

Healthcare

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Further guidance on Cheshire West released by the Law Society

The decision in Cheshire West significantly changed the law in relation to the Deprivation of Liberty Safeguards. Whilst the outcome of Cheshire West and the new test to be applied is clear, there remain a number of questions regarding how in practice the decision of the Supreme Court should be interpreted. Recent guidance from the Law Society seeks to tackle some of the key questions raised by the new law and also sets out practical guidance for interpreting the law in a range of care settings.

The guidance is detailed and sets out a helpful and comprehensive summary of the law and key issues for consideration in assessing whether an individual is being deprived of their liberty. I set out below a brief summary of some of the most helpful sections of the guidance relating to the provision of care in the acute sector.

The acid test

Cheshire West set out the "Acid Test" for determining when an individual could be deprived of their liberty. The Court held that the test requires a consideration of whether the individual is free to leave, and whether the individual is under complete and continuous supervision.

The guidance suggests that in assessing whether any individual is under continuous supervision and control, organisations should consider whether the care plan in place effectively requires carers to always need to know where the individual is and what they are doing at any one time. The guidance suggests that if the answer to both these questions is yes then this will be a "strong pointer" that the individual is under continuous supervision and control.

The guidance also suggests that this test does not apply to every single decision being taken for a specific individual but seeks to assess the "overall structure in which aspects of decision making are being allowed".

Freedom to leave?

The guidance confirms that there is difference between the freedom to leave with an ability to leave. The guidance suggests that in the context of DOLS the focus should be upon the actions of those around the individual rather than the individual themselves, and the question should be asked as to what would happen in the event that the individual expressed a desire to leave?

The guidance sets out the following "broad propositions" in relation to whether an individual is free to leave:

– If a person is not free to come and go as they wish this is "at a minimum, a pointer to the individual being subject to restrictions on their liberty"
– A person will clearly not be free to leave if they have to seek permission to relocate from the place of treatment.
– Organisations should consider what would happen if a person were to leave and not return when expected? Would steps be taken to locate and bring them back to the organisation?

Non-negligible period of time

It is clear from European case law that in order to engage Article 5 of the ECHR, an individual's liberty must be restricted for a non-negligible period of time. The guidance confirms that, understandably, this will very much depend on the particular circumstances of the case including the nature of the restriction and consequences.

The guidance acknowledges that there have been cases where individuals have been intensely restrained for as little as 40 minutes and it was held to be a deprivation of liberty.

The guidance avoids setting down a specific period of time that can be considered "safe". The guidance does however strongly suggest that it is not appropriate to use a rule of thumb (that some public bodies have adopted) that a deprivation of liberty is unlikely to arise where a person is confined for less than 7 days.

Conveyance by ambulance

Helpfully, in relation to deprivation of liberty in the hospital setting, the guidance confirms that in almost all cases it is likely that a person can be lawfully taken to a hospital or a care home by ambulance without it being a deprivation of liberty. The guidance confirms however there will be circumstances in which it could be a deprivation of liberty including where an individual has to be sedated or the journey is exceptionally long.

Accident & emergency

The guidance acknowledges that whilst individuals often only stay within A&E for a short period of time, there are circumstances in which a deprivation of liberty could occur. The guidance also acknowledges that there may be circumstances in which due to the timescales, there may be a deprivation of liberty but nothing can be done about it by way of obtaining authorisation within a sufficiently short period of time.

Acute ward setting

The guidance identifies potentially liberty restricting measures that could indicate that a DOL is taking place on an acute ward. These are not determinative but the use of these measures demonstrates a level of control over the patient:

– Physical restraint
– Locked wards
– Mittens
– Bedrails
– Frequency and intensity of observation and monitoring levels
– Requirement for a patient to remain in a certain area of the ward

Summary

The guidance from the Law Society is very helpful in combating some of the practical questions that have been raised to date with interpreting the law. The guidance acknowledges that further judicial consideration will need to be given before we are much clearer in terms of how the acid test should be applied, but this guidance certainly is welcomed on the basis that it provides some helpful and practical guidance on how to approach the DOLS in light of Cheshire West.

