal ideology. In some cases however the nurse may see assisted suicide as ethical while the law may still hold them criminally liable. Therefore any nurse that determines in a particular situation that assisting suicide is morally justified must accept the legal risks attached to that course of action.

Some would argue that to assist suicide is a beneficent act although others would see it differently as each person has an individual ethical perspective. Some would argue that the nurse or healthcare professional is doing the greatest good as by promoting the patients well-being and interest. It is helping the patient to determine how they die and the motive for this is compassion (Harris 2014).

However the opposing argument is that the benefits do not outweigh the harms, such as premature loss of a significant other and hence these effects cannot be beneficial.

Finally the question is raised do professionals have an obligation to assist in suicide? Those in favour say that assisting in suicide when all other efforts to relieve pain have been exhausted it is an act of care and compassion to help a person die. The NMC code of conduct (2015) states that nurses should act compassionately. However it might be argued that it is a nurse's role is not only relieve suffering but to take reasonable steps to respect and protect life. Caring and compassion do not extend to harming the person we are caring for by killing them which inevitably would place the registered nurse in a difficult legal, ethical and professional situation.

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## Legislation

- Abortion Act 1967
- Human Rights Act 1998
- Mental Capacity Act 2005
- Suicide Act 1961

## Cases

Hills v Potter [1983] All ER 716

R v Adams [1975] Crim LR 365 394

R v Cox [1992] BMLR 38 392

R v Moor [1999] Crim LR 2000 July 568-590

R (On the application of Nicklinson and another) v Ministry of Justice (Respondent) [2012] EWHC 2381 (Admin)

R (Pretty) v DPP and the Secretary of State for the Home Department [2001] UKHL 61

R (On application of Purdy (Appellant) v Director of Public Prosecutions (Respondent) [2009] UKHL 45