



Should We Permit Voluntary Assisted Dying?

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Abstract

The English courts have wrestled with challenges to the restrictions on euthanasia and assisted suicide for years, while the government has resisted calls to liberalise the law. Meanwhile, terminally ill people continue to travel overseas to clinics such as Dignitas, to end their lives. Assisted dying raises fundamental questions about respect for individual autonomy, protection of the vulnerable and the role the State should play.

This lecture will explain the law and explore arguments for and against liberalisation.

What Do We Mean by ‘Voluntary Assisted Dying’?

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

Assisted suicide is the act of deliberately assisting another person to kill themselves.

Those in favour frame these as acts of compassion. For example, as Baroness Bakewell expressed it in the House of Lords recently:

Easeful death is a gift the compassionate should legally bestow on patients in their dying days.¹

Basic legal position

- A doctor who deliberately ends a patient's life is guilty of murder
 - 'If the acts done are intended to kill and do, in fact kill, it does not matter if a life is cut short by weeks or months, it is just as much murder as if it were cut short by years' [*Adams, Devlin J*]
- As long as actus reus and mens rea are present it is irrelevant that:
 - Patient is terminally ill
 - Patient has consented to the termination of his/her life
 - The act is one of mercy
 - 'it is not lawful for a doctor to administer a drug to his patient to bring about his death, even if that course is prompted by the humanitarian desire to end his suffering, however great that suffering may be' [Lord Goff in *Airedale NHNS Trust v Bland* [1993] AC 789, 865].

Refusal of Treatment

- We also don't think of this as assisted dying, but again in effect it is – and death may be the goal (and it's a known outcome or side-effect)

¹ [https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill\(HL\)](https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL))

- Patient choice – cannot treat without consent
 - a. Individuals may refuse treatment → medical practitioners must then withdraw treatment

Dame Elizabeth Butler Sloss:

“If...the patient having been given the relevant information and offered the available options chooses to refuse that decision has to be respected by the doctors. Considerations of best interests of the patient is irrelevant” [Re B (Adult: Refusal of Treatment) [2002] 2 FCR 1]

Withdrawal of Treatment

There are situations in which the doctor can decide not to treat, despite the patient’s wishes.

- We don’t think of this as assisted dying, but in effect it is – but death isn’t the goal as such, it’s that treatment is futile
- Decision made by doctors (patient may agree but doctor can also withdraw regardless)

This is sometimes referred to as ‘passive euthanasia’

- Because it will result in death

When is this decision made?

- *R (Burke) v GMC* [2005] 3 FCR 169
 - Doctors are not obliged to give *treatment* simply because the patient demands it
 - But they do have to continue hydration and feeding for patient who wants it to continue and is competent

R (Burke) v GMC [2005]

Facts

- Lesley Burke had cerebral ataxia → would eventually need artificial feeding
- He wanted assurance that they would not withdraw feeding/hydration when he became incompetent (as he eventually would)
- He argued that withdrawal would → his death via starvation/dehydration
- This would violate his Art 2, 3, and 8 rights

Court of Appeal decision

- wouldn’t give a prospective judgment on what was then a hypothetical question
- Patients cannot demand treatment – it is at doctor’s discretion to offer treatment → no duty to provide artificial feeding
- BUT doctor does have a duty to do what is reasonable to keep patient alive and this usually includes artificial feeding/hydration
- Doctor can withdraw feeding/hydration where patient is non-competent, has not expressed a wish to be kept alive and is in best interests to end treatment
- Could not withdraw from competent patient who wanted feeding to continue

[follow up – they need to keep someone alive]

When can care, even feeding and hydration, be lawfully withdrawn?

When patient loses competence →

- Must follow any Advance Directive that is in place
- In absence of AD, apply ‘best interests’ test
 - *Airedale NHS Service v Bland* [1993] AC 789

Airedale NHS Service v Bland [1993]

Facts

- Crushed in the Hillsborough disaster
 - crushed ribs and two punctured lungs
- Led to oxygen to his brain being cut off for a time → serious and irreversible damage to the higher centres of the brain
 - → PVS state
- Issue = would it be lawful to withdraw all care?

Decision

- Withdrawing support would = intentional act to kill (because was such a certain consequence)
- Withdrawal = omission
- Doctors had a duty to keep patients alive → omission was potentially a breach of this duty
- Omission would not be a breach because the duty only extended to giving treatment that was in Bland's best interests
- Continued treatment was not in his best interests
 - → no duty to continue → withdrawing treatment could not constitute the actus reus of murder

Two further questions in *Bland*

1. Did treatment include hydration / nutrition?
 - Yes (ie was not basic care)
 - Therefore could be futile
 - Therefore could be withdrawn (and was, some held, an omission)
2. How can withdrawing treatment be in someone's best interests?
 - Effectively says life has no value
 - Is not burdensome
 - Prolonging treatment subjected Bland to indignities and distressed his family (Lord Goff)
 - 'to an individual with no cognitive capacity whatever, and no prospect of ever recovering any such capacity ... it must be a matter of complete indifference whether he lives or dies' (Lord Keith)
 - 'Existence in the PVS is not a benefit to the patient' (Lord Keith)
 - Futility was the justification to withdraw treatment (Lord Goff)

Post-*Bland*

PVS cases → *NHS Trust A v M*

Dame Butler Sloss:

- there is a positive obligation to give life-sustaining treatment under Art 2
- The obligation is not absolute if treatment is futile
- Withholding / withdrawing treatment can be in best interests → duty discharged
- Not degrading/inhumane if not aware (Art 3) → withdrawal does not breach

Non-PVS cases

1. Withdrawal will not be permitted where patient is conscious to some degree [*M v A NHS Trust (2011)*]
 - Has awareness → suffers pain
 - Has some quality of life
2. Withdrawal unlikely to be permitted where there is a chance of recovery [*An NHS Trust v J*]

3. Best interests is judged with reference to:
 - Quality of life [Re R]
 - What will endure as part of sustaining treatment [Re R]
 - Dying with dignity [Re G]

Comments

- These are not what we think of as 'euthanasia' in the sense I'm going to talk about today.
- But they are very relevant background
 - To some extent, on a wide understanding, some come close to euthanasia
 - Withdrawing futile care
 - Withdrawing care from the non-competent
 - Allowing people to refuse treatment
- They illustrate the grey areas
- They demonstrate how medicine and law walk a line
- Now turn to what we *do* mean by euthanasia and assisted suicide
 - But it's worth keeping these in mind when thinking about:
 - Are we legally consistent?
 - Is it more harmful to permit someone to die slowly when they refuse treatment, than to offer them a faster means to the same end?
 - Does it matter whether it is an *omission* (a failure to act) or an *act* that brings about death?
 - We'll return to that theme

Voluntary Euthanasia

General euthanasia definition: ending someone's life for their benefit

Euthanasia is illegal.