The guidance is available in full here: http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

If you would like to discuss any aspect raised in this article please contact James Cassidy.



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Chief Coroner's Guidance No. 16: Deprivation of Liberty Safeguards - what you need to know

The Chief Coroner has recently received guidance in relation to the Deprivation of Liberty Safeguards (DOLS) ("the Guidance"). By way of background, at present there are in the region of 13,000 DOLS applications per year. The Department of Health and Care Quality Commission expects that number to rise to approximately 100,000 applications per year, particularly in light of the decision in *Cheshire West*.

The Law Commission has commenced a fundamental review of DOLS provisions in the Mental Capacity Act 2005 and it is anticipated that this report will be published, with a draft Bill to follow in 2017. In the meantime, the Guidance has been published to give Coroners a steer as to what actions to take if a DOLS authorisation had been issued in respect of a deceased at the time of his/her death.

Section 1(2)(c) of the Coroners and Justice Act 2009 ("the 2009 Act") provides that a Coroner must conduct an investigation into a person's death if the deceased died whilst in custody or otherwise in state detention. The question therefore is whether a person who has been deprived of their liberty under a DOLS authorisation amounts to being in state detention.

The Guidance accepts that there are two schools of thought. The first is that state detention is defined in Section 48(2) of the 2009 Act as being if a person is compulsorily detained by a public authority within the meaning of Section 6 of the Human Rights Act 1998. Consequently, it would appear that a person whose deprivation of liberty has been authorised under the DOLS regime will only be under state detention if they are in the care of a state facility (e.g. hospital or care home).

However, a second school of thought is that, given that the mechanism by which a person's liberty may be deprived is through the authority of the state, and that they are being held in detention, effectively, under that authority, the reality is that they have been deprived of their liberty by the authority of the state. Following this process, any person about whom there is a DOLS authorisation is in state detention for the purposes of the 2009 Act.

Ultimately, the Guidance provides that it is a matter for the Coroner to decide which of these opposing views s/he prefers. However, the Chief Coroner has made it clear that he favours the second approach and it is likely that this will be seen to be a highly persuasive argument.

What impact will this have on organisations?

Realistically, if a patient subject to a DOLS authorisation dies, the Coroner will be conducting an investigation into the death, whether or not it is deemed to be natural causes or not. The nature of that investigation is a matter for the Coroner and it may be that, where the cause of death is clearly natural, the matter can be resolved by way of simply conducting and subsequently closing an investigation.

The complications will arise where the death is not natural causes and, therefore, under Section 7 of the 2009 Act, an inquest must be held with a Jury (on the basis that the deceased died in state detention and the death was unnatural).

For organisations who care for patients who are deprived of their liberty (including, therefore, hospitals and care homes) this will potentially create a huge burden due to the number of witnesses called and the length of time it will take for inquest to be heard. It is important that organisations are aware of patients (residents) who are being deprived of their liberty and so that in the event of that person's death, when notifying the Coroner, the Coroner's Officer is made aware of any deprivation of liberty authorisation in place.

It is of note that Coroners are being encouraged to err on the side of caution where an individual is in a Care Home and under a DOLS authorisation but then transferred to hospital. It is likely that, for the purposes of the inquest, if the death is shortly after such a transfer the Coroner will find that the person was, in effect, under a DOLS authorisation.

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Finally, even where an authorisation is in doubt, the guidance is clear that Coroners do not have the authority to challenge the validity of a DOLS authorisation.

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Ownership of a body – Department of Health Consultation

It is commonly accepted that there is no property in a dead body. There is however a duty on whoever holds the body to make suitable arrangements for its disposal. The Department of Health has recently released a consultation in relation to this issue in order to provide advice and support to healthcare providers.

