21

ENDING LIFE

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A. Introduction

21.01 The debates over end of life issues are among the fiercest that rage in medical law. The arguments often collapse into two diametrically opposed camps: those who believe in the principle of the sanctity of life and argue that it is never permissible to kill an innocent person, even if they strongly desire to die; and those who emphasize the principle of autonomy and believe that people should be allowed to choose for themselves when and how they will die.[1] The issues are, in fact, far more complicated than that summary may suggest and the amount of material written on the law and ethics on end of life decisions is indeed voluminous.[2] This reflects not only the complexity, but also the importance of the issues at stake.

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[1] M Charlesworth, *Bioethics in a Liberal Society* (Cambridge University Press 1993) ch 1.

[2] For just a small selection of the more recent literature see: K Yuill, *Assisted Suicide: The Liberal Humanist Case against Legalisation* (Palgrave 2014); E Wicks, *The Right to Life and Conflicting Interests* (Oxford University Press 2010); E Jackson and J Keown, *Debating Euthanasia* (Hart 2012); S Smith, *End-of-Life Decisions in Medical Care* (Cambridge University Press 2012); C Peterson, *Assisted Suicide and Euthanasia* (Ashgate 2008); D Jeffrey, *Against Physician Assisted Suicide: A Palliative Care Perspective* (Radcliffe Publishing 2008); M Warnock and E MacDonald, *Easeful Death: Is There a Case for Assisted Dying?* (Oxford University Press 2008); R Young, *Medically Assisted Death* (Cambridge University Press 2007); P Lewis, *Assisted Dying and Legal Change* (Oxford University Press 2007); S Woods, *Death's Dominion—Ethics at the End of Life* (Open University Press, 2007); R Huxtable, *Euthanasia, Ethics and the Law: From Conflict to Compromise* (Routledge-Cavendish 2007); S McLean, *Assisted Dying:*

21.02 Most deaths occur within a medical setting. Every day medical professionals make death-related decisions: whether that be to withdraw life-sustaining treatment; not to intervene with life-saving treatment; or even to provide medication that it is known will speed a person's death. Indeed in one survey of GPs it was found that 63 per cent of deaths in England involved an 'end of life decision' by a medical practitioner. Of these, 32.8 per cent involved a medical professional intervening to alleviate pain or undesirable symptoms, with potentially life-shortening effect and 30.3 per cent were cases where potentially life-saving treatment was not given;[3] 0.16 per cent involved euthanasia with the request of the patient and 0.33 per cent euthanasia

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Reflections on the Need for Law Reform (Routledge-Cavendish 2007); G Williams, *Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide* (Routledge-Cavendish 2006); N Gorsuch, (2006) *The Future of Assisted Suicide and Euthanasia* (Princeton University Press 2006); N Biggar, *Aiming to Kill: The Ethics of Suicide and Euthanasia* (Pilgrim Press 2004); S Ost, *An Analytical Study of the Legal, Moral, and Ethical Aspects of the Living Phenomenon of Euthanasia* (Oxford University Press 2004); J Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press 2002); M Sommerville, *Death Talk* (McGill Queen's University Press 2001); H Biggs, *Euthanasia* (Hart 2001); R Cohen-Almagor, *The Right To Die With Dignity* (Rutgers University Press 2001); L van Zyl, *Death and Compassion* (Ashgate 2001); M Otlowski, *Voluntary Euthanasia and the Common Law* (Oxford University Press 1997); R Dworkin, *Life's Dominion* (Harper Collins 1993).

[3] C Seale, 'National Survey of End-of-life Decisions Made by UK Medical Practitioners' (2006) 20 Palliative Medicine 3.

without the patient's consent. It has been suggested that about 18,000 patients in Britain are medically assisted to die.[4] While care must be taken when using such statistics[5] what they reveal is the extent of 'end of life' decisions-making engaged in by health professionals. This makes the legal regulation of the area all the more important.

21.03 This chapter will focus on end of life decision-making in relation to patients who have capacity. Issues surrounding the end of life decisions concerning those who lack capacity are considered in Chapter 10 and those concerning refusal of life-saving treatment are considered in Chapter 8. This chapter will start with a summary of the legal regulation of the end of life for those who have capacity. It will then turn to the ethical and legal disputes concerning the current law. Many lawyers and ethicists are unhappy with the current state of the law, which is uncertain in many places and commonly seen to lack a sound ethical foundation.[6] A popular view is that the law is in a state of flux and we may be experiencing the start of a liberalization of the law in this area.

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[4] D Price, 'What Shape to Euthanasia after Bland?' (2009) 125 Law Quarterly Review 125, 145.

[5] It may be, for example, that the percentages of euthanasia were under-reported for fear of criminal investigation.

[6] Notably while strongly disagreeing on many issues in their book summarising competing sides of the debate over euthanasia (E Jackson, and J Keown, *Debating Euthanasia* (Hart 2012)) neither Jackson nor Keown find agreement in accepting that the current law unsupportable.

B. Terminology

21.04 Before setting out the law on ending life, it will be useful to highlight two fundamental distinctions that are drawn by the law.[7] These will be explored in more detail later in the chapter. First, a basic distinction is drawn between suicide, assisted suicide, and euthanasia.[8] Suicide is the killing of a person by themselves. Assisted suicide involves a person helping another to commit suicide. Euthanasia involves a person killing another person. There is therefore a fundamental distinction between a case where a doctor gives a patient a lethal dose of medication that the patient administers to themselves, which would be assisted suicide; and a case where the doctors administers a lethal dose of medication, which would be regarded as euthanasia. Both euthanasia and assisted suicide are illegal in most circumstances. The distinction was supported by Lord Neuberger in ethical terms in *R (on the application of Nicklinson) v Ministry of Justice)*[9] where he stated:

> To my mind, the difference between administering the fatal drug to a person and setting up a machine so that the person can administer the drug to himself is not merely a legal distinction. Founded as it is on personal autonomy, I consider that the distinction also sounds in morality. . .

21.05 A second basic distinction is between cases where the euthanasia or assisted suicide is voluntary, non-voluntary or involuntary. A case of voluntary death would be

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[7] A useful overview of the ethical and legal issues can be found in D Price, 'What shape to euthanasia after Bland?' (2009) 125 Law Quarterly Review 125.

[8] Euthanasia comes from Greek 'eu' (good) and thanatos (death).

[9] [2014] UKSC 38 at [94].

where the patient has specifically requested it, with full capacity to do so; a non-voluntary death would be where the patient has not expressed a view and lacks capacity to do so; an involuntary death would be where the patient has specifically stated that they do not want to die. There are very few, if any, lawyers or ethicists who would think that involuntary euthanasia or assisted suicide would ever be acceptable. However, as discussed in Chapter 10, the law has recognized that it can be legitimate to withdraw or withhold treatment from a patient lacking capacity, leading to their death.

C. Legal Regulation of Ending Life

21.06 The starting point of a consideration of the legal regulation of the end of life is the criminal law.[10] A health care professional who deliberately kills a patient can be convicted of murder.[11] But the extent to which the normal criminal law principles apply to medical professionals is far from clear.[12] Glenys Williams has made a powerful argument that criminal law concepts are sufficiently vague to enable the courts to reach what the judge regards as 'the right decision'.[13] In other words, what determines whether a medical professional is guilty of murder is not, so much, the

[10] See also General Medical Council, Treatment and Care Towards the End of Life (GMC 2010).

[11] Crown Prosecution Service, *Nurse found Guilty of Killing his Patients* (CPS 2008).

[12] M Otlowski, *Euthanasia and the Common Law* (Oxford University Press 1997) 182.

[13] <IBT>G Williams, *Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide* (Routledge-Cavendish 2006) 2</IBT>.

substantive criminal law itself, as the interpretation that is given to the open-ended legal concepts by the judge and jury. She argues that the normal criminal law principles are not appropriate to deal with the issues medical professionals face when making end of life decisions. Indeed, several commentators have noted the reluctance of the courts to convict medical professionals for murder, except in the most extreme cases.[14] It is not surprising that one doctor working in the field has complained that the law is 'confusing and conflicting'.[15]

1. Murder

21.07 A defendant is guilty of murder if he or she causes the death of a victim with an intention to cause death or grievous bodily harm.[16] Where the defendant kills a patient, but has no intention to kill or cause grievous bodily harm, he or she may nevertheless be guilty of manslaughter. Criminal law recognizes no defence of 'euthanasia' or 'mercy killing'. Lord Goff in *Airedale NHNS Trust v Bland*[17] made that clear:

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[14] ibid.

[15] M Wilks, 'Medical Treatment at the End of Life—A British Doctor's Perspective' in C Erin and S Ost, *The Criminal Justice System and Health Care* (Oxford University Press 2007) 166.

[16] For a detailed discussion of the law of murder see J Herring, *Criminal Law* (6th edn, Oxford University Press 2015) ch 5.

[17] [1993] AC 789, 865 (HL).

> 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.

The elements of the offence as they might apply in a euthanasia type context will be discussed further.

(i) Causation: Acts

21.08 To be guilty of murder, it must be shown that the defendant caused the death of the victim. This requires proof that the defendant's actions were an operating and substantial cause of death.[18] In some cases in the medical context this will be unproblematic. There would be no difficulty in showing that a doctor who administered an inappropriate amount of a lethal drug killing a healthy patient caused the death. Less straightforward are cases where the patient is already seriously ill and it is shown that the medical treatment may somewhat have hastened the death of the patient.[19] In such cases it need only be shown that the defendant's act was *a* cause of death; it does not need to be the only cause.[20] The fact, therefore, that the maladministration of the medicine led to death was in part because the victim was very ill would not provide a defence, if it could be shown that the defendant's act was a more than a minimal contribution to the death. However, there would come a point where the contribution to the death was so minimal that the defendant's actions are not regarded as a cause. Some commentators have suggested that the law

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[18] *R v Cheshire* [1991] 3 All ER 670 (CA).

[19] *R v Cox* (1992) 12 BMLR 38.

[20] *R v Mellor* [1996] 2 Cr App R 245 (CA).

is more willing to accept this in the case of medical treatment than in other cases.[21] However, in *R v Adams*[22] Devlin J, in a trial of a doctor charged with murder, stated: '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.' That said, it is generally thought that if the medical treatment has only led to a shortening of life of a seriously ill patient of a matter of minutes, then causation will not be established.[23]

(ii) Causation: Omissions

21.09 Generally in the criminal law a person is not liable for an omission. If they come across a sick person, they are entitled to pass on by and not incur criminal liability. This is, however, subject to an important exception, where the there is a duty of care between the defendant and victim.[24] There would be a duty of care owed between a health care professional and a patient they were treating. Health care professionals are, therefore, unusually open to prosecutions for failing to treat patients. However, this potential liability is limited. It will only arise where the failure to treat was a breach of their duty.

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[21] G Williams, *Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide* (Routledge-Cavendish 2006).

[22] Unreported, but discussed in H Palmer, 'Dr Adams' Trial for Murder' (1957) *Criminal Law Review* 365.

[23] H Palmer, n 23.

[24] For a detailed discussion of the law see J Herring, *Criminal Law* (Oxford University Press 2014) ch 2.

21.10 A health care professional could not, therefore, be liable for failing to offer treatment to a competent patient who was refusing to accept any treatment. It would simply be unlawful for them to do so and so the failure to treat would not breach their duty.[25] A slight question mark might hang over this absolute prohibition. In *An NHS Foundation Trust Hospital v P*[26] a seventeen and a half year old took an overdose of paracetamol but refused all treatment to counter its effects, saying she wanted to die. Baker J accepted that the patient had a right under Article 8 to make decisions for herself, but:

> they are outweighed by her rights under Article 2—everyone's right to life shall be protected by law. The court is under a positive or operational duty arising from Article 2 to take preventative measures to protect an individual whose life is at risk.

It was presumably crucial to the reasoning in the case that patient was under the age of 18, although, in the rapidly prepared judgment, that was not made clear. It may be that in other cases of borderline capacity a patient's refusal can be overridden, relying on Article 2.[27]

21.11 Similarly, a doctor is not required to give treatment which will not benefit a patient. In the end of life context it might even be determined that receiving life-prolonging

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[25] *Ms B v An NHS Trust* [2002] EWHC 429.

[26] [2014] EWHC 1650 (Fam).