An important distinction is made on the consent of the person involved

- **voluntary euthanasia** – A person makes a conscious, competent decision to die and asks for someone to do this for them (they do not end their own life)
- **non-voluntary euthanasia** – A person takes the decision on someone else's behalf to end their life
 - it might be because the ill person previously expressed a wish for their life to be ended in such circumstances
 - it might *not* tally with what the person wanted / expressed a view on
 - we'd be better to refer to that as **involuntary euthanasia**
 - it might be (broadly understood) where a person is unable to give their consent (for example, because they're in a [coma](#)) and someone else decides for them
 - in law, we don't tend to call this 'non-voluntary euthanasia' but rather a best interests decision to withdraw care
 - we might want to think about that distinction...

Assisted Suicide

Definition: the act of deliberately assisting another person to kill themselves

Assisted suicide is illegal under the terms of the Suicide Act (1961) and is punishable by up to 14 years' imprisonment.

Trying to kill *yourself* however is not a crime.

Key distinction between Voluntary Euthanasia and Assisted Suicide

- Voluntary euthanasia: doctor or other person causes death
- Assisted suicide: individual causes his/her own death

This has both legal and ethical implications, as we shall see.

Why do people seek either of these

General

A series of high profile cases, which we will return to at times, give a good sense of why some people seek to die.

1.1.1 Tony Nicklinson

- Locked in syndrome
 - Could not talk
 - Could not feed himself
 - Unable to move except his eyes
 - Entirely dependent on others for his care
 - Not terminally ill
 - Was likely to live for some years
 - Unable to take his own life
 - Dignitas does not perform euthanasia (only assists suicide)
 - No country in the world will offer euthanasia to non-residents

He described his life thus: 'My life can be summed up as dull, miserable, demeaning, undignified and intolerable' - Nicklinson

[other examples]

Voluntary Euthanasia

People want voluntary euthanasia for a number of reasons:

- cannot commit suicide themselves
 - they are incapacitated and so cannot end their life on their own
 - Tony Nicklinson – he
 - Paul Lamb

Assisted Suicide

People choose to pursue assisted suicide for a number of reasons:

- cannot request voluntary euthanasia legally
 - cannot access means to commit suicide themselves
- cannot bring themselves to do it

How do people commit assisted suicide?

- Taking drugs
- Travelling to a clinic that will enable them to do so
 - The clinic assists them
 - Dignitas Clinic in Switzerland
 - They may also be 'assisted' by anyone who helps them to get to the clinic

Committing suicide at Dignitas

- Dignitas clinic in Switzerland provides means for persons to commit suicide
- Requires a number of meetings with staff to evaluate the person's mental state and desire to die
- Person is provided with means to commit suicide – pentobarbital taken orally.
- Person is warned before taking the pentobarbital that it will cause death
- Pentobarbital causes the person to fall into a coma by depressing the central nervous system. Over time, the depressing leads them to stop breathing.

Examples from case law of assisted suicide

What is the current law?

Assisted Suicide

Covered by the *Suicide Act 1961* (as amended by the Coroners and Justice Act 2009)

1 *Suicide to cease to be a crime*

The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.

2 *Criminal liability for complicity in another's suicide*

(1) A person ("D") commits an offence if—

- (a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and
- (b) D's act was intended to encourage or assist suicide or an attempt at suicide.

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

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

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

If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence.

Pretty v UK [2002]

ECHR case

Facts

- Mrs Pretty suffered from Motor Neurone Disease (a progressive, degenerative disorder that leads to death)
- She sought an undertaking from DPP that her husband would not be prosecuted if he helped her to commit suicide
- DPP refused: he would only determine how to act once he had the facts before him
- She sought judicial review of the decision

Argued

- Pretty argued his refusal violated her rights under the European Convention / Human Rights Act
 - *Article 2 – right to life*
 - Included a right to determine the manner of one's death
 - This encompassed a right to commit suicide
 - *Article 3 – prohibition on torture*

- Prohibitions on assisting her to commit suicide left her in an inhumane, degraded state
- This state arose due to actions of the State
- *Article 8 - right to privacy*
 - Decisions about how to die were a matter of privacy
 - In denying her the ability to die in a manner of her choosing, her privacy was violated
 - Akin to arguments about abortion
- *Article 9 – freedom of religion and belief*

House of Lords decision

- No prima facie violation of her rights
 - prosecution for assisting/abetting suicide does not undermine rights under:
 - Article 2 – right to life
 - Article 3 – prohibition on torture
 - Article 8 - right to privacy
 - Article 9 – freedom of conscience and religion
 - Article 14 – freedom from discrimination
 - Convention did not require states to permit assisting in suicide
 - any effect on her rights as the law stood was reasonable and proportionate
 - → DPP could exercise his discretion as he chose
- She appealed to the European Court of Human Rights

European Court of Human Rights decision

- Rejected her claim
 - Article 2 - Right to Life does not have a negative aspect
 - Article 3 - Suffering from natural illness where still provided treatment does not equate to torture
 - Article 9 - belief in euthanasia was not of the kind protected by this article
- Did not reject the possibility that Art 8 rights might be invoked in relation to decisions about quality of life
 - but there were strong reasons in favour of the UK Suicide Act provisions
 - these did not so impinge on Convention rights as to be disproportionate

Conclusions / Segue

R (Purdy) v DPP [2009]

Facts

- Debbie Purdy suffered from Multiple Sclerosis (progressive degenerative disease)
- Considering travelling to Switzerland to commit suicide
 - would need her husband's help if she left it until later stages of the disease
 - might go earlier if he could not help her
- Sought clarification from DPP on application of Suicide Act provisions to those who assist in suicide

Argued

- DPP was clearly exercising his s 2(4) discretion in not prosecuting people who helped other go to Switzerland to commit suicide (around 100 had done so)

- therefore he must be applying some criteria to determine when to choose not to prosecute
- these should be made public
- failure to do so infringed her Convention rights

Divisional Court decision

- *Pretty* applied:
 - her rights were not infringed in a manner that was disproportionate
- Was given leave to appeal
- Before case went to appeal, DPP released detailed guidance on his reasoning on another case: the decision not to prosecute family members who helped Daniel James to die at Dignitas (he was a 23 yo rugby player who had been paralysed by an accident and wanted to die)
 - factors suggesting prosecution appropriate
 - assisting suicide is a serious offence
 - factors suggesting prosecution inappropriate
 - James had attempted to commit suicide and seemed likely to continue trying
 - the assistance given was minor
 - none of those assisting stood to gain from his death (they had tried to talk him out of it)

Court of Appeal decision

- dismissed Purdy's claim
 - DPP could not and should not guarantee he would not prosecute
 - would effectively suspend the operation of s 2(1) in certain cases which was beyond his authority
 - there was enough guidance now available on when prosecution might be pursued

House of Lords decision

- Purdy appealed to the House of Lords and her claim succeeded
 - her right to life had been engaged
 - Her decision to commit suicide fell under Art 8(1) – right to privacy
 - Interference with her right to privacy could be justified (under Art 8(2)) but required legal justification
- Lord Brown:

“there will on occasion be situations where ... It would be possible to regard the conduct of the aider and abettor as altruistic rather than criminal, conduct rather to be understood out of respect for an intending suicide's rights under Article 8 than discouraged so as to safeguard the right to life of others under Article 2”
- Current guidance on when such an interference with her Art 8 right might be made was insufficient
- DPP was required to provide an offence-specific policy identifying the facts and circumstances he would take into account in deciding whether to prosecute under s 2(1)

Comments on *Purdy*

- Important to note
 - Purdy did not change the law
 - Assisted suicide still illegal
- For some, this wasn't far enough:

- Lord Hope: people should not be forced to linger on in old age or in states of advanced physical and mental decrepitude which conflict with strongly held ideas of self and personal identity
- Picks up the privacy aspect
- But it did require the DPP to give clear guidance on when a prosecution would be made
- Guidance was released in 2010

3.1.1 DPP's Guidance on Assisted Suicide Prosecution

A prosecution is more likely to be required if certain factors are present. Factors relate to the victim and to the suspect.

Victim related factors that increase the likelihood of prosecution:

- victim under 18 years of age
- victim lacked legal capacity to reach an informed decision to commit suicide
- victim had not reached a voluntary, clear, settled and informed decision to commit suicide
- victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect
- victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative
- the victim was physically able to undertake the act that constituted the assistance him or herself

Suspect related factors

- suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication;
- suspect gave encouragement or assistance to more than one victim who were not known to each other
- suspect was paid by the victim or those close to the victim for his or her encouragement or assistance
- suspect was acting in his or her capacity as a medical professional, a professional carer or as a person in authority
- suspect was involved in providing a physical environment in which to allow another to commit suicide
- suspect knew the victim intended to commit suicide in a public place where the act might be seen
- suspect was not wholly motivated by compassion
- suspect pressured the victim to commit suicide or did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide
- suspect had a history of violence or abuse against the victim

Was this a sufficient step? Was it the right step?

- Clarity was a good thing
 - Removed some stress from those who might support someone
- For those who wanted assisted suicide to be legalised, the effect of *Pretty, Purdy* and the DPP guidance is insufficient
 - We'll examine the arguments shortly
- Some have also argued that clarity was a *problematic* step
 - Kate Greasley
 - has argued that the DPP's guidance make the situation worse, rather than better
 - Undermines discretion to outline factors that determine when it will be exercised

- We can point to good reasons to legitimate assisted suicide already
- Criminalisation of assisted suicide is problematic
- we do not need to take the *Purdy* path
- Guidance mandates a particular way of assisting
- Clarification of when prosecutions will not be made implicitly legitimises assisted suicide – inconsistency/incoherence
- Clarification leads to determinations on the value of some lives (those that may be assisted to end)

Voluntary Euthanasia

- Doctors are rarely convicted of murder for voluntary euthanasia
- Juries and the judiciary often seem sympathetic to doctors acting compassionately:
 - “think long and hard before deciding that doctors of the eminence we have heard ... have evolved standards which amount to committing crime” [*R v Arthur* per Farquharson J (to the jury)]
 - “You may consider it a great irony that a doctor who goes out of his way to care for [a patient] ends up facing the charge he does.” [*R v Moor* per Hooper J]

The law offers doctors and others accused of murder or manslaughter in euthanasia situations a series of possible defences:

1. Diminished responsibility
 - eg A family member or similar who ends the life of someone in terrible pain or distress may successfully please diminished responsibility
 - can reduce the charge to manslaughter
 - can affect sentencing
 - unlikely to be available to doctors as they probably cannot show the requisite ‘abnormality of mind’ (from the knowledge of the suffering) [Homicide Act 1957 s 2(1)]
2. Provocation
 - must lose control
3. Suicide pact
 - reduces to manslaughter
4. Doctrine of Double Effect
 - An act leading to death must be the substantial and operating cause of that death [*R v Cheshire* [1991] 3 All ER 670]
5. Self-defence
 - eg conjoined twins Jodi and Mary

R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice (Respondent) [2014] UKSC 38

Tony Nicklinson sought voluntary euthanasia, which was illegal.

The issue was whether *voluntary euthanasia* could be, in some sense, a *defence* to a charge of murder.

He sought declarations on two arguments that might, depending on the answer, have enabled him to pursue euthanasia.

1. That the common law defence of *necessity* would be available to a charge of murder in a case of voluntary active euthanasia and/or to a charge under s2(1) of the 1961 Act in the case of assisted suicide;

And/or

2. That the current law of murder and/or of assisted suicide *is incompatible with his right to respect for private life under Article 8* (European Convention on Human Rights), contrary to s1 and 6 of the Human Rights Act 1998, in so far as it criminalises voluntary active euthanasia and/or assisted suicide.

1. So was he being prevented from making a private decision (to die) by the laws criminalising voluntary euthanasia and assisted suicide?

A series of caveats for when the defence of necessity could arise were offered:

1. the doctor had prior confirmation
2. patient's life was one of unbearable suffering
3. no alternative means to relieve suffering
4. decision is clearly voluntary and informed and settled
5. doctor satisfied that duty to ease suffering outweighs duty to preserve life

Supreme Court decision

1. Voluntary euthanasia was not a defence to murder
 - For Parliament to put in place a system that protects the community
 - Court could not create such a system
2. Restrictions on euthanasia did not breach Art 8 rights
 - Margin of appreciation
 - Was for Parliament to enact laws – not for Court to usurp this role (followed *Purdy*)

Reflections on the state of the law

What does the community think about this law?

Whether we should permit assisted dying has been a topic of considerable debate for many years, and there are many ways we can get a sense of public views on it.

Surveys

What do the general populace think?

According to the Campaign for Dignity in Dying (a lobby group pressing for a change in the law),

- 84% of the public support the choice of assisted dying for terminally ill adults²
- 86% of people with a disability support a change to the law.³

However, other groups challenge the results.

For example, another organisation, Right to Life UK, argues that such polls are misleading and skewed, pointing out criticisms of the robustness of Dignity in Dying's survey data. They assert, for example, that:

- 'Whether respondents to a poll are exposed to counterarguments to the introduction of assisted suicide ... appears to have an impact on the percentages of respondents who state they support introducing assisted suicide. In one [poll](#), undertaken by Savanta ComRes, of people in England, Scotland and Wales, **support for assisted suicide dropped from 73% to 43% when respondents were presented with counterarguments**. A poll that was run only in Scotland showed [similar results](#).'