The case of Williams v Williams (1882) held that the duty to dispose of a dead body is incumbent on the personal representatives of the deceased. This position has been expanded upon over the years and additional duties have been imposed upon:

- The owner of a household/premises in which the Deceased died. This would include an NHS Trust or any other healthcare premises, where there are no other arrangements made for the Deceased
- The Local Authority for the area in which the body is found. Where there are no suitable arrangements for the disposal of the body, the duty may fall on the Local Authority to cremate or bury the body of any person who has died or been found dead in the Authority's area

As a consequence of the above, a hospital can be in lawful possession of a dead body and, subject to the claims of others, it can have a duty and a right to make arrangements to dispose of the deceased. This premise was examined in the case of University Hospital Lewisham NHS Trust v Hamuth and others (2006) where there was a dispute between the Deceased's family and the named personal representative over the validity of the will. It was held by the Court that as the identity of the personal representative would not be settled imminently the Trust had a right to decide on the funeral arrangements.

NHS Trusts may be aware that the Department of Health recently opened a consultation concerning the release of dead bodies from hospitals. The purpose of the consultation relates to the administrative issues and seeks to formalise documentation for the release of dead bodies into the possession of the person(s) who are charged with making arrangements for the funeral.

The consultation was opened as the Department of Health had concerns that some hospitals were causing unnecessary delays in releasing bodies and in turn causing unnecessary distress to the families of the Deceased.

Although no formal research was undertaken on the issue, the Department of Health believed that some NHS Trusts required family members to present specific forms to the bereavement service staff in order for a body to be released. Such documentation included the "Green Form" issued by the register of deaths or the "Burial Order" issued by a coroner.

There is however no legal requirement for a hospital to receive a copy of the Green Form or burial order prior to releasing the body, but it is of course the responsibility of the hospital to put in place processes for the safe and correct release of bodies to family members or funeral directors.

In order to improve and provide a more consistent approach, a draft release form has been prepared by the Department of Health for the release of bodies. It is hoped that the form will eventually provide a template that may be adopted by hospitals and the Department has requested comments on their draft form.

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Lost years case update

Background to 'lost years' claims

The House of Lords decision in *Pickett v British Rail Engineering [1980]* established the principle that damages for lost years could include a sum to cover loss of earnings in that period, whatever the age of the claimant. Such losses are recoverable in adult claims on the basis that that person has been deprived the opportunity to use their income in the way they would have wished had their life expectancy not been reduced.

In the subsequent case of *Gammell v Wilson [1982]* this point was revisited in relation to lost years claims by children and Lords Diplock and Scarman agreed that such awards were not available to young children. Lord Diplock was of the opinion that in cases where there was no history of previous steady employment, *"the judge would be faced with a task that is so purely one of guesswork that it is not susceptible of solution by the judicial process"*.

Lord Scarman said:

"In the case of a young child, the lost years of earning capacity will ordinarily be so distant that assessment is mere speculation. No estimate being possible, no award - not even a "conventional award" - should ordinarily be made. Even so, there will be exceptions: a child television star, cut short in her prime at the age of five, might have a claim: it would depend on the evidence."

Later the same year the position was confirmed in the Court of Appeal in the case of *Croke (a minor) v Wiseman [1982]*. The Court of Appeal considered the position regarding loss of years and provision for dependents. In view of the Courts' decisions in *Pickett and Gammell*, the Court of Appeal found that there were social policy grounds why a 'lost years' claim could never be brought by a young child.

1. In the case of a child there are no dependants, and *"if a child is dead there can never be any dependants and, if the injuries are catastrophic, equally there will never be any dependants. It is the child that will be dependent. In such circumstances, it seems to me entirely right that the court should refuse to speculate as to whether in the future there might have been dependants for the purpose of providing a fund of money for persons who will in fact never exist"*
2. The court could and should refuse to speculate as to whether, but for the accident, the child in adult life might have had dependants, for whom he might have wanted to provide a fund of money, this, it was said would require speculation *"about an impossible and hypothetical situation"*
3. *"Not only does it (the Court) have to assess what sum the plaintiff might have been earning, but it also has to make an assessment of the sum that would not have been spent on the plaintiff's own living expenses and would have, therefore, been available to spend upon his dependants. In the case of a living claimant of mature years whose life expectation has been shortened and who has dependants, there are compelling social reasons for awarding a sum of money that he knows will be available for the support of his dependants after his death. It was this consideration that led to the result in Pickett's case"*

Totham v Kings College Hospital NHS Foundation Trust [2015]

The claimant, a child, claimed damages for serious brain injuries sustained during her birth. She suffered from cerebral palsy having sustained a grade 2 hypoxic ischaemic injury. She lacked muscle strength and was unable to mobilise without help. She presented with severe learning difficulties but attended a mainstream primary school with one-to-one support.