[27] G Richardson, 'Mental capacity in the shadow of suicide' (2013) 9 International Journal of Law in Context 87.

or sustaining treatment will not benefit the patient. As Lord Browne-Wilkinson held in *Airedale NHS Trust v Bland*:

> [I]f there comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion) that further continuance of an intrusive life support system is not in the best interests of the patient, he can no longer lawfully continue that life support system: to do so would constitute the crime of battery and the tort of trespass to the person.[28]

Although those *dicta* were considering the specific case of those receiving life support while suffering from persistent vegetative state, presumably they can be applied in a broader context. There will be other cases at the end of life where a responsible body of medical opinion would determine that it would not be in the interests of a patient to receive the treatment.[29] In such a case the failure to provide treatment would not amount to a breach of duty and so criminal liability would not ensure. That would be so even if the patient were requesting the life-saving treatment.[30]

21.12 Even where it is established that the doctor breached the duty of care through not offering treatment the prosecution may face a difficulty in establishing that the breach caused the death. It would be necessary to show that had the correct treatment been given the patient would have lived. In many critical cases it may be hard to prove what would have happened had treatment been provided.

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[28] [1993] 1 All ER 821, 882 (HL).

[29] See further Chapter 10.

[30] *R (on the application of Burke) v General Medical Council* [2005] EWCA Civ 1003.

21.13 As we have just seen, the law draws a fundamental distinction between acts and omissions.[31] One survey of UK medical practitioners suggests that 75 per cent accept a moral distinction between active and passive euthanasia as of important moral significance.[32] This distinction is one which has attracted considerable ethical debate. As we have seen in law it is rarely lawful to do an act which causes the death of the victim. However, not providing treatment for a patient is lawful, indeed required, when the patient with clear capacity has refused to consent to the treatment or the treatment is not beneficial. The distinction can be supported in terms of causation. An omission, it is said, cannot cause death, because death is caused by the underlying medical condition. By contrast an actor can take over authorship and full responsibility for what happens.[33]

21.14 Despite the popularity of the distinction it has proved difficult to justify and explain at a theoretical level. It is far less popular among philosophers, than among lawyers.[34] Two leading medical ethicists, Beauchamp and Childress, state: 'the

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[31] E Garrard and S Wilkinson, 'Passive Euthanasia' (2005) 29 Journal of Medical Ethics 297; J Coggon, 'On Acts, Omissions and Responsibility' (2008) 34 Journal of Medical Ethics 576.

[32] J Coulson, 'Till Death Us Do Part' (1996) BMA News Review 23.

[33] M Stauch, 'Causal Authorship and the Equality Principle: A Defence of the Acts/Omissions Distinction in Euthanasia' (2000) 26 Journal of Medical Ethics 237.

[34] For arguments supporting the distinction between killing and letting die see M Stauch, 'Causal Authorship and the Equality Principle: A Defence of the Acts/Omissions Distinction in Euthanasia' (2000) 26 Journal of Medical Ethics 237; A Mcgee, 'Does

distinction between killing and letting die suffers from vagueness and moral confusion. The language of killing is so thoroughly confusing—causally, legally, and morally—that it can provide little if any help in discussion of assistance in dying.'[35] Lord Mustill likewise was not convinced by the distinction and feared that because of the weight attached to it the law is 'morally and intellectually misshapen'.[36] Lord Goff in *Bland* admitted that the distinction between acts and omissions can produce some apparently arbitrary results:

> it can be asked why, if the doctor, by discontinuing treatment, is entitled in consequence to let his patient die, it should not be lawful to put him out of his misery straight away, in a more human manner, by a lethal injection, rather than let him linger on in pain until he dies. But the law does not feel able to authorise euthanasia, even in circumstances such as these, for, once euthanasia is recognised as lawful in these circumstances, it is difficult to see any logical basis for excluding it in others.[37]

Most recently, Lord Neuberger in *R (on the application of Nicklinson) v Ministry of Justice*[38] seemed similarly troubled by the distinction and referred to 'a certain and

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Withdrawing Life-Sustaining Treatment Cause Death or Allow the Patient to Die?' (2014) Medical Law Review 26.

[35] T Beauchamp and J Childress, *Principles of Biomedical Ethics* (Oxford University Press 2003) 146.

[36] <IBT>*Airedale NHS Trust v Bland* [1993] AC 789, 885 (HL)</IBT>.

[37] ibid, 905.

[38] [2014] UKSC 38 at [22].

understandable discomfort with the notion that switching a machine off actually is an omission.'

21.15 Even some opponents of euthanasia are critical of the distinction between acts and omissions. To John Keown[39] the focus on acts and omissions avoids the key question: did the doctor intend to produce death? He argues that if a doctor intends to kill this is wrong. Whether the doctor intended to produce death by an act or an omission is just a detail about the method of killing which should not carry moral weight.

21.16 A further difficulty with the distinction is that it can be difficult to know where to draw it. Is switching off a life support machine an act or an omission? Glanville Williams makes the point in this way:[40]

> The question then arises whether stopping a respirator is an act of killing or a decision to let nature take its course? Common sense suggests it is the latter. Suppose that the respirator worked only as long as the doctor turned a handle. If he stopped turning, he would be regarded as merely commencing to omit to save the patient's life. Suppose, alternatively, that the respirator worked electrically but was made to shut itself off it would be an omission. It can make no moral difference that the respirator is constructed to run continuously and has to be stopped. Stopping the

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[39] J Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press 2002) 14.

[40] G Williams, *The Sanctity of Life and the Criminal Law* (Faber and Faber 1957) 237.

respirator is not a positive act of killing the patient, but a decision not to strive any longer to save him.

21.17 Some commentators argue that the difficulties in making the distinction between an act and omission reveals that the moral principles governing a doctor's decision on how to treat or not treat a patient should not focus on the distinction between withholding or withdrawing treatment, but rather what duties a physician owes her or his patient. Emily Jackson argues:

> Imagine a doctor has two competent adult patients connected to the same artificial ventilator. Patient A wants to continue living, and patient B wants to die. The doctor switches off the machine and both patients die. In relation to Patient A, because the doctor is under a duty to treat her, switching off the machine is characterized as an action, and the doctor might be guilty of murder. But in relation to patient B, switching off the machine is an omission . . . . the morally relevant fact is not whether what the doctor does is an omission or an action, but rather whether the background against which the decision has been taken justifies the doctor's conclusion that life, in these circumstances, should not be artificially prolonged.[41]

She goes on to argue that once we accept that sometimes it is better for a person to be allowed to die than for them to be offered treatment we are accepting that in some cases it would be better for a person to die. If we are willing to make that

[41] E Jackson, 'Whose Death is it Anyway? Euthanasia and the Medical Profession' (2005) 57 Current Legal Problems 415.

assessment in relation to those patients where the issue is withdrawal of life-sustaining treatment, the same principle should apply to cases where a patient needs a positive act to achieve death.[42] That argument takes us to the debate over the validity of the sanctity of life principle, which will be discussed shortly.

(iii) Mens rea: Intention

21.18 To be guilty of murder it must be shown that the defendant intended to cause death or grievous bodily harm. There will be no difficulty in cases where it was the purpose of the defendant's actions to cause the death of the victim. Harder are cases of so-called 'oblique intention' where the defendant foresees that death will result from his or her action, but acts for some other purpose.[43] In the medical context it is rare that a medical professional will be giving treatment wanting to kill the patient. More common will be the scenario where the professional's primary purpose was to give treatment to lessen pain, but they were aware that a side consequence of doing so was that the medication would hasten death.

21.19 Generally the law on oblique intention in criminal law is governed by the decision of the House of Lords in *R v Woollin*.[44] This states that a jury are only entitled to find a

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[42] E Jackson, 'Secularism, Sanctity and the Wrongness of Killing' (2008) 3 Biosocieties 125, 126.

[43] Notably in the Mental Capacity Act 2005, s 4(5) a person, in deciding whether to provide life-sustaining treatment to someone who lacks capacity, 'must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death'.

[44] [1991] 1 AC 82 (HL).

defendant intended death or grievous bodily harm if that was a virtually certain consequence of the defendant's actions and the defendant realized this.[45] It is important to appreciate that this leaves the jury with a discretion to determine whether or not to find the necessary intention. It is perfectly open to the jury to conclude that although death or grievous bodily harm was the virtually certain consequence of the defendant's actions they will not find intention.[46] To the consternation of some academics the courts have refused to offer guidance to juries on how to decide whether or not to find intent.[47]

21.20 It is unclear whether the *Woollin* direction is to be used in cases of medical professionals providing lethal doses of pain-relieving medication. If it does it would mean that a doctor who provided a pain-relieving drug, foreseeing that it would be bound to shorten life, but that not being their purpose, would be at the mercy of the jury, who would, under the *Woollin* direction, need to conclude whether or not this was a case where they would choose to find intention. However, it seems from the reported cases of doctors charged with murder or attempted murder following the administration of pain relieving drugs, that judges avoid giving the direction on oblique intention that is normally given in criminal law. Instead juries are told that if the doctor did not act for the purpose of causing death, then he or she cannot be

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[45] Where it is the defendant's purpose to cause death there is no reason to give the 'virtual certainty direction' because purpose will amount to intention automatically.

[46] *R v Matthews and Allayne* [2003] Cr App R 30 (CA).

[47] The judge should not seek to tell the jury how to exercise their discretion: *R v Wright* [2000] *Crim LR* 928 (CA).

guilty of murder.[48] The trials of Doctors Carr;[49] Adams,[50] and Moor,[51] all of whom had provided patients with lethal amounts of drugs, resulted in acquittals. It, is, however difficult to determine whether these are because of a difference in the way trial judges presented the law to juries, or the attitudes of juries themselves, or perhaps both.

21.21 Indeed it seems that the cases where doctors or other medical professionals have been convicted of murder fall into two primary categories. First, those where an individual appears to have been acting for the purpose of killing. A good example is *R v Cox*[52] where a doctor injected a patient with a lethal amount of potassium chloride. He was convicted of attempted murder. The expert evidence was that the amount of the drug given was sufficient to kill the patient and that it had no analgesic value. Further, the victim was found not to be terminally ill. However much one may have been willing to be flexible with the notion of intention it was difficult to get away from the conclusion that Dr Cox intended to kill. There was no other reason for acting in the way he did. Notably in this case he was given a suspended sentence. To be convicted

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[48] See the discussion in R Huxtable, *Euthanasia, Ethics and the Law: From Conflict to Compromise* (Routledge Cavendish 2007) ch 2.

[49] Unreported, Sunday Times, 30 November 1986.

[50] The case is recorded in H Palmer, 'Dr Adams' Trial for Murder' (1957) Criminal Law Review 365.

[51] Discussed in C Dyer, 'British GP Cleared of Murder Charge' (1999) 318 British Medical Journal 1306.

[52] (1992) 12 BMLR 38.

of attempted murder, but not to be given a sentence of immediate custody is unusual, and reflects the facts that these cases are not seen by the judiciary in the same light as 'normal' murders.

21.22 It may be that the judges in these cases are simply failing to give the correct direction that the criminal law requires. However, some commentators have suggested that the general law on intention does not apply to cases involving health care professionals and that where a health care professional is following an accepted body of medical practice it cannot be said that they have committed a crime.[53] Lord Goff's statements in *Airedale NHS Trust v Bland*[54] might suggest this:

> [It is] the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life. Such a decision may properly be made as part of the care of the living patient, in his best interests; and, on this basis, the treatment will be lawful.

To similar effect, Lord Neuberger in *R (on the application of Nicklinson) v Ministry of Justice*[55] stated 'a doctor commits no offence when treating a patient in a way which hastens death, if the purpose of the treatment is to relieve pain and suffering (the so-called "double effect")'.

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[53] This was the view of the Attorney-General in evidence to House of Commons Select Committee, *On the Assisted Dying for the Terminally Ill Bill* (*Hansard*, 2005), para 13.

[54] [1993] 1 All ER 821 (HL).

[55] [2014] UKSC 38 at [18].

21.23 Similar issues arise when the courts are dealing with cases where a relative has administered a lethal medication to a terminally ill patient. There have been cases where, in fact, the motivation of the relative has been to obtain an inheritance. In such a case the juries will not hesitate to convict of murder.[56] Where, however, there is a case of 'mercy killing', the court may be more reluctant to find an intention to kill, or to use a defence to a charge of murder.[57] These will be discussed later.