In the ComRes survey they cite, 74% of respondents agreed or strongly agreed with the proposal for a bill:

² <https://www.dignityindying.org.uk/assisted-dying/public-opinion/>

³ <https://www.dignityindying.org.uk/assisted-dying/public-opinion/>

“to enable mentally competent adults in the UK who are terminally ill, and who have declared a clear and settled intention to end their own life, to be provided with assistance to commit suicide by self-administering lethal drugs.”⁴

Support dropped only slightly (to around 63%) when respondents were told that various medical groups (such as the BMA) and major disability groups (such as Disability Rights UK) did not support the proposal.

The support dropped when the counter-argument was raised, where the argument was that there was a risk of people feeling pressured to end their life early to avoid being a burden (financially or with caring responsibilities) on their loved ones.

However support remained at 58-59% even when it was asserted that end-of-life care would worsen due to financial costs (compared with the cost of drugs to enable people to commit suicide, which were very low); and when it was explained that in countries that have permitted assisted dying, there has been an expansion to include non-terminal cases, disabled people and children.

There is much more data, and we don't have time to go into it in detail.

But we can take some things from this:

- There is clear support
- There is strong resistance
- The support does not evaporate in the face of counter arguments, but it does decrease – but it's still majority support

I don't want to comment on the survey designs themselves, but I will say that survey design and how information is put to people clearly has an impact on views in this complex, heated area.

What should we do with such data?

We should take seriously that there is strongly divided opinion and respect that.

What do medical professionals think?

The British Medical Association:

Following an extensive survey of members, on 14 September 2021 the BMA policy-making body (the representative body) voted in favour of a motion changing the BMA's policy from opposition to a change in the law on assisted dying, to a position of neutrality.⁵

The official position is:

“This means we will neither support nor oppose attempts to change the law. We will not be silent on this issue, however. We have a responsibility to represent our members' interests and concerns in any future legislative proposals and will continue to engage with our members to determine their views.”⁶

This was informed by, but not entirely determined by the survey of members.

Members views were quite evenly split:

Q: Do you personally support or oppose a change in the law on prescribing drugs for eligible patients to self-administer to end their own life?

- Support = 50%
- Oppose = 39%

Q: Would you be willing to participate in any way in the process if the law changed on prescribing drugs for eligible patients to self-administer to end their own life?

- Yes = 36%

⁴ ComRes survey

⁵ <https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying>

⁶ <https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying>

- No = 45%

Q: Do you personally support or oppose a change in the law on doctors administering drugs with the intention of ending an eligible patient's life?

- Support = 37%
- Oppose = 46%

Q: Would you be willing to participate in any way in the process if the law changed on doctors administering drugs with the intention of ending an eligible patient's life?

- Yes = 26%
- No = 54%

There are a few important things we should take from this:

- Those who watch / experience death the most, have split views, but with a slant away from supporting euthanasia (less so assisted suicide)
 - They, more than any of us, know about death (as a profession)
 - BUT many members of the BMA don't work in end of life care
 - So as a group, that's not entirely true
 - We know how they tended to feel as sub-groups:

generally more supportive specialties: anaesthetics, emergency medicine, intensive care and obstetrics & gynaecology.

generally more opposed specialties: clinical oncology, general practice, geriatric medicine and palliative care.

So in fact, the groups who deal *most* with people at end of life were less supportive

- They may be a skewed group in another way – their vocation, their job is to *preserve* life
 - It would understandable if for many of them, the idea of not preserving it was difficult to accept
 - That might make sense for those involved in palliation
 - OR they simply know more about how effective palliative care can be
 - That the population might fear the end of life and support euthanasia because they are *less* aware of what palliation can achieve
- They were clearly resistant to having to *participate*
 - And it might be a problem if the people who are supposed to support the process don't want to
 - But this might be manageable
 - Conscientious objection
 - Specialised service providers

Pressure for change

Unsurprisingly, then, there has been pressure to change the law and it has met with substantial resistance.

High-profile campaigns have been run on both sides.

For a change in the law:

- Dignity in Dying
- Humanists UK

Opposing a change in the law:

- Care not Killing

- Right to Life
- CARE

Various attempts have been made to change the law, all so far ineffective.

Outline of attempts to change the law

Over the past 20 years, there have been a series of attempts to change the law, none of which (bar the impact of *Purdy*) have brought about change.

2001	<i>Pretty</i>	Rejected by Supreme Court Right to life did not include a right to die, and nor did the right to private life include a right to choose the manner or timing of death.
2002	<i>Pretty</i>	ECHR did agree that right to private life did include right to choose how to end her life BUT that English ban on assisted dying was legitimate (as a protection of vulnerable people)
2005	<i>Joffe Bill: Assisted Dying for the Terminally Ill Bill</i> Private members' bill	Did not make it past Committee stage of House of Lords
2009	<i>Purdy</i>	House of Lords agreed that DPP needed to offer guidance on how a decision to prosecute for assisting death would be made
2014	<i>Nicklinson / Lamb / Martin</i>	Failed Supreme Court said the matter was for Parliament Except to the extent that <i>Martin</i> → DPP adding guidance that the involvement of healthcare professionals was a factor <i>in favour</i> of prosecution
2014	<i>Falconer Bill: Assisted Dying Bill</i>	Made it Second Reading but then did not progress (General Election)
2015	<i>Marris Bill</i> Private member's bill House of Commons modelled on Falconer (but incl. High Court as body that needs to approve request)	Defeated at Second Reading
2018	<i>Conway</i>	New attempt based on right to private life. Failed at Court of Appeal. <i>Nicklinson</i> remained authoritative
2019	<i>Newby / Lamb</i>	Another case. Refused permission to proceed to full hearing by High Court bc <i>Nicklinson</i> remained authoritative.
2021	<i>Meacher Bill</i> Private member's bill May 2021 For terminally ill adults Full capacity Voluntary request Resident in England/Wales for 12 mths Apply to High Court	Did not get further than Second Reading in the Lords

What is the current state of debate on changing the law?

So the current state of the situation is that there have been numerous attempts to change the law, and all have failed.

- Attempts via courts (including European Court of Human Rights)
- Attempts via introduction of private member's bills in Parliament
 - As Government itself does not support assisted dying

Why have they failed? What reasons were given?

We'll look at courts first – because they threw it back to Parliament. Then at why Parliament has rejected it.

What have the courts said?

What has been said in Parliament?

Bear in mind, the most recent bill failed at Second Reading in House of Lords. But we have some sense of the House of Commons view from the reaction to the Marris bill (2015) which made it to Second Reading in House of Commons.

Falconer bill debate = 10 hours

Marris bill debate = 4 hours

Meacher bill debate = 8 hours

It's a long and complex debate. I will draw out some key arguments that were made across the three debates

For the bills

- 'tried and tested model from overseas'
- Fear of a traumatic dying process
 - Give comfort and reassurance to people and their families
- Fear due to (Baroness Meacher):
 - Suffering that cannot be alleviated by palliation
 - Nausea
 - Fungating wounds
 - Motor neurone disease
- The only way to avoid suffering is to starve oneself to death or try to take one's life
- By 2021, felt there had been a change in views
 - BMA, Royal College of Physicians had withdrawn their opposition
 - Seeing examples of other countries liberalising their laws
- Assisted death framed as a 'complementary part of palliative care'
- No evidence of 'slippery slope' in countries that have introduced changes to their laws
- Put in place greater safeguards than the law as it stands
 - Protective of those who choose to die by refusal of treatment, suicide, starvation et al, or who travel to die
- To give choice
 - Wrong to say that people don't know what is right for them.