The Claimant's life expectancy was 47 and she was aged 7 at the date of trial. The defendant NHS Trust admitted liability but a number of heads of damage remained in dispute, in particular a claim for loss of earnings and pension up to the age of 93.6 years, notwithstanding the judgment in Croke which, as discussed above, restricts a claim to the period of life expectancy in such cases.

In assessing damages for future loss of earnings and pension payable the Court followed Croke but set out that the decision was inconsistent with the principle of compensation as set out in Wells v Wells [1999]. The Court held that, had it not been bound by the decision in Croke it would have made an award for the 'lost years' following the claimant's reduced life expectancy in accordance with the principle of full compensation.

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For Croke to be overturned the issue must be heard by the Supreme Court. As Laing J strongly asserted in Totham, this point 'should' be resolved by the Supreme Court, and it is likely to be only a matter of time before this comes to pass.

If you have any questions or would like to discuss this matter further, please contact Letitia Barrable.



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Providing or withholding medical treatment to patients who lack capacity – when and how do I apply?

The Judgement of Mrs Justice Theis in the matter of *Sandwell and West Birmingham Hospitals NHS Trust v CD, EF, AB, NHS Sandwell and West Birmingham CCG* [2014] EWCOP 23 gave some practical advice on applications to the Court of Protection and in particular gave her thoughts on steps that should be taken before any application and on the issue of timing.

This matter concerned an application by Sandwell and West Birmingham NHS Trust ("the Trust") seeking declarations as to AB's capacity to make decisions about serious medical treatment and as to her best interests in respect of whether she should receive life sustaining treatment should such treatment become necessary. AB, a 20 year old patient who suffered from a number of medical conditions including severe learning disability and cerebral palsy resulting in very severe disability, lacked capacity to make these decisions within the meaning of the Mental Capacity Act 2005. Following her admission to the intensive care unit with pneumonia, the Trust issued an application for a declaration not to treat her because AB's treating medical team did not consider that it would be in her best interests to receive (i)invasive ventilation, (ii)cardio pulmonary resuscitation, or (iii)inotropes and renal support therapy should her condition deteriorate.

The Application was initially made by the Trust late on a Friday afternoon when the only information available to the Judge was the application, some medical notes and a two page document from the joint speciality lead in critical care medicine at the Trust. Counsel for the Trust was present but AB's parents had no representation at the hearing. An appointment had been made with a solicitor to discuss eligibility for public funding the following Monday. In the meantime, AB's mother attended the hearing by telephone while at the hospital. Further, the Official Solicitor was not in attendance as, according to the Trust, the Official Solicitor had indicated that he would need an Order from the Court before he could become involved.

The Judge, Mrs Justice Theis, considered that AB needed her own representation and needed to be joined as a party. She therefore contacted the Official Solicitor who arranged for Counsel to attend when the hearing was re-commenced later that evening. It was not possible to secure representation for the parents in the short time available. By this time, as AB's condition was not as critical and there was a window available for when a further application could be made if required, the Judge considered it would not be appropriate to grant the declaration sought without further investigation. Unfortunately, there was no draft order in word format which could be amended and Counsel had to draft an order from scratch which took some time. A further hearing was scheduled for four days later where directions were set down and the matter was listed for a hearing over a month later so that updating medical evidence could be obtained from AB's treating clinician and a report obtained from a clinician instructed by the Official Solicitor. Upon review of his report and discussions between AB's parents and her clinicians regarding proposed palliative care, the parties were able to reach agreement that it was not in AB's best interests to be given certain life sustaining treatment.