21.24 The distinction the law draws between intention and foresight is controversial. Some commentators believe that if a person does an act aware it will cause death they must be held to account for it, whether it happened to be their purpose for acting or not.[58] Most commentators who make this point are in fact supporters of euthanasia. Their point is that given that nearly everyone agrees that giving pain-relieving medication is permissible, even if it shortens life, we should also accept that intentional shortening of life is permissible. The precise nature of the medical professional's state of mind should not matter.

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[56] *R v Cumming* [2006] EWCA 3223.

[57] H Biggs, 'Criminalising Carers: Death Desires and Assisted Dying Outlaws' in B Brooks-Gordon, F Ebtehaj, J Herring, M Johnson, and M Richards, M (eds), *Death Rites and Rights* (Hart 2007).

[58] C Foster, J Herring, K Melham, and T Hope, 'The Double Effect Effect' (2011) 20 Cambridge Quarterly Healthcare Ethics 56.

21.25 Many supporters of the current law support the doctrine of double effect.[59] There is no one approved definition of the doctrine, although all versions accept that in some circumstances a person who is doing an act with the purpose of producing result A, but foreseeing that result B will also result from their actions, will be held to intend result A, but not result B. John Keown's version is representative of many formulations. He refers to four principles that render it permissible to do an act which produces a bad consequence:

(1) The act one is engaged in is not itself bad.

(2) The bad consequence is not a means to the good consequence.

(3) The bad consequence is foreseen but not intended.

(4) There is sufficiently serious reason for allowing the bad consequence to occur.[60]

It will be noted that this test is not simply one of assessing 'intention'. The fourth factor demonstrates that there is an element of moral assessment that takes place to determine whether the act is permitted. There is, therefore, a degree of ambiguity over whether the doctrine should be understood as a definition of intention, or rather, as seems more likely, a definition of the circumstances in which it is permissible to do an act which is very likely to lead to a bad consequence. Its application in the case of pain-relieving medication involves an assessment that the pain-relieving qualities

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[59] For a useful discussion see D Price, 'Euthanasia, Pain Relief and Double Effect' (1997) 17 Legal Studies 323.

[60] J Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press 2002) 20.

of the medication are a good enough reason to permit the use of the medication, despite its likelihood to cause death.[61]

21.26 Those who support the distinction between foresight and intention argue that our moral assessment of an act will often hinge on it. Compare, for example, the friend who makes an unpleasant remark about your appearance intending to hurt you, from the friend who made the same remark, not intending to hurt you but wanting to tell the truth, but realizing you might be distressed. The first person is unlikely to remain a friend, while the second may well be forgiven for their insensitivity.

21.27 Supporters of the distinction between intention and foresight argue that with intention the result is the reason for which a person acts and hence it shows that it was a key element in their moral evaluation. Whereas a foreseen result is not one which has motivated the actor and therefore they have less to account for. This argument is often supported by examples of cases where we would say the actor foresaw the result but did not intend it: the binge drinker may foresee a hangover but does not intend to produce it; the law lecturer may foresee her students will be bored, but not intend that; the police officer breaking bad news to relatives of a traffic victim accident may foresee their distress, but does not intend it. Indeed, supporters of double effect, argue, to suggest that in these cases there is intention to produce

[61] C Foster, J Herring, K Melham, and T Hope, 'The Double Effect Effect' (2011) 20 Cambridge Quarterly of Healthcare Ethics 56.

these undesirable results is absurd.[62] These examples, they argue, show how important the difference between intention and foresight is to our moral intuitions.

21.28 There are, however, plenty of commentators who reject the distinction between intention and foresight. Baroness Warnock has described it as 'absurdly pedantic'.[63] John Harris[64] argues that it places too much weight on how one expresses the problem. If a doctor was to say 'My intention was to end the pain of the patient, by killing him. I realized that the medication would kill him, but that was not my motivation' is death intended or foreseen? While most supporters of the distinction would argue that there is a fundamental difference between a case where a doctor intended to end pain, by killing, and where a doctor intends to end pain but realizes death will result at the same time, to opponents the distinction involves playing with words.

21.29 Even if one accepts the distinction is of fundamental moral importance there is another question and that is whether it is one the law can rely on.[65] It is important to appreciate that the law cannot necessarily match precisely all the sophistication that a perfect ethical analysis may wish to rely on. The law must utilize tests that are capable of proof and are comprehensible to people who will be guided by them. Such

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[62] J Finnis, 'Intention and Side-effects' in R Frey and C Morris (eds), *Liability and Responsibility* (Oxford University Press 1991).

[63] M Warnock, *An Intelligent Person's Guide to Ethics* (Duckbacks 2001) 39.

[64] J Harris, *The Value of Law* (Oxford University Press 1984) 44.

[65] C Foster, J Herring, K Melham, and T Hope, 'The Double Effect Effect' (2011) 20 Cambridge Quarterly of Healthcare Ethics 56.

concerns are less of an issue for those dealing with high ethics. So one could conclude that whatever the theoretical merit of the double effect doctrine it fails to provide sufficient guidance to those who must seek to comply with the law; and fails to provide sufficient clarity to courts who must decided whether there has been a breach the law. If a doctor, for example, administers a pain-relieving drug intending to kill a patient, how are we to know whether it was his or her intention to kill or not? Indeed, can a doctor be able to separate out their own intentions and foresight? As one doctor has written:

> Physicians are driven by a fundamental imperative to reduce pain and suffering. When faced with a patient who is suffering both physically and mentally, the primary effort will be to give whatever treatment is appropriate to achieve this aim, providing net benefit in terms of best interest. It is unrealistic to think that the doctor at all times keeps from his mind the thought that part of that benefit includes death. Obviously, whether the doctor acts on this thought will define whether he or she remains within accepted ethical and legal practice, but that these thoughts will arise must be simply a natural part of a doctor's professionalism. They are particularly difficult to deal with when the patient also articulates a wish to discuss assisted dying.[66]

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[66] M Wilks, 'Medical Treatment at the End of Life—A British Doctor's Perspective' in C Erin and S Ost, *The Criminal Justice System and Health Care* (Oxford University Press 2007) 170.

While these are important points, one should recall that everyone agrees that a line must be drawn somewhere between which killings are permitted and which are not. Although there are difficulties with the place where the line is currently drawn, there may be ambiguity and difficulties of proof wherever it is drawn.

(iv) Defences to murder

21.30 Criminal law provides a number of defences to a charge of murder. Most are not relevant in the context of medical law. Before going into the detail of defences which might apply, it is important to recognize there is no general defence of mercy killing.[67] Lord Neuberger in *R (on the application of Nicklinson) v Ministry of Justice*[68] explained:

> Mercy killing is a term which means killing another person for motives which appear, at least to the perpetrator, to be well-intentioned, namely for the benefit of that person, very often at that person's request. Nonetheless, mercy killing involves the perpetrator intentionally killing another person, and therefore, even where that person wished to die, or the killing was purely out of compassion and love, the current state of the law is that the killing will amount to murder or (if one or more of the mitigating circumstances are present) manslaughter.

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[67] J Horder, 'Mercy Killings—Some Reflections on Beecham's Case' (1988) Journal of Criminal Law 309.

[68] [2014] UKSC 38 at [17].

In fact, it is rare for cases of 'mercy killing' to result in a murder conviction;[69] normally defences are available which reduce the charge to manslaughter, especially in the case of carers who kill their seriously ill relative or friend.

21.31 Before considering these defences, it is useful to have in mind the distinction, important to criminal lawyers, between a justification and an excuse.[70] In short, a justification involves an argument that the killing was morally right, or at least that it was morally permissible. On the other hand, an excuse finds that the killing was not morally permissible but that the actor does not deserve blame. This distinction is, perhaps most relevant in a case where a spouse, civil partner, or other family member kills a loved one after a long period of care. In such a case there are two kinds of defences the family member may seek to raise in response to such a charge. The first is that he or she was lawfully permitted to do the action. The second is that she was driven to despair by the circumstances and was not wholly responsible for her actions. This may lead to a defence based on, for example, diminished responsibility.[71]

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[69] Although see *R v Inglis* [2011] WLR 1110 and *R v Cocker* (1989) *Criminal Law Review* 740 (CA).

[70] J Herring, *Criminal Law* (6th edn, Oxford University Press 2014) ch 12.

[71] H Biggs, 'Criminalising Carers: Death Desires and Assisted Dying Outlaws' in B Brooks-Gordon, F Ebtehaj, J Herring, M Johnson, and M Richards, (eds), *Death Rites and Rights* (Hart 2007).

21.32 (a) Diminished responsibility The defence of diminished responsibility is set out in s 2(1) Homicide Act 1957, as amended by the Coroners and Criminal Justice Act 2009:

(1) A person ('D') who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which—

(a) arose from a recognised medical condition,

(b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A), and

(c) provides an explanation for D's acts and omissions in doing or being a party to the killing.

(1A) Those things are—

(a) to understand the nature of D's conduct;

(b) to form a rational judgment;

(c) to exercise self-control.

(1B) For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct.'

There have been cases where a person has been caring for a terminally ill relative and has suffered depression or other abnormality of the mind, as a result of the exhaustion and stress that twenty-four-hours-a-day care can produce.[72] The defence is only a partial

[72] *R v Taylor* [1979] CLY 570, where a man who killed his autistic child was put on probation. For a further helpful discussion see H Biggs, 'Criminalising Carers: Death Desires and Assisted Dying Outlaws', in B Brooks-Gordon, F Ebtehaj, J Herring, M Johnson, and M Richards (eds), *Death Rites and Rights* (Hart 2007).

defence and so even if it is successfully raised a defendant will be convicted of manslaughter, but then usually face only a minimal sentence.[73] In one notorious case[74] a 100-year-old man killed his dependent wife after she kept being moved between care homes. The Crown Court Judge, Mr Justice Leveson described the killing as an act of love and he was given a community rehabilitation order.

21.33 (b) Necessity In exceptional circumstances the defence of necessity may be available to a criminal charge. Generally speaking there is no defence in the criminal law that a defendant produced a greater good by killing the victim. For example, it would not be lawful for a doctor to kill one patient so that her organs could be transplanted into several other patients and thereby save their lives. However, it seems that in highly exceptional cases the defence of necessity, that the defendant acted in way which was the lesser of two evils, will succeed.

21.34 In *Re A (Conjoined Twins)*[75] the Court of Appeal were required to determine the fate of Jodie and Mary, who were conjoined twins. Jodie was the stronger of the two. Mary's heart and lungs did not function adequately and it was only because she shared a common artery with Jodie that she was alive. Their condition meant that, in effect, Jodie's heart was pumping blood for Mary as well as herself. The medical evidence indicated that Jodie's heart was under strain and that without a separation

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[73] *R v Jones*, The Guardian, 4 December 1979; a conviction for manslaughter in a case of mercy killing was punished with a conditional discharge.

[74] S Ost, 'Euthanasia and the Defence of Necessity', in C Erin and S Ost, *The Criminal Justice System and Health Care* (Oxford University Press 2007).

[75] [2001] Fam 147 (CA).

operation the twins would die within a few months. If an operation were performed the consequence would be that Mary would die, but Jodie could be expected to have a relatively normal life. In short the alternatives were to do the operation which would kill Mary; or not to intervene which would lead, in a few months time, to both Mary and Jodie dying. The medical team caring for the girls wanted to perform the operation, but the parents objected, primarily on religious grounds. The case was ultimately heard before the Court of Appeal, who declared that the operation would be lawful.

21.35 The Court of Appeal held that no criminal offence would be committed by performing the operation. It was accepted that the operation would cause the death of Mary. Even though her death was not part of the doctors' aim or purpose, Lord Justices Ward and Brooke held that because they realized that it was a virtually certain consequence of the procedure they could be taken to have intended it.[76] In reaching this conclusion they failed to analyse in detail the *Woollin* test (which they purported to apply). In particular they failed to emphasize that the *Woollin* test gives the jury the option not to find intention, even where the result is appreciated as a virtually certain consequence of their act. It may be that they thought that this was a case where it would be appropriate to find intention, but if so no explanation is provided for why they thought that.

21.36 All of the members of the Court of Appeal agreed that if the doctors did the operation they would have a defence to any potential murder charge. Lord Justice

[76] Lord Justice Robert Walker held that there was no intention, relying on the doctrine of double effect (discussed at para 21.25).