Summed up well by Lord Sherbourne:

Society has decided that it knows better than you. Even though this is the most important decision that anybody can take about their own life, society has said: ‘You are denied that choice and you have to suffer.’” I cannot accept that; it is wrong and cruel.⁷

Against the bills

- Difficult to put into effect
 - Hard to judge ‘6 months to live’
 - How can we really know if a decision is competent, free of pressure and so forth
 - Workload for the High Court
- Possibility of malicious motives
 - not possible to guard adequately against the abuse of the very elderly and the very ill by greedy and manipulative relations and friends (Lord Adonis)
- Slippery slope concerns driven by expansion in the law elsewhere
 - Eg expansion of criteria in Netherlands, Canada, Belgium
- Offers the temptation to allow death in times of heightened emotion
- Not really choice – better to offer more palliation and give real choices
- Concern to protect the vulnerable

Baroness Masham of Ilton:

“Vulnerable people need protection, not the threat of being killed if life becomes too difficult. How can they trust doctors if the Bill is accepted?”⁸

Major arguments in play that apply to both

I would usually want to structure this part of a lecture by exploring the arguments on both sides, going through then one at a time. For example, respect for autonomy as an argument for *permitting* assisted suicide and voluntary euthanasia.

But as you’ll see, the picture is more complex than this and doesn’t lend itself to such a breakdown, because many of the factors or issues or principles raised in the debate, can actually be made on *both* sides.

It is one of those areas of bioethical debate where both sides have similar goals (respecting autonomy, protecting people from harm), but come to *opposite* conclusions.

As the Archbishop of Canterbury said in the House of Lords in the debate on the Meacher bill: ‘Everyone here shares the best of intentions.’

To see why, and to appreciate the complexity of these issues, it’s better work through the principles and arguments together.

Respect for autonomy

1. Subjective values
2. Short term / long term
3. Choice / richer autonomy

The issue of autonomy is complex, and very much cuts both ways in this debate.

To start, we need to think about what we mean by ‘autonomy’ and why we value it.

⁷ [https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill\(HL\)](https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL))

⁸ [https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill\(HL\)](https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL))

What is autonomy?

[what do we mean by autonomy?]

We mean the ability to make competent choices about our lives.

[why we value it]

- We find value in being in control of our own lives
- We can bring our own subjective values to bear
 - We know what is best for us, and so if we choose, we will choose what is most likely to make our lives go well

[why, perhaps, we over-value it]

- Sarah Conly points out that often we *don't* know what is best for us in terms of meeting our subjective desires
 - We make bad choices
 - We are afraid
 - We don't understand information
 - We are influenced by things that we shouldn't be influenced by

[are choices free? Pressure / guilt]

- Often, too, our choices are not necessarily authentic
 - Pressure
 - guilt

[vulnerable people]

- this is particularly true of people who are vulnerable

[but taking away autonomy feels like a terrible thing]

- particularly true in the context of death
 - Personal nature of death
 - 'Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny' (Dworkin)

Permitting Choice about Death Promotes Autonomy

- Respects personal views
- Manner of death = critical interest (Dworkin)

And if we restrict that choice, if people want to die badly enough, they will try to do so if they can. At the moment, those people are not protected.

Baroness Meacher (debates):

"We will also hear much today about vulnerable people, which is absolutely right, but there are no legal safeguards for dying people who decide to end their lives early, whether by starving or, on occasion, shooting themselves. We propose a rigorously safeguarded system that would end these barbarous deaths and protect vulnerable people."

Responses

1. Sanctity of life is more important (come back to this)
2. Our death is not a self-regarding act → affects others → choice should be constrained
3. Protecting the autonomy of some will undermine that of others if legitimating euthanasia → pressure
4. Choice to die can never be fully autonomous

- a. May be depressed
 - i. But we know that knowing they have the choice → they feel LESS stressed and don't use the choice
- b. May not be fully autonomous
 - i. John Keown questions how autonomous many requests for assisted dying would be
 - 1. He notes the high levels of depression among the terminally ill
 - 2. He also cites data that show that once that depression is treated, a great majority withdraw their decision to die
 - ii. A response to this is that this isn't an argument against assisted dying, it's an argument *for* better support and it demonstrates that *even when treated* some will still have a settled desire to die – which is thwarted in a prohibitive system
- c. They may really be making a cry for help
 - i. But even if many are doing so, that doesn't mean that *all* are doing so
 - 1. If we don't believe them, then we necessarily deny people precisely what they wish we would give them
 - 2. And we can in first instance give palliation, do what we can, work with them → when the decision is settled, then we can follow it – but if we don't permit, this isn't possible
- d. ill people change minds
 - i. Love sick teenager (Dworkin)
 - ii. But they have good reasons + we can put in place controls to help
- e. May be that can't choose to give up all your autonomy (the slavery argument)
 - i. But it's not having autonomy that's beneficial, its being able to do what we want, and this includes choosing death

Imperfect Decision-Making and Permissive Systems

In a perfect, permissive system, where we accepted that autonomy should be the driving principle, the premise would be that people were making free, informed choices.

But we know that's not the case

(a) Pressure

- Pressure might be put on people
 - Some they might feel and that's ok
 - Some they might not be happy about and that's not ok
- Pressure can be subtle → probably can't prevent it
- Affects the vulnerable most – particularly those without support networks
- Katrina George – feminist perspective – women feel pressure due to social role – not to be a burden etc

(b) Abuse of the system

- By family
- By doctors
- By hospitals
- Could fix via systems + bringing into open probably prevents abuse that happens now

(c) Guilt and feeling like a burden

When people approach the end of life, they may feel like a burden and that even though they might want to live longer, they *should* end their lives (if the option is there) to remove the burden they place on others.

This would be particularly likely in cases where a loved one is taking on a care burden.

As the BMA has pointed out, in the absence of assisted dying being lawful, people can voice these concerns but feel safe that their lives will not be ended by a ‘helpful’ doctor. The BMA is not suggesting this *will* happen, but rather that some patients *may believe* that a doctor might ‘give up’ on them (as some already do). If we permitted assisted dying, these fears might be exacerbated.

We also, arguably, send messages with the laws that we enact. It is often suggested that permitting assisted dying sends a message that some people *ought* to take up this option – it’s on the table, so they should consider it.

For some, this extends further to a believe that such laws send the message that some lives are actually *less* valuable than others because they can be ended. This is particularly of concern in relation to the elderly and disabled communities.