In her Judgment, Mrs Justice Theis took the opportunity to provide guidance to parties when making Applications of this nature. She raised concerns regarding the timing and practical arrangements for the out of hours hearing on that Friday afternoon. She noted that in this case it was clear four days before the Application was made that there was an issue between the Trust and the parents. She stated that the issuing of an Application at that time would not have prevented efforts continuing to seek to resolve matters as these could run in parallel. Importantly, issuing the application at this earlier stage would have meant it was more likely there would have been an effective on notice hearing, with all parties being represented. In her Judgment she noted that the issuing of an Application in these cases provides more time for some basic steps to be taken including:

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1. Making suitable and sensitive arrangements for the parents to be able to participate in the hearing and ensuring that there is someone at the hospital to assist the parents in participating with the hearing. AB's mother initially attended the hearing on the telephone when she was in a public area of the hospital which was not suitable
2. Providing sufficient time, where possible and appropriate, for the parents' solicitors to be able to secure public funding in advance of the hearing so that they can be represented at the hearing
3. Alerting the Urgent Applications Judge and Clerk of the Rules at the earliest opportunity that an Application is likely so that the Official Solicitor can be alerted to the Application in more time to enable him to get a direction from the court for him to be invited to represent the patient. This also allows him to see the papers and start making enquiries at the earliest opportunity before attending the hearing
4. Preparing a word version of the draft order so any amendments can be made promptly
5. Ensuring that the statement in support of the out of hours Application gives sufficient information regarding the history and the patient's quality of life.

   Mrs Justice Theis stated that such information is essential material when considering the context in which such an application is being made

In practice

It is clear from Mrs Justice Theis' Judgment that when considering making an Application requesting a declaration for providing or refusing treatment, parties should err on the side of making applications sooner rather than later. This enables safeguards to be put in place to ensure an effective hearing and that all parties' Article 6 rights are protected. Some of the points above, such as notifying the Clerk of the Rules or arranging for a draft Order in word format may seem minor issues, but all contribute to a smooth running and prepared hearing which will assist the Judge and hopefully lead to a swifter resolution.

If you have any questions about the issues raised in this article, please contact Elisabeth Broadley.



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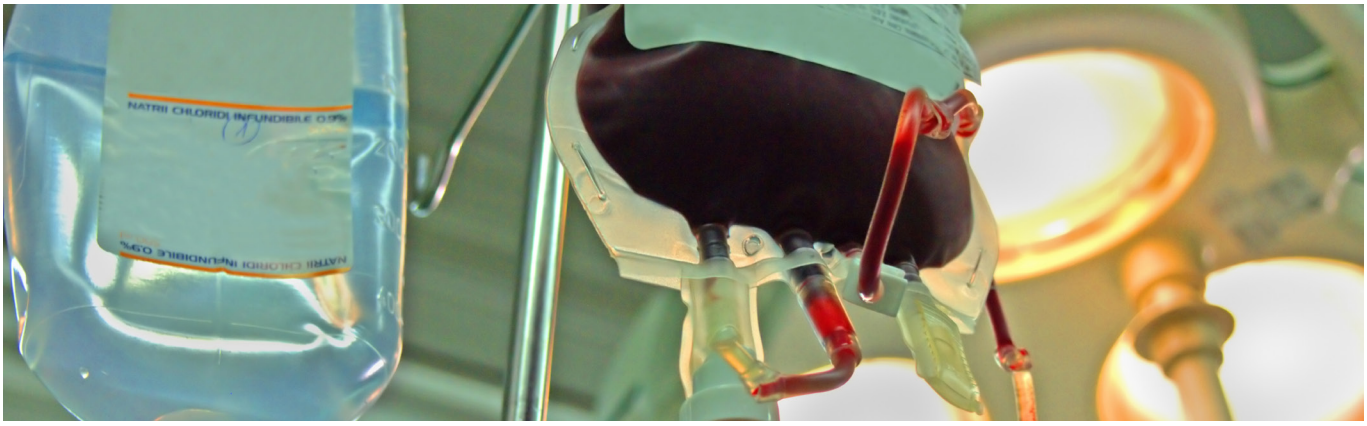

Material contribution - case update: *ST v Maidstone* (2015)

In clinical negligence cases, the issue of causation is often complex and the most difficult legal test for the Claimant to prove. There have been a large number of cases where the court has considered the issue of causation in great detail and the recent case of *ST (A protected party by his Mother and Litigation Friend KT) v Maidstone & Tunbridge Wells NHS Trust* is no exception.