Robert Walker argued that the defence of private defence could apply. He regarded Mary to be, in effect, attacking or at least threatening Jodie in an unjustified way. The doctors could therefore perform the operation to protect Jodie from the threat. The majority of the Court of Appeal thought that as Mary and Jodie had been born the way they were it could not be said that Mary was posing an unjust threat or attacking Jodie. However, Lord Justices Ward and Brooke thought this was a case where the doctors could rely on the defence of necessity. There was some reluctance to state precisely when such a defence may be available. Indeed, probably the best interpretation of the case is that there will be rare circumstances where the defence of necessity will be available, but these will be determined on a case-by-case basis and require highly unusual facts.

21.37 The decision in *Re A* has generated substantial academic debate.[77] The issues raised are complex. To some commentators the case is an unwelcome departure from the

[77] See, eg, J McEwan, 'Murder by Design: The "Feel-Good Factor" and the Criminal Law' (2001) 9 Medical Law Review 246; B Hewson, 'Killing off Mary: Was the Court of Appeal Right?' (2001) 9 Medical Law Review 281; J Harris, 'Human Beings, Persons and Conjoined Twins: An Ethical Analysis of the Judgment in Re A' (2001) 9 Medical Law Review 221; R Huxtable, 'Separation of Conjoined Twins: Where next for English Law?' [2002] Criminal Law Review 459; V Munro, 'Square Pegs and Round Holes: The Dilemma of Conjoined Twins and Individual Rights' (2001) 10 Social and Legal Studies 4; S Michalowski, 'Sanctity of Life—Are Some Lives More Sacred Than Others?' (2002) 22 Legal Studies 377; K Mason, 'Conjoined Twins: A Diagnostic Conundrum' (2001) 5 Edinburgh Law Review 226.

principle that necessity is not a defence to murder and that a person can never be killed simply in order to benefit others.[78] On such a view the courts should be criticized for placing greater value on Jodie's life than they did on Mary's.[79] Other commentators have criticized the decision for failing to place sufficient weight on the views of the parents, given the fact that strong moral arguments could be made both in favour of performing the operation and opposing it.[80] The decision has been seen to raise broader issues by other academics. Vanessa Munro suggests that the decision demonstrates in dramatic form how individualistic conceptions of rights can fail to capture sufficiently the interconnection between individuals.[81] While to Barbra Hewson the case shows how the cultural norm of individuality and restoring 'physical normality' dominated the decision.[82]

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[78] J McEwan, 'Murder by Design: The "Feel-Good Factor" and the Criminal Law' (2001) 9 Medical Law Review 246.

[79] S Michalowski, 'Sanctity of Life—Are Some Lives More Sacred than Others?' (2002) 22 Legal Studies 377.

[80] R Gillon, 'Imposed Separation of Conjoined Twins—Moral Hubris by the English Courts' (2001) 27 Journal of Medical Ethics 3.

[81] V Munro, 'Square Pegs and Round Holes: The Dilemma of Conjoined Twins and Individual Rights' (2001) 10 Social and Legal Studies 4.

[82] B Hewson, 'Killing off Mary: Was the Court of Appeal Right?' (2001) 9 Medical Law Review 281.

21.38 It has been suggested by some commentators that the defence of necessity could be used in the euthanasia context.[83] Tony Hope uses a striking example to make the point:

> A driver is trapped in a blazing lorry. There is no way in which he can be saved. He will soon burn to death. A friend of the driver is standing by the lorry. This friend has a gun and is a good shot. The driver asks the friend to shoot him dead. It will be less painful for him to be shot than to burn to death.[84]

On the assumption that the reader believes it would be appropriate to shoot the driver, Hope suggests that the same response should be made to a doctor who gives a terminally ill patient in great pain a lethal injection. In both cases the actor is simply choosing the lesser of two evils. However, given the great reluctance of the courts to use necessity as a defence in criminal law[85] it seems very unlikely that the courts will take this route. Indeed

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[83] S Ost, 'Euthanasia and the Defence of Necessity' in C Erin and S Ost, *The Criminal Justice System and Health Care* (Oxford University Press 2007).

[84] T Hope, *A Very Short Introduction to Medical Ethics* (Oxford University Press 2004), 15.

[85] S Gardner, 'Direct Action and the Defence of Necessity' (2005) *Criminal Law Review* 371.

in *R (Nicklinson) v Ministry of Justice*[86] at first instance the argument that necessity could apply in an end of life case was firmly rejected.[87]

21.39 (c) Prosecutorial discretion In other cases of 'mercy killing' a prosecution may not even be brought. The Crown Prosecution Service will only bring proceedings if it is in the public interest. In the case of Rachel Heath the judge asked the CPS to reconsider whether it was in the public interest to try for attempted murder an elderly cancer patient who was in pain and was killed by a professional carer. The CPS decided to withdraw the prosecution.[88] Statistics for the years 1982 and 1991 show that only twenty-four cases of 'mercy killings' were brought to court. Of these, only one led to a murder conviction and sixteen to a manslaughter conviction. Of the latter category only three defendants were sent to prison. As shall be discussed shortly in *R (on the application of Purdy) v DPP*[89] the House of Lords decided that the DPP needed to issue clearer guidance on what factors would be taken into account when deciding whether to prosecute someone for assisting suicide. As a result the DPP has produced new guidelines, which will be summarized later.[90]

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[86] [2012] EWHC 2381 (Admin)

[87] For an argument that necessity should be available see J Herring, 'Escaping the Shackles at the End of Life' (2013) 21 Medical Law Review 48

[88] Unreported, but discussed in H Biggs, *Euthanasia* (Hart 2001) 46.

[89] [2009] UKHL 45, discussed in K Greasley, 'R(Purdy) v DPP and the Case for Willful Blindness' (2010) Oxford Journal of Legal Studies 301.

[90] Director of Public Prosecutions, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (Crown Prosecution Service 2014).

2. Suicide

21.40 The law's response to suicide is somewhat uneasy. It used to be a crime to commit suicide. Suicide was regarded as murder of the self.[91] Indeed, bizarrely, attempted suicide at one time carried the death sentence.[92] The current law, found in the Suicide Act 1961, states that is not a crime to commit suicide nor attempt to commit suicide.

The reasoning behind the decriminalization of suicide was explained by Lord Sumption in *R (on the application of Nicklinson) v Ministry of Justice*[93]:

> The reason for decriminalising suicide was not that suicide had become morally acceptable. It was that imposing criminal sanctions was inhumane and ineffective. It was inhumane because the old law could be enforced only against those who had tried to kill themselves but failed. The idea of taking these desperate and unhappy individuals from their hospital beds and punishing them for the attempt was as morally repugnant as the act of suicide itself. It was ineffective because assuming that they truly intended to die, criminal sanctions were incapable by definition of deterring them.

So it is wrong to suggest the decriminalization of suicide recognized a right to kill oneself.[94] Rather, the change in the law recognized that the stress of the prosecution is likely to work against the benefits of the treatments being offered by the medical

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[91] J Stephen, *A History of the Criminal Law of England* (Routledge 1996, 1883) 16.

[92] G Williams, *The Sanctity of Life and the Criminal Law* (Faber and Faber 1957) 274.

[93] [2014] UKSC 38 at [212]

[94] For a discussion of the ethical issues see J Vong, 'On Whether Suicide is Immoral: In Defence of Kant's Moral Prohibition on Suicide Solely to Avoid Suffering' (2008) 34 Journal of Medical Ethics 655.

profession. It is therefore rather concerning to read of the use of Anti-Social Behaviour Orders against those who attempt to commit suicide.[95] Lord Sumption's explanation also solves a dilemma that the law does not outlaw suicide but it does prohibit the encouragement or assistance of suicide, as we shall discuss later.

21.41 The definition of suicide is complex.[96] It is generally understood to occur when a person intentionally kills themselves. This would indicate that it would be not be suicide for a person to undertake a highly risky activity, aware that it carried the danger of death, at least unless it was their purpose to die as a result. In *Secretary of State for the Home Department v Robb*,[97] Thorpe LJ did not regard the death of a prisoner from a hunger strike as suicide. He provided no reasons for this conclusion, but presumably it is a recognition that the individual's purpose was not to die, but to achieve their mark of protest. This would seem to indicate that a person who wished to undertake a risky form of treatment which carried a risk of death, hoping it would not kill them, would not be committing suicide. A doctor providing that treatment would, likewise, not be assisting a suicide, if the patient were to die.[98]

21.42 It is not clear whether suicide can be committed by omission. In particular whether a person who refuses life saving treatment because they want to die, is committing

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[95] S MacDonald, 'A Suicidal Woman, Roaming Pigs and a Noisy Trampolinist: Refining the ASBO's Definition of Anti-Social Behaviour' (2006) 69 Modern Law Review 183.

[96] J Donnelly, *Suicide: Right or Wrong* (Prometheus Books 1998).

[97] [1995] Fam 127 (FD).

[98] There would be a possibility of gross negligence manslaughter if there was no body of professional opinion which regarded the risky form of treatment as appropriate.

suicide. This is a potentially very significant question because if it is suicide, then a person who encourages or helps a patient to make such a decision could be convicted of assisting suicide. There are two primary issues. The first relates to intention. Where the patient was refusing treatment in order to avoid the pain or indignity of the treatment, rather than to die, is that suicide?[99] Second, there is still debate over whether 'letting nature take its course' and not having treatment can be regarded as amounting to suicide. As we saw earlier, normally in criminal law an omission is not regarded as causally significant unless there is a duty to act. So suicide by omission could only exist when or if there is a duty to receive treatment to keep alive. Although the courts have not directly considered the issue in this context, it is generally well established in medical law that a person is entitled to refuse treatment and, therefore, the law does not appear to recognize a duty to accept treatment.[100] It seems, therefore, unlikely that the courts would find a patient who refused treatment to be committing suicide and therefore unlikely that a medical professional who assisted or encouraged someone to refuse treatment would be guilty of assisting suicide.[101]

3. The duty to prevent suicide

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[99] See *R v Blaue* [1975] 1 WLR 1411 (CA), where a patient who died after refusing a blood transfusion on account of religious beliefs was said not to have committed suicide.

[100] *Ms B v An NHS Trust* [2002] EWHC 429.

[101] For a contrary view see J Keown, 'A Futile Defence of Bland: A Reply to Andrew McGee' (2005) 13 Medical Law Review 393.

21.43 It is generally assumed that a person is entitled to prevent another person from committing suicide. In some cases the law goes further and imposes an obligation to prevent a person from committing suicide. Uncontroversially this applies where a person lacking capacity is attempting to commit suicide. Doing so would fall under the general obligation to promote the best interests of those lacking capacity. However, the obligation extends to cases where a person has capacity. The duty arises where a person is in the care of a state authority, and then there is a duty to take reasonable steps to ensure they do not commit suicide. For example, in *Reeves v Commissioner of the Police of the Metropolis*[102] the House of Lords held that the prison services were under a duty to prevent a sane prisoner committing suicide. Similar reasons would apply in relation to a hospital in relation to patients detained under the Mental Health Act 1983. In *Rabone v Pennine NHS Foundation Trust*[103] it was held that Article 2 of the European Convention on Human Rights imposed such an obligation. The case was brought by parents of young a woman who suffered from depression and had been informally admitted to hospital following a suicide attempt. She was assessed at high risk of suicide but the hospital allowed her home for two days leave, during which she committed suicide. The Supreme Court confirmed that there was a duty to protect people from a real and immediate risk of

[102] [2000] AC 360. An obligation on the prison authorities to prevent suicide will also arise under the Human Rights Act 1998: *Savage v South Essex NHS Trust* [2008] UKHL 74.

[103] [2012] UKSC 2.

suicide when they were under the control of the state. It did not matter that she was not formally detained under the 1983 Act.