It should be noted that some high profile commentators have *supported* the idea that there is nothing wrong with regarding oneself as a burden. John Keown quotes Baroness Mary Warnock as arguing:

“If you’re demented, you’re wasting people’s lives... your family’s lives --- you’re wasting the resources of the National Health Service.”⁹

Preventing Harm / Paternalism / protecting people from themselves / harm prevention

I’ve headed this section in my notes ‘Preventing Harm’ and as I wrote it, I thought well again, this cuts both ways, and we should remember that anyone making an argument about assisted dying probably believes that their view, on balance, is the one that leads to the least harm.

How can this be?

Well, being *permissive* and allowing assisted dying can:

- Free people from harming situations
 - Pain
 - Indignity (Nicklinson)
 - Fear
 - Misery
 - [mental health cases from other countries]
- Fulfil their preferences
 - Some people gain peace from knowing they have control over how and when they will die
 - We know that many people in states where they can access assisted dying, then choose not to avail themselves of it
 - Some want to die at a particular time not to escape harm now, but to avoid it later
 - [cases where they committed suicide together – partners]
 - [cases where the pre-empted illness by committing suicide]

But we can also discern harms that being permissive might create, or greater harms that are avoided by preventing people from ending their lives, despite what they say they want:

Harm argument

1. It harms people to live in a way that is painful or not wanted
2. Life is not good if we don’t personally find value in it

⁹ Jackson and Keown, *Debating Autonomy*

Response: Palliation and supportive care

The obvious and reasonable response to this point is that much can be done (perhaps much more than many people realise) via supportive and palliative care.

Palliative care is not just about pain management. It also addresses other distressing symptoms, like insomnia, and shortness of breath. In its wider sense, it also encompasses support for anxiety, depression, dealing with eating problems, and mobility issues, amongst many others.

But palliation is imperfect.

Can palliation end all pain and suffering at the end of life?

It can do a great for many people.

But it has its limits.

Heather McQueen said of her mother's death:

*"That week that followed, as we watched everything unfold in its full horror, we watched the fear growing in her face. There was the hunger and being parched. She could not take fluids by mouth. She was also in great pain from the radiation burns and tumours and all the tubes she was dealing with. They gave her morphine, but there are specific amounts of morphine you are allowed to give."*¹⁰

There is also the problem that people may worry that they will be the person palliation cannot help. For example, Sandy Briden (Dignity in Dying) said:

"My thoughts are filled with uncertainty and fear that my pain and sickness will not be controllable - but having the option of an assisted death would change all that. I think about dying constantly - what will happen if the tumours on the left or the right grow fastest, how am I going to die, whether I will be in pain."

And palliation cannot take away the impact of Parkinson's disease, Motor Neuron Disease or Multiple Sclerosis and their impact on daily living. Tony Nicklinson's case is a prime example. No amount of palliation can give back what some people have lost and which they so valued.

Nor can it alleviate some of the other concerns people may have, such as loss of dignity or loss of the ability to do the things they once loved.

That said, we need to be careful not to under-estimate how much palliation *can* do, and how comfortable people can be made. It is very much worth noting that the BMA survey showed that palliative care doctors are less supportive of euthanasia --- perhaps because they know just how much can be achieved.

But as Emily Jackson argues, even given that, the perspective that is most important is that of the individual patient who is experiencing their particular symptoms, and the impact that palliation is having on them.

I agree. I think it is problematic to take the view of a group about cases in general and, via a law that is not permissive, effectively impose it on everyone as though it holds true for all. Demonstrably, it does not, given what we have heard from those who have sought to die.

Issue with Both Arguments: Risk of Error

- We may get decisions about choices wrong
 - But bringing it into the open helps avoid this – have open conversation
- We may get decisions about what is good for people wrong
 - Utilitarian view – is the cost of risk of getting it wrong v. cost of people living on when do not want to?
- We couldn't have a perfect system

Archbishop of Canterbury in the recent debate put it well when he said:

¹⁰ <https://www.dignityindying.org.uk/story/heather-mcqueen/>

“We know that the sad truth is that not all people are perfect, not all families are happy, not everyone is kind and compassionate. No amount of safeguards can perfect the human heart. No amount of regulation can make a relative kinder or a doctor infallible. No amount of reassurance can make a vulnerable or disabled person feel equally safe and equally valued if the law is changed in this way.”¹¹

But by way of response, Baroness Hayman reasonably pointed out:

“we do not have a kind and infallible system at the moment, and I believe that our legislation would be kinder and less fallible in many areas if we pass this Bill.”¹²

It arguably comes down to the balance of harms, an issue to which we will return.

Sanctity of Life argument

For others, however, there is a different way to frame the issue --- that life is sacred and should be preserved.

- Partly a religious view but not entirely
- Values all life – no arbitrary killing
- Not vitalism – not that life must be sustained at all cost, just that life is valuable
- Life is valuable for its own sake
 - Cf utilitarians – it’s only valuable for the good it brings us (eg Rachels, Savulescu)
 - Life without goods is not worth protecting (Harris)
- But other ways to see value than just good to us
 - Value to those around us (Herring)
 - Cf Dworkin – value is in critical interests
 - Argues that sanctity is not (even for supporters) absolute – young life lost is worse than older life lost – because it’s also about opportunity, good etc
 - Three ways life is valuable
 - Intrinsically – just good to be alive
 - instrumentally – gives good things to the community
 - subjectively – for the person (a form of instrumental value) – gain good things for self

Is the argument compelling?

What I think this argument does is remind us to take considerable pause. Life is valuable, and we should not lightly conclude that it is not. We should not be quick to see others as a burden, and we should not consider individuals in utilitarian terms – and that of course is the worry behind some slippery slope arguments.

That is also why is clearly wrong not to help someone as best we can when they feel their life has no value.

But to impose life upon someone who competently and in a settled view tells us that life, for them, is intolerable is cruel. I think also sanctity of life arguments stray away from what makes life valuable --- which is the ability to take pleasure in our lives. When that this no longer true, that life is not valuable *for us*. Accepting this doesn’t mean we believe that someone’s life itself is not valuable, but that it no longer holds value *for them*.

That is a key distinction, and I think straying into the language of ‘sanctity’ and ‘value’ obscures this.

A person remains valuable and important, and their life something precious, which should be respected and not impinged upon, at the same time as it being true that they no longer find value in living. The two concepts are not mutually exclusive. In fact, in my view, we respect the value of people precisely by respecting their

¹¹ [https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill\(HL\)](https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL))

¹² [https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill\(HL\)](https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL))

perspective about how they are experiencing life. To do otherwise, is in fact to fail to respect them as moral agents, because we impose our own subjective views upon them, assuming we are right and they are mistaken.

Other reasons to constrain choices

Impact on others

Some choices, but surprisingly few, only affect ourselves.

Most choices that we make will have an impact on someone else.