In clinical negligence claims the Claimant must prove that on the balance of probabilities there is a 51% chance a past event occurred or would have occurred. However, in some instances the injury may have had several causes and it may not therefore be possible to satisfy the 'but for' test. This was considered at length in the case of *Bailey v Ministry of Defence* (2009).

***Bailey v Ministry of Defence* (2009)**

In the case of *Bailey* the Claimant aspirated vomit leading to a cardiac arrest and hypoxic brain damage. The Claimant was treated negligently but he also had pancreatitis.

In Bailey, it considered those cases where the injury could have been caused by both negligent and non-negligent acts or omissions. In these circumstances, it was ruled that the 'but for' test for causation should be relaxed i.e. the defendant may be liable where its negligence made a material contribution to the injury.

In this case it was proven that medical science would be unable to put a percentage value on how much each of the acts contributed to the injury. Therefore if the Claimant can show the breach was "more than negligible" in contributing to the injury, then the test would be satisfied.

In Bailey the Court of Appeal found that both pancreatitis and the negligence had an impact and therefore the evidence did not satisfy the 'but for' test.

The Court of Appeal went on to set out the key elements concerning 'material contribution' in causation:

1. A number of factors caused the injury
2. The claimant is unable to satisfy the 'but for' test due to lack of evidence or medical science cannot prove it
3. The Defendant is unable to show that 'but for' the negligence the damage would have been the same
4. The claimant can prove that the negligence was 'more than negligible' or that it made a 'material contribution' to the severity or extent of the injury.
5. The extent or percentage of the negligence cannot be measured

***ST v Maidstone & Tunbridge Wells NHS Trust* (2015)**

Bailey was considered at length in *ST v Maidstone & Tunbridge Wells NHS Trust*.

The Claimant suffered congenital haematological conditions including hereditary spherocytosis. The level of haemoglobin (Hb) in the blood for an average child is 11. ST's level was much lower.

When his Hb level dropped below 5 he required an emergency blood transfusion. When ST was 2½ years old he developed an upper respiratory tract infection. On 24th November 2004 his Hb level was 3.3. The hospital discharged ST home and advised that he would need to return the next day for a transfusion.

At 11.00 on 25th November 2004 ST underwent a one hour transfusion.

On 26th November 2004, ST required a four hour transfusion. Shortly after, ST's condition deteriorated and he suffered seizures and a stroke resulting in permanent brain damage.

The Defendant Trust admitted that the transfusion should have commenced by 02.00 on 25th November 2004. The Court also found that the failure to properly administer IV fluids and the decision to use Frusemide during both transfusions amounted to negligence.

The Court was also satisfied that on the balance of probabilities the primary cause of the claimant's strokes was a focal cerebral arteriopathy caused by the upper respiratory tract infection.

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In the Claimant's first argument they alleged that the failure of the Trust to provide a transfusion earlier caused there to be a risk (albeit a small risk) of ST suffering with cardiac problems leading to a brain injury. However, the Claimant failed to satisfy the strict 'but for' test.

For the Claimant's second argument they referred to the case of *Bailey*. They alleged that the Defendant Trust's failures 'materially contributed' to ST's injuries.

Swift J concluded on this exact point at paragraph 215 of his judgment:

'*… the Claimant faces similar problems to those which I referred to when dealing with his primary case. Once again, I accept that there is a possibility that the various conditions, or some of them, may have combined cumulatively or synergistically with the arteriopathy to cause his strokes. However, there is no objective and reliable evidence that the Claimant's dehydration, acute chronic haemolysis and/or severe anaemia, whether together or separately, contributed with the arteriopathy to cause his strokes. That being the case, I cannot reach the conclusion that it was so and the Claimant's secondary case must fail*'.