21.44 Less straightforward are cases where the would-be suicide is not under the care of a state authority. It seems in such cases that the state authorities are not obliged to intervene, but in some cases they may. In *Re Z (An Adult: Capacity)*[104] Mrs Z, aged 65, suffered from cerebella ataxia. This was an incurable and terminal condition which caused her to become increasingly disabled. She had become determined that she wanted to commit suicide. She was no longer physically capable of killing herself and so wanted to travel to Switzerland where assisted suicide was permitted. Her husband, Mr Z, made the travel arrangements and planned to travel with her. When the local authority learned of their plans the local authority became concerned. Mrs Z's social worker believed Mrs Z to be competent but also was concerned that Mr Z would be committing the criminal offence of aiding and abetting suicide by making the arrangements. The local authority therefore applied to court, seeking to invoke its inherent jurisdiction to prevent Mr Z from removing Mrs Z from the jurisdiction. An interim injunction was ordered until a full hearing could take place.

21.45 By the time of the hearing there was evidence which established that Mrs Z had legal capacity to make her own decisions. Justice Hedley lifted the interim injunction. He held that in cases of this kind the duties of the local authority were:

(i) to investigate the position of a vulnerable adult to consider what was her true position and intention;

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[104] [2004] EWHC 2817.

(ii) to consider whether she was legally competent to make and carry out her decision and intention;

(iii) to consider whether any other (and if so, what) influence may be operating on her position and intention and to ensure that she has all relevant information and knows all available options;

(iv) to consider whether she was legally competent to make and carry out her decision and intention;

(v) to consider whether to invoke the inherent jurisdiction of the High Court so that the -question of competence could be judicially investigated and determined;

(vi) in the event of the adult not being competent, to provide all such assistance as may be reasonably required both to determine and give effect to her best interests;

(vii) in the event of the adult being competent to allow her in any lawful way to give effect to her decision although that should not preclude the giving of advice or assistance in accordance with what are perceived to be her best interests;

(viii) where there are reasonable grounds to suspect that the commission of a criminal offence may be involved, to draw that to the attention of the police;

(ix) in very exceptional circumstances, to invoke the jurisdiction of the court under the Local Government Act 1972, section 222 (which enables a local

authority to bring proceedings to a court in relation to inhabitant in their area).[105]

Considerable media attention was paid to a case in December 2008 where Daniel James[106] died in a Dignitas Swiss Clinic.[107] He was a 22-year-old student who had suffered a serious spinal injury during a rugby training session, causing paralysis from the chest down and a range of other mobility problems. Before his visit to Dignitas he had tried unsuccessfully to commit suicide. His parents and a friend had helped with the arrangements for him to travel there. The Director of Public Prosecution decided against a prosecution of his parents and the friend for assisting his suicide.[108] His case highlighted the uncertainty over when the CPS would prosecute in a case of assisted

[105] At [19].

[106] The Daniel James case is discussed in A Mullock, 'Overlooking the criminally compassionate: what are the implications of prosecutorial policy on encouraging or assisting suicide?' (2010) 18 Medical Law Review 442 and S Ost, 'The de-medicalisation of assisted dying: is a less medicalised model the way forward?' (2010) 18 Medical Law Review 497.

[107] Dignitas is an organization that has facilities to assist those who wish to commit suicide (<http://www.dignitas.ch/>).

[108] Director of Public Prosecutions, *Decision On Prosecution—The Death By Suicide Of Daniel James* (Director of Public Prosecutions 2009). For a discussion of the discretion of the DPP in relation to assisted suicide see R Tur, 'Legislative Technique and Human Rights' [2003] Criminal Law Review 3 and Calvert-Smith and O'Doherty, 'Legislative Technique and Human Rights: A Response' [2003] Criminal Law Review 384.

suicide. This uncertainty has been to some extent removed by subsequent clarifications to the DPP guidance, discussed below (at para 21.xx).

4. Assisting suicide

21.46 As already mentioned it is an offence under s 2 of the Suicide Act 1961 to assist or encourage suicide. However s 2 (as amended by the Coroners and Criminal Justice Act 2009) states:

> (1) A person ('D') commits an offence if—
>
> (a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and
>
> (b) D's act was intended to encourage or assist suicide or an attempt at suicide.
>
> (1A) The person referred to in subsection (1)(a) need not be a specific person (or class of persons) known to, or identified by, D.
>
> (1B) D may commit an offence under this section whether or not a suicide, or an attempt at suicide, occurs.
>
> (1C) An offence under this section is triable on indictment and a person convicted of such an offence is liable to imprisonment for a term not exceeding 14 years.

21.47 The offence includes providing equipment or advice to another to commit suicide. Where a defendant forced a person to commit suicide, that could be charged as manslaughter or even murder.[109] Aiding suicide would be charged where a defendant gave a person assistance and, as a result, the victim chose in a free, voluntary, and

[109] *R v Kennedy* [2007] UKHL 38.

informed way to commit suicide. A straightforward case, one might think, would be where a health care professional gives a lethal dosage of drugs to an individual, aware that they intend to use them to commit suicide. Although even that example is not beyond doubt. In *R v Chard*[110] a doctor gave tablets to a patient at her request. The patient committed suicide by taking the tablets. The doctor was acquitted of assisting suicide because he had just given the patient the option of committing suicide. Such an argument would, however, mean that it would be very rare that a person could be convicted of assisting suicide. It may be that the explanation of the result in *R v Chard*[111] is that the doctor did not intend to help the victim to commit suicide. To be guilty as an accomplice to suicide it must be shown that suicide was foreseen and that the defendant intended to assist that suicide.[112] In *Gillick v West Norfolk and Wisbech AHA*[113] it was stated that a doctor who gave contraception to an under-16-year-old girl would not be regarded as assisting unlawful sexual intercourse because he would not want her to engage in sex. Similarly, if a doctor gave pain relief pills to a patient, not wanting to use them to commit suicide, but foreseeing that the patient might, he or she might, in the same way, escape criminal liability.

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[110] <IBT>The Times, 23 September 1993</IBT>.

[111] ibid.

[112] *R v Bryce* [2004] EWCA Crim 1231; *R v S* [2005] EWCA Crim 819.

[113] [1985] 3 All ER 402.

21.48 Significantly, s 2(4) of the Suicide Act requires the consent of the DPP to commence any prosecution for assisting suicide.[114] That implies an acceptance by Parliament that there will be cases where prosecution for assisting suicide would not be appropriate. It is this discretion which in recent years has become the focal point for legal proceedings in this area.

21.49 In *R (on the application of Purdy) v DPP*[115] Debbie Purdy was aged 45 and suffering from progressive multiple sclerosis. She stated that she was becoming weaker and suffering great pain. She foresaw that she might at some time in the not too distant future decide to end her life and travel overseas to a country that permitted assisted suicide. One possibility was to go to Switzerland to use the services of Dignitas (an organization that makes arrangements for people who wish to commit suicide). If she were to pursue that plan, she would need the assistance of her husband, but was concerned that if he was involved he might face a prosecution for assisting suicide. She sought from the DPP a reassurance that if her husband were to assist her in travelling overseas he would not be prosecuted. The DPP was unwilling to do more than refer to the Code of Prosecutors which set out the general guidance on when prosecutions of crimes will be brought. The couple challenged that decision in court. The case went to the House of Lords, which found in Ms Purdy's favour.

21.50 At the heart of their reasoning was the conclusion that Debbie Purdy's decision to seek assisted suicide fell within Article 8(1). Any interference in that right could be

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[114] For a good example of when the offence will be prosecuted see *R v Howe* [2014] EWCA Crim 114.

[115] *R (on the application of Purdy) v DPP* [2009] UKHL 45.

justified under Article 8(2) but that interference had to be justified by law. To amount to 'law' the legal obligation had to be sufficiently clear. The guidance offered by the DPP failed to be sufficiently clear. This was especially unsatisfactory because the issues surrounding assisted suicide were sensitive and controversial and so officials needed clear guidance. In particular there was insufficient guidance as to what factors would indicate whether a prosecution was in the public interest. The court therefore ordered the DPP to produce clear guidance on how he would exercise his discretion on whether to prosecute for assisting suicide.

21.51 Perhaps the most significant aspect of the decision in Purdy is that a decision to end one's life falls within Article 8(1) and is, therefore, protected as a right. In reaching this decision their Lordships overturned their conclusion in *R (on the application of Pretty) v DPP*[116] that Article 8 did not cover a decision to commit suicide. They justified their change in position by reference to the decision in the ECtHR in *Pretty v UK*.[117] It must be admitted that that judgment was not as clear as it could have been on the question of the extent to which Article 8 covered end of life decisions.[118] The European Court there stated:

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[116] [2001] UKHL 61.

[117] *Pretty v UK* [2002] 2 FCR 97.

[118] *R (on the application of Purdy)*, n 115. At [67] it stated: 'The applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The Court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8 § 1 of the Convention.' But confusingly later at [87]: 'The Court has found

> The very essence of the Convention is respect for human dignity and freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.[119]

Whatever debates might be had about the dicta in the case, their Lordships in *Purdy* regarded it as sufficient to justify a reinterpretation of Article 8.

21.52 It is important not to exaggerate the significance of *Purdy*. Their Lordships were not saying there was a right to die.[120] The decision does not cast doubt on the interpretation of Article 2 given by the ECtHR in *Pretty v UK*.[121] The ECtHR saw Article 2 as imposing an obligation to protect life and so it could be taken to include

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above that the applicant's rights under Article 8 of the Convention were engaged' (at [61–67]).

[119] *Pretty v UK*, n 117, at [65].

[120] For discussions on 'a right to die' see: A du Bois-Pedain, 'Is There a Right to Die?' in B Brooks-Gordon, F Ebtehaj, J Herring, M Johnson, and M Richards (eds), *Death Rites and Rights* (Hart 2007); J Coggon, 'Ignoring the Moral and Intellectual Shape of the Law after Bland: The Unintended Side-effect of a Sorry Compromise' (2007) 27 Legal Studies 100.

[121] [2002] 2 FCR 97.

a right to die. At the same time the courts have confirmed that Article 2 does not generate an absolute right to all treatment that could sustain life. If, in a doctor's medical opinion, such treatment would be futile or inappropriate it need not be given.[122]

21.53 Nor were their Lordships saying that it should not be an offence to assist a person in committing suicide. The finding was that the decision to commit suicide fell within Article 8. This is significant because Article 8(2) permits an interference with Article 8 rights. Indeed their Lordships in *Purdy* were in no doubt that there could be circumstances in which it was necessary to interfere in a person's decision to commit suicide. Baroness Hale stated:

> Clearly, the prime object must be to protect people who are vulnerable to all sorts of pressures, both subtle and not so subtle, to consider their own lives a worthless burden to others. . . . But at the same time, the object must be to protect the right to exercise a genuinely autonomous choice. The factors which tell for and against such a genuine exercise of autonomy free from pressure will be the most important.[123]

Their Lordships were simply stating that the law on assisting suicide needed to be sufficiently clear to enable a person to know whether they would be guilty of an offence if they were to assist suicide.

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[122] *R (on the application of Burke) v General Medical Council* [2005] EWCA Civ 1003; *Re OT* [2009] EWHC 633 (Fam).

[123] *Purdy*, n 115, at [65].

21.54 The significance of the ruling in *Purdy* is that any outlawing of assisting suicide must be justified. Lord Brown emphasized that it should not be assumed that all acts of assistance are wrong:

> suppose, say, a loved one, in desperate and deteriorating circumstances, who regards the future with dread and has made a fully informed, voluntary and fixed decision to die, needing another's compassionate help and support to accomplish that end (or at any rate to achieve it in the least distressing way), is assistance in *those* circumstances necessarily to be deprecated? Are there not cases in which (although no actual defence of necessity could ever arise) many might regard such conduct as if anything to be commended rather than condemned? In short, as it seems to me, there will on occasion be situations where, contrary to the assumptions underlying the Code, 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. (para 83)

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21.55 One final significance of the *Purdy* decision is that it might give strength to claims in future which rely on Article 14 of the ECHR. In *Pretty v UK*[124] Ms Pretty, relying on Article 14, claimed that the English law had not placed a criminal bar on those physically capable of doing so from committing suicide, but that those who lacked the physical capacity for doing so were unable to commit suicide. This it was

[124] <*IBT*>*Pretty v UK* [2002] 2 FCR 97</IBT>.

claimed was discrimination on the grounds of disability. The argument was rejected by the ECtHR who found that even if there was discrimination it was objectively reasonably justifiable in order to protect vulnerable people:

> . . . there is, in the court's view, objective and reasonable justification for not distinguishing in law between those who are and those who are not physically capable of committing suicide. Under art 8 of the Convention, the court has found that there are sound reasons for not introducing into the law exceptions to cater for those who are deemed not to be vulnerable. Similar cogent reasons exist under art 14 for not seeking to distinguish between those who are able and those who are unable to commit suicide unaided. The borderline between the two categories will often be a very fine one and to seek to build into the law an exemption for those judged to be incapable of committing suicide would seriously undermine the protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse.[125]

21.56 It should be emphasized that generally, a stronger justification is required for discriminatory treatment than for other interferences in a person's rights. Indeed it is notable that Lord Bingham in his judgment in the House of Lords stated:

> If article 2 does confer a right of self-determination in relation to life and death, and if a person were so gravely disabled as to be unable to perform any act whatsoever to cause his or her own death, it would necessarily

[125] ibid, at [89].

follow in logic that such a person would have a right to be killed at the hands of a third party.[126]

This may be taken as an acceptance that Article 14 arguments in relation to assisted suicide would carry weight, if only the right to commit suicide can be found to exist within the Convention. As *Purdy* has now found that suicide decisions fall within Article 8, that argument might well be brought before the courts again.