Choices at the end of life are rarely ones that affect only ourselves, because we exist embedded in relationships with other people. Our death is a loss to them, and hence if we choose to die sooner, and are permitted to do so, that loss will come sooner for them. We might wish that someone would hold on for longer, and we might consider that giving them the option to die creates the opportunity for them to cause us this loss sooner.

But, on the other hand, the manner and timing of our death has other negative impacts on people. Watching a loved one die slowly and in pain, or lose their dignity, is obviously traumatic.

Living or dying, both affect others.

This creates a reason to constrain choices if we think that people should be restricted in choosing to do things that would harm others. We do this in many contexts – much of the criminal law is concerned with just such behaviours.

But is it a good reason to prevent someone making a choice of how to die?

I don't believe it is.

Death does affect others, but the person it affects most is the person who dies. That feel the consequences or their choice, and hence their interests should be given the most weight.

This may well include them making an *other-regarding* decision. That might be live, and not pursue assisted dying, because they are prepared to suffer if it means staying longer for those they love. Or it might mean choosing to die because they feel they are a burden. That choice might be one freely made, or pressured (which is a concern), but it might be made because they choose to place the needs of others ahead of their own.

When we consider how to regulate, then, we need to account for both the impacts of these choices, and take a view on whose interests should dominate.

Slippery Slope arguments

It is sometimes suggested that if we open the door to assisted dying, we will then be on a slippery slope, eventually permitting things that we consider to be abhorrent.

There are a number of forms of this concern.

- 1) If we allow voluntary euthanasia, we will eventually allow Involuntary euthanasia
 - a) We will become used to death → hardened against the harms → involuntary will seem less bad → accept it (esp. resourcing aspect)
- 2) If we allow voluntary euthanasia, there's no reason to limit it to terminally ill people if it's grounded on autonomy
 - a) For example: the love sick teenager problem

But the thing with slippery slope arguments is to closely consider:

- What would make them slippery?
- Are their inherent stopping points that prevent us slipping further?

Response to argument one – the slip from voluntary to involuntary euthanasia

There is a big jump to forcing something on someone – unlikely we will make it because of good reasons not

to (respect for autonomy).

Response to argument two – the slip from terminal illness cases to others

- a) This might be a *good slip*
 - i) Part of a wider commitment to letting people live their lives as they choose
- b) Arguments for paternalism might restrict
 - i) - the ‘thank me later’ view
 - ii) Some slip may be good, but some control would be needed
 - (1) Could we create this?
- c) If life has lost good for someone, then it doesn’t matter how this has happened
 - i) The terminal illness requirement in some euthanasia models creates a relatively sharp line to prevent excessive slippage
 - (1) But it prevents allowing people their autonomy / accounting for subjective values at the end of life
 - ii) But we might put in place tests to ensure this is true and irreversible

Arguments specifically relating to Voluntary Euthanasia

Impact on doctors / medical professionals

It is not surprising that a large number of doctors surveyed by the BMA did not support euthanasia, and were less supportive of it than they were of assisted suicide.

Not only are they a profession committed to saving life, they are also those who would be called upon (potentially) to end lives when requested. This would, potentially, have deeply problematic impacts on some medics. We would need at the very least to have clear guidance to allow for conscientious objection.

But even with that in place, a raft of problems open up when we permit assisted dying.

- Doctors will be exposed to requests, openly, from those who wish to die
 - This will be difficult for them to manage in some cases
- Doctors will have to shift from carer, to someone who ends life
 - For some, this will affect their ability to care for patients, if they must step away from their care at the end of life
- It may have a negative impact on the doctor / patient relationship
 - Will patients’ trust in their healthcare professionals be reduced if they know that their doctor has actively ended the lives of others?
 - Particularly if the patient is convinced by concerns about slippery slopes, this may erode trust
- Conversely, though, as Emily Jackson suggests, patient trust might be increased if the patient knows that their desires about the end of their life will be respected.

Capacity to ensure choice is voluntary

A particularly strong argument against permitted assisted dying, particularly euthanasia, is whether it will be possible to ensure choice is voluntary.

We can say that it is necessary in the abstract, but reality can we achieve this?

We’ve seen the problems already.

But from a regulatory perspective, a permissive system would need to have:

- Mechanisms for obtaining consent
- Ensuring the decision was voluntary and free from pressure

- Was settled

Who is to determine this? Likely doctors with support. This may be difficult. It leaves room for error if done poorly. Despite the considerable regulation of medicine in this country, we know that errors happen, mistakes are made. It would be foolish to think this wasn't true of a system of assisted dying.

We would need to accept that they may be mistakes and that the system will be imperfect.

Arguments for and against specifically relating to Assisted Suicide

Impact on those who assist

One of the particular issues with the law as it stood pre-*Purdy* was the anxiety it created for those who wanted help to die about the impact on those they left behind.

Allowing suicide to be assisted has a range of negative impacts on those who are called upon (particularly if euthanasia is not also permitted)

- Guilt if they refuse
- Guilt if they acquiesce
- Fear that they will fall foul of the prosecution guidelines
- Doing a poor job and causing harm
- Being ill-placed to be sure that someone's consent is really voluntary
- Emotional burden

Impact on those who seek if not permitted

Like many things that the law seeks to prohibit, we know that they happen anyway.

This was the case with abortion prior to the 1967 Act. And we know it's the case with suicide in people facing illness or other things that make their life go poorly.

But just because people do do something, or want to do something, does not mean that the law should permit it. There are many behaviours the law legitimately, and I think rightly, tries to prevent even where they might largely affect only the person who does them.

Seat belt laws are a good example. Controls on drugs are another.

For the reasons I've discussed, there are good reasons to pause before simply allowing people to commit suicide if they say they want to.

But we need to compare what happens when we prevent them from lawfully committing suicide with assistance, and when we are permissive.

The key is to notice the *assisted* part – these are not people who can easily find ways to end their lives. Like Tony Nicklinson, they may be so incapacitated that they can only resort to measures like starving themselves. There are many reports, too, of people ending their lives in distressing ways because they had no other options. They die *badly* when they might otherwise have died *easefully*.

So in this case, it may be that the prohibition does harm because it means that some people who have a settled, committed desire to die but cannot avail themselves of help to do so in a way they would prefer, turn to alternatives that are less good or actively harming.

That, however, is one side.

On the other, we have to remind ourselves that giving people an option to do something is not a neutral act. Simon Rippon argues, in the context of organ sales, that offering the option of a choice to sell alters their position. Instead of not being able to sell and it simply not being an option (unless they find a black market), now they are *not electing to sell* when they don't sell but could. This creates a completely different choice architecture.

The same, I think, would be true of assisted suicide (and euthanasia). Once the option is on the table, it becomes much more of a possibility that it would otherwise be. It becomes not only more accessible, but also more conceivable. There is a clear pathway to do it. It would be lawful, possibly, to offer advice on how it could be done, or services to facilitate it. Many barriers that would turn away anyone other than the most

determined would be removed, and arguably (without strong protections of some form) some people who might have found it too difficult to pursue their choice and given it up (because it was not entirely committed) will not do so, and so will die when they might have lived.