Summary

Claimants mostly fall short on their causation evidence being unable to establish the 'but for' test. As a result, judgments reporting specifically on causation are lengthy and complex.

In the case of *ST v Maidstone & Tunbridge Wells NHS Trust*, the case details are also complex and this makes the analysis of the causation principle even more difficult. However, the case was decided upon based on its own facts. In summary, the result in ST showed that it can be extremely difficult to prove that the Defendant's failures materially contributed to the cause of the Claimant's injuries.

No doubt this will not be the last time we hear about this causation principle and there will again be an in-depth judgment on material contribution causation in the near future. For the moment though, the case of *ST* confirms the legal test set out in Bailey.

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Assisted dying: will anyone of us have the right to make a choice?

On 16 January this year the House of Lords revisited the Assisted Dying Private Member's Bill proposed by Lord Falconer. The bill reached the committee stage with 150 proposed amendments and with a new government, its future is unclear. Lord Falconer has however already expressed a desire to re-introduce the Bill to the present session of Parliament.

The Suicide Act 1961 makes it a criminal offence punishable with up to 14 years in prison for anyone to encourage or assist a suicide or suicide attempt. Belgium, Luxembourg and the Netherlands have already implemented assisted dying legislation but it remains unlikely that England and Wales will follow suit in the foreseeable future and so those wanting to die will have to continue to travel abroad to foreign clinics to do so.

The preamble to the Bill states it is to "enable competent adults who are terminally ill to be provided at their request with specified assistance to end their own life". Every part of that laudable aim raises questions of ethics, morality, religion and medicine and this is why the future of the Bill is unclear.

The Bill sets out a number of criteria to try to guard against the exploitation of those dying and misuse by those providing assistance:

- there must be a clear and settled intention to end the person's life
- that intention must be "declared"
- it must be the reasonable opinion of a registered medical practitioner that the patient has less than 6 months live

It is proposed that a written declaration is made and signed by the patient to the effect that they wish to end their life and this must be witnessed by a non relative or someone not involved in their care. The declaration must be countersigned by the doctor who is going to assist the end of life and another registered doctor who is not the witness, in the same practice as the other counter signatory or a relative. The counter signature is to confirm the terminally ill person has made the decision of their own free will and has been fully informed of the palliative care and hospice options available.

The most recent debate illustrates the high emotions the subject elicits. The subject was whether the words "assisted dying" should be changed to "suicide". Some peers, such as Lord Winston considered the change necessary to make it clear to those making the decision what it is to which they are agreeing to avoid them being taken advantage of; others took the view that the stigma of suicide needs to be removed from the Bill. It seems that on this occasion to wish to avoid stigma won over perceived clarity and this amendment failed.

One objection raised by those against the Bill is that it allows the vulnerable to be taken advantage of by avaricious relatives. It is also argued that it will tempt doctors into assisting death by offer of payment. It is unclear from the Bill whether the drugs and care required to assist suicide would be available on the NHS but this is perhaps unlikely. The spectre of Harold Shipman haunts the argument against the Bill and some present a picture of poor defenceless elderly victims at the mercy of greedy murdering doctors. This is emotive but is it likely to be a real problem? In addition it is argued that relatives will press their dying relatives into making the decision to die earlier than they would otherwise want, but again does this seem likely to be a big problem? Many patients now are sent home for care by relatives with access to large bottles of morphine but this does not seem to have resulted in a spate of killings of unwanted relatives.

Ethically it is of course argued that doctors should not be assisting death. That however is something which has been

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happening by omission for many years. It is well known that hospitals sometimes make a decision not to resuscitate a patient and turn off life support and many argue that therefore assisted dying is already going on. In law there is a good deal of argument as to whether an omission in law is any different from a positive act but that does not address the reason why this subject is so problematic. In permitting assisted dying for those with only a very few months to live the Bill is asking us to set aside hundreds of years of religious, moral and medical teaching. It is for that reason that it seems unlikely we are going to see any legalised assisted deaths in this country for some years yet.

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