21.57 It is important to emphasize that *Purdy* was not suggesting that all decisions to commit suicide are covered by Article 8. The wish of a person lacking capacity to commit suicide would not fall within Article 8. Also their Lordships in their discussion had in mind a case where a person who was terminally ill wished to commit suicide. Whether they would conclude that a person, with capacity, who wished to commit suicide for what others would regard as a frivolous reason fell within Article 8 may be open to debate. Baroness Hale stated somewhat elliptically in *Purdy*: 'It is not for society to tell people what to value about their own lives. But it may be justifiable for society to insist that we value their lives even if they do not.'[127]

21.58 Since *Purdy*, the European Court has offered further clarification on the human rights dimension. In *Koch v Germany*[128] it was clear that a person with a close relationship to the person who wishes to die (eg a partner) will be able to invoke a right under Article 8 in connection with the person's wish to die. Similarly, it has

[126] [2002] 1 All ER 1, 6–7.

[127] *Purdy*, n 115, at [68].

[128] (2013) 56 EHRR 6.

been confirmed that if a person wishes to commit suicide, the state is not under a duty to provide them with their chosen means to do so.[129] However, if the state does provide assistance in some cases, there must be clear guidance setting out when assistance is or is not to be made available.[130]

21.59 The ECtHR has, therefore, established a reasonably clear approach to end of life issues. Article 8 does protect a right to determine how to end one's life, but a state is permitted to outlaw assisted suicide, providing there is sufficient justification under paragraph 2. However, the precise balancing between the rights falls within a state's 'margin of appreciation'.

The Supreme Court in *R (on the application of Nicklinson) v Ministry of Justice*[131] is currently the leading case on the issue of human rights and assisted suicide. However, it is a broad ranging judgment involving some complex issues of human rights and constitutional law, as well as the discussion of medical matters. The case was brought by two appellants. The best known was Tony Nicklinson, who died following the hearing of the case at the High Court, but in whose name the litigation continued. He suffered from 'locked-in syndrome' and was paralysed below the neck and could not speak. He communicated by blinking to indicate a letter on a board held up by his wife or an eye blink computer. He told the court:

> My life can be summed up as dull, miserable, demeaning, undignified and intolerable. . . . it is misery created by the accumulation of lots of things which are minor in

[129] *Haas v Switzerland* (2011) 53 EHRR 33.

[130] *Gross v Switzerland* (2014) 58 E.H.R.R. 7.

[131] [2014] UKSC 38.

themselves but, taken together, ruin what's left of my life. Things like . . . constant dribbling; having to be hoisted everywhere; loss of independence, . . . particularly toileting and washing, in fact all bodily functions (by far the hardest thing to get used to); having to forgo favourite foods; . . . having to wait until 10.30 to go to the toilet . . . in extreme circumstances I have gone in the chair, and have sat there until the carers arrived at the normal time.[132]

The other appellant, known as Martin, also suffered from locked-in syndrome. They both appealed against the findings of the lower courts that the current law on assisted suicide did not infringe their human rights. The Director of Public Prosecutions appealed against an order in the Court of Appeal that the prosecution guidance on assisted suicide needed further clarification as it applied to professionals.

21.60 The majority of their lordships (seven of the nine; Lady Hale and Lord Kerr dissenting) rejected an argument that the ban on assisted suicide imposed a 'blanket ban' and so was impermissible under the European Convention on Human Rights. The majority took the view that the European Court of Human Rights had made it clear that the precise regulation of assisted suicide was within the margin of appreciation, meaning that each country could determine for it the balance of rights on the regulation of assisted suicide under Article 8. The majority held that ideally parliament would address the issue and determine what balance was appropriate for England. Only if it refused to would it fall to the courts to make the determination. The majority held that the court could, in theory, determine that the ban on assisted

[132] <IBT>*R (on the application of Nicklinson and another) (Appellants) v Ministry of Justice* [2012] EWHC 2381 (Admin)</IBT> at [13].

suicide infringed convention rights, but that parliament should be given the opportunity to consider amending the law first. Lord Neuberger summarized the conclusion for why as follows:

> First, the question whether the provisions of section 2 should be modified raises a difficult, controversial and sensitive issue, with moral and religious dimensions, which undoubtedly justifies a relatively cautious approach from the courts. Secondly, this is not a case like *Re G* where the incompatibility is simple to identify and simple to cure: whether, and if so how, to amend section 2 would require much anxious consideration from the legislature; this also suggests that the courts should, as it were, take matters relatively slowly. Thirdly, section 2 has, as mentioned above, been considered on a number of occasions in Parliament, and it is currently due to be debated in the House of Lords in the near future; so this is a case where the legislature is and has been actively considering the issue. Fourthly, less than thirteen years ago, the House of Lords in *Pretty v DPP* gave Parliament to understand that a declaration of incompatibility in relation to section 2 would be inappropriate, a view reinforced by the conclusions reached by the Divisional Court and the Court of Appeal in this case: a declaration of incompatibility on this appeal would represent an unheralded *volte-face*.[133]

The holding of the Supreme Court was very limited. The majority (Lady Hale and Lord Mance dissenting) thought it was not appropriate at this point in time to issue a

[133] ibid, at [116].

declaration of incompatibility. [134] However, a majority indicated that in the future it could hold that the bar on assisted suicide was contrary to the European Convention on Human Rights, as interpreted by the English courts. There was clearly a degree of disagreement on this issue. Lady Hale and Lord Mance appeared willing to issue a declaration of incompatibility immediately. However, the rest of the Justice were not willing to do so. Lords Neuberger, Mance, and Wilson, while indicating that a declaration of incompatibility could not currently be made, leave strong hints that unless compelling new arguments are made they would be minded to make a declaration of incompatibility. Lords Sumption, Hughes, Reed, and Clarke appear currently less inclined to make to issue of incompatibility, believing the issue to be one for the legislature.

21.61 The Supreme Court did however recommend that the DPP review her guidance in so far as it applied to professionals assisting suicide. Following the decision in *Nicklinson* the Director of Public Prosecutions updated its guidance that it had

[134] By contrast in Carter v A-G [2015] SCC 5 the Canadian Supreme Court held the prohibition on assisted dying void as contrary to the Canadian Charter of Rights 'insofar as it deprives a competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition': [4].

produced following the Purdy decision. The guidance lists factors which will be taken into account when deciding when to prosecute in a case of assisted suicide.[135]

A prosecution is more likely to be required if:

1. the victim was under 18 years of age;
2. the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;
3. the victim had not reached a voluntary, clear, settled, and informed decision to commit suicide;
4. the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
5. the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;
6. the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;
7. the suspect pressured the victim to commit suicide;
8. the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;
9. the suspect had a history of violence or abuse against the victim;

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[135] <IBT>Director of Public Prosecutions, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (2014)</IBT>.

10. the victim was physically able to undertake the act that constituted the assistance him or herself;
11. the 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;
12. the suspect gave encouragement or assistance to more than one victim who were not known to each other;
13. the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;
14. the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care**;**
15. the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;
16. the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organization or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

21.62 A prosecution is less likely to be required if:

1. the victim had reached a voluntary, clear, settled, and informed decision to commit suicide;
2. the suspect was wholly motivated by compassion;
3. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
4. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
5. the actions of the suspect may be characterized as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;
6. the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

The guidance goes on to explain how these factors should be used.

21.63 The DPP made it clear that in issuing these guidelines he was not changing the law. The Suicide Act 1961 had made it clear that it was not necessarily correct to prosecute in every case of assisted suicide. The DPP emphasized that the list of factors provided had to be used with care:

> Assessing the public interest is not simply a matter of adding up the number of factors on each side and seeing which side has the greater number. Each case must be considered on its own facts and on its own merits. Prosecutors must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall

assessment. It is quite possible that one factor alone may outweigh a number of other factors which tend in the opposite direction. Although there may be public interest factors tending against prosecution in a particular case, prosecutors should consider whether, nonetheless, a prosecution should go ahead and for those factors to be put to the court for consideration when sentence is passed.[136]

D. Slippery Slopes

21.64 One important issue in the current debate surrounds slippery slopes. A slippery slope argument states that even if it is morally acceptable to permit A, it should not be permitted because it would lead to B, which is morally unacceptable.[137] The application of such an argument to euthanasia is then made that even though we might be able to conceive of individual cases or categories of cases where it would be appropriate to allow euthanasia, legalizing the practice would inevitably result in it being used in circumstances which would be unacceptable.

21.65 John Keown[138] has argued that are two kinds of slippery slope arguments that can be made in this context. First, that as a matter of logic, once voluntary euthanasia is permitted there are no arguments which would justify opposing involuntary euthanasia and so one will necessarily lead to another. Second, as a matter of practice, it is not possible to put in place procedures to ensure that there is no involuntary euthanasia. Indeed, in considering the position in countries where

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[136] ibid, at [39].

[137] D Lamb, *Down the Slippery Slope* (Croom Helm 1988).

[138] J Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press 2002).

voluntary euthanasia has been allowed critics claim that there is evidence that involuntary euthanasia has occurred.[139]

21.66 The first of Keown's arguments is that supporters of euthanasia are on the horns of a dilemma. Either they accept that autonomy is the key principle and then anyone who wishes to die should be allowed to do so. Or we restrict euthanasia to only those who are in great pain or facing a terminal illness. He suspects that most euthanasia supporters, would favour the latter option. But by so restricting autonomy, he claims, we are impliedly saying that in those cases the decision that is being made is a good one. The slippery slope comes in because once we allow this we must accept that it will be sensible for incompetent people in a similar situation to be killed. So, we start off by allowing a small group of people to exercise their autonomy to kill themselves or be killed, but we end up authorizing the killing of those lacking capacity who are terminally ill. Keown might find support for his view in evidence that in Holland where euthanasia has been made lawful under certain circumstances (see below 21.69) there is now much debate over when it is appropriate to kill disabled neonates.[140] Not everyone is convinced by Keown's argument. One response is to suggest that it is perfectly coherent for the law to only allow euthanasia when we have both an exercise of autonomy *and* a belief that the decision is a reasonable

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[139] See the discussion at para 21.66 *et seq*.

[140] E Verhagen and P Sauer, 'The Groningen Protocol—Euthanasia in Severely Ill Newborns' (2005) 352 New England Journal of Medicine 959.

one.[141] Whether this attempt to combine autonomy and beneficence is sustainable is one of the central themes in the debate.

21.67 The second slippery slope argument is about the impact of any change in the law on practice. If the law permits euthanasia or assisted suicide in certain fixed situations, is it inevitable that the safeguards will be bypassed and there will be an ever increasing number of people dying under the scheme? For example, people may be pressurized into agreeing to being killed when that is not their wish; doctors may be willing to allow patients to be killed, even though the patient's condition does not fall exactly within the parameters of the rules; and the need to save resources may increase the pressures on doctors and patients to engage in euthanasia.

21.68 Both supporters and opponents of euthanasia have referred to what has happened in Netherlands and Oregon, US. In the former, euthanasia has been permitted in certain circumstances and in the latter, assisted suicide. Perhaps not surprisingly to opponents these countries show that safeguards put in place to prevent the slippery slopes just mentioned have been ineffective,[142] while to supporters these examples show how it is possible to have a well regulated regime which protects vulnerable people.