Once it is on the table, it is also up for discussion. The 'I'm a burden' issue arises again – now, the ill person is choosing not to take an option they could take. That is quite different to staying alive because it is not permitted to have someone help you to die.

Again, we come back to the balance of harms on each side. In many ways, it is an empirical question --- where is the greatest harm?

How can we resolve these issues?

It is tempting to say the answer is simple, in either direction:

Do nothing. The matter is too vexed for the law to manage. Leave it as something that may happen, have few prosecutions but interfere no more.

As Baroness Cavendish put it in the recent House of Lords debate, however:

“The easiest thing to do when faced with complex moral issues such as this is nothing, but let us think about what doing nothing means. To do nothing in this context is to consign more people to slow, agonising deaths; to force relatives to risk a jail sentence if they help; and to leave some people going to Switzerland earlier than they wish to, if they are lucky enough to have that option, or in other cases starving themselves to death.”¹³

One woman, Kit, a 37 year old who spoke to Baroness Davidson ahead of the recent Lords' debates put this point more eloquently than I can:

“It feels unfair that those who don't have a terminal illness are making decisions on behalf of those of us who do”.

Baroness Davidson added an important point of her own

“For myself, I think there is a greater imbalance. Those such as Kit who wish this—who desperately want it—are not imposing the same outcome on those who do not. But those who are arguing against are denying others even the choice.”¹⁴

The alternative is to liberalise. Let everyone make their choice. Then each person can act according to their values, and we encompass all views.

But we have seen that this is no solution, because of the legitimate concerns that have been raised.

We are, then, at an impasse, it might seem. But must we act? Emily Jackson makes the argument, rightly in my view, that the status quo is indefensible for a number of reasons.

First, as Baroness Cavendish points out, people do already die as a result of their own choices or those of doctors, as we have seen, but those deaths are not necessarily of the kind they would have wanted.

- Withdrawal of treatment → not necessarily an easeful death
- Refusal of feeding → drawn out death by starvation
- The doctrine of double effect → protecting doctors who might relieve pain but in doing so hasten death
 - Though as she points out, many palliative care experts argue that this is not in fact the outcome of using pain relief
 - But the problem is that the defence remains open and accepted and hence doctors can avail themselves of it, yet it is deeply flawed.

¹³ [https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill\(HL\)](https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL))

¹⁴ [https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill\(HL\)](https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL))

We also already allow for other ways for people to die, and we make decisions for those who cannot choose themselves. We already, then allow, voluntary death or elected death. The one thing we don't allow is overt patient request for a swift death of the kind they want.

That, to me, seems perverse.

And yet... and yet the objections, the concerns have bite.

What do I think we can do to make our way through it?

Are there examples we can draw on of successful systems?

We need to consider what we think success would look like.

- Few if any errors
- Robust consenting system
- Compassion and care for those who would prefer to live, while permissive enough for those who choose not to
- A means to avoid imposing our values on others
 - Not to impose our own view of the good
 - While accounting for the legitimate paternalist views that protecting people from themselves might be the right thing to do
 - To do this, we'd have to draw a line in a robust place
 - The love sick teenager?
 - i. Oregon
 - ii. Switzerland
 - iii. Other?

Conclusions

The great problem with this debate is that is terribly emotive.

Almost anyone who has a view on it will have a personal story that partly, inevitably, unavoidably informs that view.

We shouldn't design the law around personal stories, but nor should be set them aside and not consider them.

For me, the debate fundamentally comes down to a balance of harms question. Both sides have good outcomes.

If we prohibit assisted dying, we know we will avoid some deaths that were not really consensual. We will protect some vulnerable people from being pressured into dying before they wished they would. We will give those people days or weeks or months of life they would otherwise have lost. And we will give their loved ones those days, too..

But if we permit it, we know that some people will, as a consequence, avoid the pain and indignity from which palliation and care could not have saved them. We know that some people will find peace in dying on their own terms. And we know that there will be people who will not then resort to taking their own lives in terrible circumstances. We know this because we have heard their personal stories – Tony Nicklinson, Debbie Purdy, Noel Conway --- and we know it because it is a fact that there are conditions that we cannot palliate, pain that we cannot control, indignities that we cannot prevent. I know because I watched my father die from the complications of Parkinson's disease. He had excellent healthcare, everyone did everything they could to make his final weeks tolerable, but it wasn't enough.

The only resolution if we frame the issue in this way is to balance those harms. If we limit our view today to those with a terminal illness, whose life is soon to end, then the answer to me is clear --- a loss of some of those days of life, when that life is already close to ending, is a lesser harm than the harms that we impose on those we force life upon when they wish to escape it. We cause them to experience pain, fear and suffering.

But while I have my own view on this, I don't think we can resolve this debate in that way, because even though I believe a small amount of lost life is a lesser harm than exposure to pain and suffering, there can be legitimate disagreement on this point.

So the only way this can be resolved by the law, in my view, is to return to one of the most fundamental principles that guides our law --- respect for autonomy. Taking someone's choice about of the most important moments in their lives is an imposition that should not be tolerated if we wish to respect each person's individuality. I think Emily Jackson puts it well when she says if do otherwise, we impose one person's values on another. To me, that is wrong. While it is right to act beneficently, to support, to help, it is not right to impose on someone a life they do not want.

We take a risk, yes, that sometimes we will get it wrong, but there is much we can do to mitigate that risk. We can draw lines and avoid the larger risks of slipping further down that slope if we wish. We can put in place safeguards, just as we put in place safeguards for so many other decisions that we permit people to make – financial decisions being a good example. It is possible, and we have models from elsewhere from which we can learn. On balance, there is more we can do to prevent that risk, than we can to ameliorate the harms we know we will cause if we do make the law more permissive.

Finally, the key reason I think we should liberalise (carefully) is that only through liberalisation can we allow people to live life according to their values --- choosing to die or not to die. A prohibition on assisted enables only one group to live by their values. The others cannot. In a secular society where we allow for difference in values and difference in viewpoints, the only way we can achieve respect for all these difference in the context assisted dying is to be permissive. Allowing people their freedom does come at a cost, and we need to avoid that as far as we can, but I think that the alternative of telling people they cannot make their own choice about the most serious event in their lives has to be considered far worse.

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References and Further Reading

Crown Prosecution Service on Assisted Suicide

<https://www.cps.gov.uk/publication/assisted-suicide>

BBC, Ethics of Euthanasia

<https://www.bbc.co.uk/ethics/euthanasia/overview/introduction.shtml>

CARE UK (against permitting assisted suicide)

<https://care.org.uk/cause/assisted-suicide/arguments-for-and-against-assisted-suicide-and-euthanasia>

Dignity in Dying (in favour of permitting assisted suicide and voluntary euthanasia)

<https://www.dignityindying.org.uk/>