1. The Netherlands

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[141] H Lillehammer, 'Voluntary Euthanasia and the Logical Slippery Slope Argument' [2002] Cambridge Law Journal 545.

[142] J Keown, 'Euthanasia in the Netherlands' in J Keown (ed), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge University Press 1995).

21.69 Holland has permitted euthanasia in certain circumstances.[143] Essentially, the Dutch law permits a doctor to kill a patient who has produced a request which is voluntary and well-considered; who is suffering in a way which is lasting and unbearable; and where there is no prospect of improvement in his or her condition. Both doctor and patient must believe that there is no reasonable solution to his or her plight apart from assisted suicide or euthanasia. An independent physician must be consulted and confirm that the conditions are met.

21.70 While there has been considerable attention paid to the Dutch scheme, perhaps predictably there has been no consensus over the lessons to be learned from it. It certainly seems that some doctors are performing euthanasia or assisted suicide without completing the appropriate paperwork and registering it with the authorities. Whether this is a sign of doctors simply avoiding bureaucracy or of a slippery slope with killings taking place outside the scope of the scheme is a matter of fierce debate.[144] John Finnis has argued that in Holland there is a considerable level of non-voluntary euthanasia:

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[143] The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, amending Art 293 of the Penal Code of the Netherlands.

[144] For a detailed discussion of the Dutch law, see J Griffiths, H Weyers, and M Adams, *Euthanasia and the Law in Europe* (Hart 2008); B Onwuteaka-Philipsen, A van der Heide, M Muller, M Rurup, C Rietjens, J Georges, A Vrakking, J Cuperus-Bosma, G van der Wal, and P van der Maas, 'Dutch Experience of Monitoring Euthanasia' (2005) 331 British Medical Journal 24; A Van der Heide, B Onwuteaka-Philipsen, M Rurup, H Buiting, J van Delden, J Hanssen-de Wolf, A Janssen, R Pasman, J Rietjens, C Prins, I

> when you look at those figures, the bottom line is this: we find that not just 1,300 or 2,300 or another 1,000 but 25,306 cases of death were accelerated by medical intervention intended wholly or partly to terminate life . . . And of these Dutch deaths, well over half, or fifty eight percent—14,691—were without any explicit request.[145]

Indeed, concern about the Dutch scheme has been expressed by the United Nations Human Rights Committee[146] and the Committee on Legal Affairs and Human Rights of the European Parliament.[147] The latter body stated that the studies:

> have demonstrated a disturbingly high incidence of euthanasia being carried out without the patient's explicit request and an equally disturbing

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Deerenberg, J Gevers, P van der Maas, and G van der Wal, 'End-of-life Practices in the Netherlands under the Euthanasia Act' (2007) 356 New England Journal of Medicine 1957; S Smith, 'Evidence for the Practical Slippery Slope in the Debate on Physician-assisted Suicide and Euthanasia' (2005) 13 Medical Law Review 17; S Smith, 'Fallacies of the Logical Slippery Slope in the Debate on Physician-assisted Suicide and Euthanasia' (2005) 13 Medical Law Review 224.

[145] J Finnis, 'Euthanasia, Morality and the Law' (1998) 31 Loy L A L Rev 1123.

[146] The United Nations Human Rights Committee, *Concluding Observations of the Human Rights Committee: Netherlands* (United Nations 2001).

[147] <IBT>European Parliamentary Assembly, Social, Family Affairs and Health Committee (2003) *Euthanasia* (European Parliament 2003)</IBT>.

failure by medical professionals to report euthanasia cases to the proper regulatory authority.[148]

21.71 Many commentators have not been persuaded that the evidence from Holland is concerning, particularly in the light of more recent studies which have found greatly improved rates of reporting. The reporting rate of euthanasia and physician-assisted suicide increased from 41 per cent in 1995, to 54 per cent in 2001 and to 80 per cent in 2005.[149] In 2005, 1.7 per cent of all deaths in Netherlands were reported to be euthanasia and 0.1 per cent assisted suicide. These were lower than 2001, which if accurate, would suggest some of the slippery slope arguments are not supported by the evidence from Holland. However, the figures also show that of all deaths 0.4 per cent were end of life decisions with no explicit request from the patient.[150] Also, 7.1 per cent of all deaths involved the use of palliative sedation and these were significantly up on the figures for 2001, which might indicate an increase in the use of -physician involvement in death.

21.72 A study in 2007 of relatives of those who had died under the Dutch euthanasia laws found 92 per cent saying they believed that lawful euthanasia or assisted suicide had contributed favourably to the patient's end of life.[151] Another study claimed that

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[148] ibid, para 1.

[149] <IBT>Van der Heide et al, 'End-of-Life Practices in the Netherlands' n 144</IBT>.

[150] ibid.

[151] J-J Georges, B Onwuteaka-Philipsen, M Muller, G van der Wal, A van der Heide, and P van der Maas, 'Relatives' Perspective on the Terminally Ill Patients who Died after

there was no evidence from Holland that vulnerable people were being pressurized into euthanasia without their consent.[152] It is, therefore, difficult at this point to be entirely sure what the picture is of death practices in a state which permits euthanasia. Penney Lewis, after a thorough review of the evidence writes:

> There is no evidence from the Netherlands that the legalization of voluntary euthanasia caused an increase in the rate of non-voluntary euthanasia . . . Evidence in relation to other jurisdictions is mixed; while rates of non-voluntary euthanasia in some prohibitive jurisdictions are higher than the Dutch rate, in other prohibitive jurisdictions the rates are lower. Lacking solid baseline evidence, the current evidence does not support the drawing of inferences either that legalization causes an increase in the rate of non-voluntary euthanasia or that such rates are higher under a prohibitive approach. Furthermore, it seems likely that cultural factors may significantly influence baseline rates, thus further decreasing the possibility of drawing -inferences from evidence in one jurisdiction as to what will happen in another.[153]

2. Oregon

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Euthanasia or Physician-assisted Suicide: A Retrospective Cross-sectional Interview Study in the Netherlands' (2007) 31 Death Studies 1.

[152] Van der Heide et al, 'End-of-life practices in the Netherlands, n 144.

[153] P Lewis, 'The Empirical Slippery Slope from Voluntary to Non-voluntary Euthanasia' (2007) Journal of Law, Medicine and Ethics 197.

21.73 In 1994 Oregon, a State in the US, passed the Death with Dignity Act 1994.[154] This permitted doctors to provide a patient with a lethal quantity of drugs for the purpose of assisting a patient's suicide. However, this was only permitted in certain carefully proscribed circumstances and it did not allow the doctor to administer the drug her- or himself. In other words the legislation permitted physician-assisted suicide, not euthanasia. The patient must be found to be acting voluntarily and be competent.

21.74 A total of 1173 people have died since the law was passed. In 1998, 16 Oregonians used physician-assisted suicide. This increased to 27 in 1999, 37 in 2004 and to 71 in 2013. This means that 2.19 in a thousand Oregonians die through physician-assisted suicide.[155]

21.75 Some interesting information has emerged from Oregon about the individuals who typically seek physician-assisted suicide:

- The most common medical conditions among those using to Act to commit suicide were those suffering from cancer and motor neurone disease.[156]
- The most common reason given for wanting to die was loss of autonomy and not being able to do the things which made life enjoyable and a loss of dignity. Forty-four per cent of those using the Act mentioned fears about

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[154] R Cohen-Almagor and M Hartman, 'The Oregon Death With Dignity Act: Review and Proposals for Improvement' (2001) 27 *Journal of Legislation* 269.

[155] Oregon Public Health Division, *Death with Dignity Act* (Oregon, PHD 2014).

[156] This condition is also known as ALS (amyotrophic lateral sclerosis) or Lou Gehrig's disease.

being a burden to their family or friends as a major factor leading them to seek suicide:[157] In 2013 around 70 per cent of those who died were aged 65 or over. Younger people with terminal illnesses were more likely to seek PAS than older people with terminal illnesses.

- There was a significant difference between rates of men and women seeking PAS.in 2013. 62 per cent were men and 38 per cent were female.
- Asian Oregonians were three times more likely than white Oregenians to seek PAS. Divorced and never married people were two times more likely than married people to do so.
- There was a strong association between having attended higher education and seeking PAS.[158]

So far it does not appear from the evidence that there is widespread abuse of the system,[159] but Bonnie Steinbock believes it as yet unproven whether the benefits of the Oregon system outweigh the disadvantages of potential abuse.[160] In 2013, no

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[157] Department of Human Services, *Fifth Annual Report on Oregon's Death with Dignity Act* (DHS 2003) 20.

[158] Department of Human Services, *Annual Report* (Salem: Oregon, DHS 2013).

[159] E Dahl and N Levy, 'The Case for Physician Assisted Suicide: How Can It Possibly be Proven?' (2006) 32 Journal of Medical Ethics 335.

[160] M Battin, A van der Heide, L Ganzini, G van der Wal, and B Onwuteaka-Philipsen, 'Legal Physician-assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups' (2007) 33 Journal of Medical Ethics 591.

cases were referred to the Board of Medical examiners, with complaints that the paperwork for prescriptions under the Act was inadequately completed.[161]

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3. Conclusions

21.76 Looking at the international evidence it is hard to form definitive conclusions. Lord Neuberger provided a thoughtful conclusion in *R (on the application of Nicklinson) v Ministry of Justice*:[162]

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> It is true that the Falconer Report, supported by the reports of the two Canadian panels, states that in the Netherlands, Oregon and Switzerland there is no evidence of abuse of the law, which permits assisting a suicide in prescribed circumstances and subject to conditions. However, negative evidence is often hard to obtain, there is only a limited scope for information given the few jurisdictions where assisted suicide is lawful and the short time for which it has been lawful there, and different countries may have different potential problems. In other words, the evidence on that point plainly falls some way short of establishing that there is no risk. The most that can be said is that the Falconer commission and the Canadian panels could find no evidence of abuse.

21.77 Before we leave the slippery slope argument we should note that it should not be assumed that countries which outlaw euthanasia are immune from slippery slopes.

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[161] Ibid.

[162] [2014] UKSC 38 at [88].

As the Shipman case shows, even in England an enormous number of patients can be killed without the authorities being alerted.[163] It has been suggested that the rates of euthanasia and assisted suicide in England and Holland are little different: the real difference being that in Holland it is done openly and in a regulated way, while in England it is done in secret.[164]

E. Vulnerable People

21.78 There is general agreement that if euthanasia or assisted suicide is to be made legal in England there would need to be a scheme in place to ensure that vulnerable people were not pressurized into agreeing to be killed against their genuine wishes. Beauchamp and Childress[165] suggest that it should be accepted that assisted suicide should not be simply permitted in every case where a patient wishes to die. However, they suggest that assisted suicide is justified if the following nine conditions are satisfied:

(1) A voluntary request by a competent patient;

(2) An ongoing patient–physician relationship;

(3) Mutual and informed decision-making by patient and physician;

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[163] J Thunder, 'Quiet Killings in Medical Facilities' [2003] Issues in Law and Medicine 211.

[164] E Jackson, *Medical Law* (Oxford University Press 2012) 958. Although see R Magnusson, *Angels of Death: Exploring the Euthanasia Underground* (Yale University Press 2002) for evidence of "underground euthanasia" in Australia.

[165] T Beauchamp and J Childress, *Principles of Biomedical Ethics* (Oxford University Press 2003) 151.

(4) A supportive yet critical and probing environment of decision-making;

(5) A considered rejection of alternatives;

(6) Structured consultation with other parties in medicine;

(7) A patient's expression of a durable preference for death;

(8) Unacceptable suffering by the patient;

(9) Use of a means that is as painless and comfortable as possible.

21.79 The difficulty in seeking to protect the vulnerable is that the expression of a desire to be killed can result from a range of complex social and psychological phenomena.[166] As already mentioned those who desire death may be suffering depression, pain, and isolation and their decisions may not reflect a full exercise in autonomy.[167] There have been concerns that those choosing to die may be greatly influenced by concerns over the cost of the patient's treatment, especially if it means a great reduction in the inheritance that can be left to their children. Those who make arguments like these often emphasize the number of people who change their minds over end of life issues.[168] Further, it is not unknown for relatives desperate for an inheritance to encourage or enable suicide.[169]

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[166] A Street and D Kissane, 'Dispensing Death, Desiring Death' (2000) 41 Omega 231.

[167] J Menikoff, 'The Vulnerability of the Very Sick' (2009) Journal of Law, Medicine and Ethics 51.

[168] J Pacheco, P Hershberger, R Markert, and G Kumar, 'A Longitudinal Study of Attitudes Toward Physician-assisted Suicide and Euthanasia Among Patients with Noncurable Malignancy' (2003) American Journal of Hospice and Palliative Care 99.

[169] *R v McShane* (1977) 66 Cr App R 97 (CA).

21.80 Katrina George has argued that women especially are liable to make choices about euthanasia which are not voluntary.[170] She refers to 'structural inequalities and disparities in power—most evident in women's experience of violence—and social and economic disadvantage and oppressive cultural stereotypes that idealize feminine self-sacrifice and reinforce stereotyped gender roles of passivity and compliance'.[171] These concerns may be supported by a study of assisted suicide in Dignitas and Exit Deutsche (assisted suicide organizations in Switzerland) which found that 65 per cent of those using their services were women.[172] By contrast there is no evidence of gender affecting those who seek assisted suicide in Oregon or the Netherlands.[173]

21.81 Perhaps the most valid concern is that there will be a change in social attitudes and expectations that will impact on vulnerable people. Such pressure will be hard to

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[170] <IBT>K George, 'A Woman's Choice? The Gendered Risks of Voluntary Euthanasia and Physician-assisted Suicide' (2007) 15 Medical Law Review 1</IBT>.

[171] ibid, 2–3; H Biggs and K Diesfled, 'Assisted Suicide for People with Depressions: An Advocate's Perspective' (1995) Medical Law International 2.

[172] S Fisher, C Huber, L Imhof, R Mahrer Imhof, M Furter, S Ziegler, and G Bosshard, 'Suicide Assisted by Two Swiss Right-to-die Organisations' (2008) 23 Journal of Medical Ethics 810.

[173] M Battin, A van der Heide, L Ganzini, G van der Wal, and B Onwuteaka-Philipsen, 'Legal Physician-assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups' (2007) 33 Journal of Medical Ethics 591.

detect. This fear was well captured by Lord Sumption in *R (on the application of Nicklinson) v Ministry of Justice*:[174]

> The vulnerability to pressure of the old or terminally ill is a more formidable problem. The problem is not that people may decide to kill themselves who are not fully competent mentally. I am prepared to accept that mental competence is capable of objective assessment by health professionals. The real difficulty is that even the mentally competent may have reasons for deciding to kill themselves which reflect either overt pressure upon them by others or their own assumptions about what others may think or expect. The difficulty is particularly acute in the case of what the Commission on Assisted Dying called 'indirect social pressure'. This refers to the problems arising from the low self-esteem of many old or severely ill and dependent people, combined with the spontaneous and negative perceptions of patients about the views of those around them. The great majority of people contemplating suicide for health-related reasons, are likely to be acutely conscious that their disabilities make them dependent on others. These disabilities may arise from illness or injury, or indeed (a much larger category) from the advancing infirmity of old age. People in this position are vulnerable. They are often afraid that their lives have become a burden to those around them. The fear may be the result of overt pressure, but may equally arise from a spontaneous tendency to place a low value on their own lives and assume that others do so too.

[174] [2014] UKSC 38 at [228].

Their feelings of uselessness are likely to be accentuated in those who were once highly active and engaged with those around them, for whom the contrast between now and then must be particularly painful. These assumptions may be mistaken but are none the less powerful for that. The legalisation of assisted suicide would be followed by its progressive normalisation, at any rate among the very old or very ill. In a world where suicide was regarded as just another optional end-of-life choice, the pressures which I have described are likely to become more powerful. It is one thing to assess some one's mental ability to form a judgment, but another to discover their true reasons for the decision which they have made and to assess the quality of those reasons. I very much doubt whether it is possible in the generality of cases to distinguish between those who have spontaneously formed the desire to kill themselves and those who have done so in response to real or imagined pressure arising from the impact of their disabilities on other people. There is a good deal of evidence that this problem exists, that it is significant, and that it is aggravated by negative modern attitudes to old age and sickness-related disability. Those who are vulnerable in this sense are not always easy to identify (there seems to be a consensus that the factors that make them vulnerable are variable and personal, and not susceptible to simple categorisation).

F. Refusal of Treatment and Death

21.82 As discussed in Chapter 8, once it is determined that a person has capacity to refuse treatment their wishes must be respected.[175] Giving them treatment without their consent is unlawful. This is so even where doing so will result in their death. As the Court of Appeal in *R (on the application of Burke) v General Medical Council*[176] explained:

> a patient who is in desperate clinical need of a blood transfusion and who has no wish to die may, for religious reasons, not wish to receive one although the consequence is almost certain death. Where a competent patient makes it clear that he does not wish to receive treatment which is, objectively, in his medical best interests, it is unlawful for doctors to administer that treatment. Personal autonomy or the right of self determination prevails.[177]

However, this does not mean that a doctor must provide treatment to a patient which is needed to keep them alive. As explained in Chapter 10 in the case of a person lacking

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[175] *R (on the application of Burke) v General Medical Council* [2005] EWCA Civ 1003. See further A McGee, 'Finding a Way Through the Ethical and Legal Maze: Withdrawal of Medical Treatment and Euthanasia' (2005) 13 Medical Law Review 357; P de Cruz, 'The Burke Case: The Terminally Ill Patient and The Right To Life' (2007) 70 Modern Law Review 306; H Biggs, '"Taking Account of the Views of the Patient", But Only if the Clinician (and the Court) Agrees - R (Burke) v General Medical Council' [2007] Child and Family Law Quarterly 225.

[176] <IBT>*R (on the application of Burke)* n 175</IBT>.

[177] ibid, at [30].

capacity the treatment will be determined on what is in a person's best interests. If the person has capacity and has requested treatment, they do not automatically have a right to it. It may be determined that it is not appropriate for them to be given it. Even if a competent person requests treatment the doctor may determine not to give it to them because the fundamental duty of the doctor is to comply with their duty of care towards the patient. The Court of Appeal in *Burke* explained, discussing the provision of artificial nutrition and hydration (ANH):

> So far as ANH is concerned, there is no need to look far for the duty to provide this. Once a patient is accepted into a hospital, the medical staff come under a positive duty at common law to care for the patient. The authorities cited by Munby J . . . establish this proposition, if authority is needed. A fundamental aspect of this positive duty of care is a duty to take such steps as are reasonable to keep the patient alive. Where ANH is necessary to keep the patient alive, the duty of care will normally require the doctors to supply ANH. This duty will not, however, override the competent patient's wish not to receive ANH. Where the competent patient makes it plain that he or she wishes to be kept alive by ANH, this will not be the source of the duty to provide it. The patient's wish will merely underscore that duty.[178]

As a result, the Court of Appeal refused to make a declaration that given Mr Burke's desire to be given ANH this would never be withdrawn unless he expressly so requested.

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[178] ibid, at [32].

He took his case to the ECtHR (*Burke v UK*[179]) but was not successful. The ECtHR found that he had not demonstrated that there was a real or imminent risk that his concern that artificial nutrition and hydration would be withdrawn. The court noted the presumption in favour of prolonging life in UK law and the fact that doctors would take into account his previous wishes when determining what treatment to provide, meant that it would be very unlikely that ANH would be withdrawn from him.

G. Reform of the Law

1. Autonomy

(i) Autonomy-based arguments

21.83 To those who take a more liberal approach to end of life decisions, it is the principle of autonomy which is central to the ethical debates over euthanasia. In short, people should be allowed to lead their own lives as they wish and have control over their bodies. If a person wishes to die it is not for anyone else to reject their decision on the basis that it is seen as foolish or contrary to some kind of quasi-religious view on the sanctity of life. We respect people's choices about how they wish to live their lives not because they are necessarily good choices, but because it is their choice.[180] John Harris writes that prohibition of euthanasia is:

> simply a form of tyranny; an attempt to control the life of a person who has her own autonomous view about how that life should go. The evil of

[179] Application 19807/06, July 7 2006.

[180] A Pedain, 'The Human Rights Dimension of the Diane Pretty Case' (2003) Cambridge Law Journal 181.

> tyranny does not require explication in terms of the nature of sanctity of life, but rather in terms of respect for persons and of their autonomy. Euthanasia should be permitted, not because everyone should accept that it is right, nor because to rail to do so violates a defensive conception of the sanctity of life, but because to deny a person control of what, on any analysis, must be one of the most important decisions of life, is a form of tyranny, which like all acts of tyranny is an ultimate denial of respect for persons.[181]

21.84 Autonomy-based views accept that we all have different views of what a good death is. For some that will be ending their life before they feel they start to lose control of their bodies and become undignified, for others it might be striving to keep alive until the very end. But, we should allow each person to decide for themselves how they wish to die and the law should not intervene to restrict that choice, especially over a matter of such intimate and personal importance as the style of death.[182] Opponents of euthanasia, it is claimed, are seeking to impose their own ethical or religious beliefs on others.[183]

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[181] J Harris, 'Euthanasia and the value of life', in J Keown (ed), *Euthanasia Examined* (Cambridge University Press 1995) 202.

[182] J Raz, 'Death in Our Life' (2013) 30 Journal of Applied Philosophy 1.

[183] M Williams, 'Death Rites: Assisted Suicide and Existential Rights' (2005) 1 International Journal of Law in Context 183.

21.85 Ronald Dworkin[184] has sought to explain further why decisions over death are those which are particularly deserving of respect. He distinguishes between critical interests and experiential interests. Experiential interests are those a person has in pursuing things that a person enjoys doing in and of themselves: for example, eating ice cream; watching a favourite TV show. Critical interests are those things which we believe make us what we are and are central to our understanding of ourselves and our identity. Critical interests, he argues, are especially important to a person, and there need to be particularly good reasons if the state is to interfere in decisions relating to them. Hence it is that especial protection is given to religious belief or sexual practices because these tend to be central to a person's identity of who they are. By contrast, restrictions on a person's experiential interests are easier to justify. He argues that a person's views over how they will die are critical interests and, therefore, deserve especial respect. As he and some other philosophers have put it:

> Certain decisions are momentous in their impact on the character of a person's life—decisions about religious faith, political and moral allegiance, marriage, procreation, and death, for example. Such deeply personal decisions pose controversial questions about how and why human life has value. In a free society, individuals must be allowed to make those decisions for themselves, out of their own faith, conscience, and convictions . . . Most of us see death—whatever we think will follow it—as the final act of life's drama, and we want that last act to reflect our

[184] R Dworkin, *Life's Dominion* (Harper Collins 1993) 231.

> own convictions, those we have tried to live by, not the convictions of others forced on us in our most vulnerable moment . . .[185]

(ii) Responses to the autonomy argument

21.86 Some of the most common responses to the autonomy argument will now be considered. First, there are those who argue that the autonomous wishes of an individual who wishes to be killed need to be weighed against the wider interests of society. Our society does not allow people to do anything they want, we restrict autonomy when its exercise will cause a serious harm to others or the wider society. What, however, is the harm that allowing euthanasia will produce?

21.87 The House of Lords Select Committee on Medical Ethics has stated:

> We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue

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[185] R Dworkin, T Nagel, R Nozick, J Rawls, T Scanlon, and J Jarvis Thomson, 'The Philosophers' Brief' in M Battin, R Rhodes, and A Silvers (eds), *Physician Assisted Suicide* (Routledge 1998).

> of euthanasia is one in which the interests of the individual cannot be separated from the interests of society as a whole.[186]

That, however, fails to make clear what the harm to society is. There is an implied reference to the distress that relatives and friends of the deceased may feel at their death, but it is not clear that that will be any more or less if euthanasia is permitted or not. Alternatively it may be argued that there is a basic moral value of principle which underpins society's moral order and must be protected by the law.[187] However, the argument that the criminal law should be used to uphold moral standards and principles is one that has largely fallen from favour in other areas of the law.[188]

21.88 Perhaps the strongest case for a state interest in prohibiting euthanasia is that allowing euthanasia will mean that some patients will feel pressurized into saying they want to die. The argument can be put this way: if we allow euthanasia although this will mean that some people will be able to exercise their autonomy and die as they wish, there would be others who would be pressurized into agreeing to be killed. It would be preferable, the argument goes, to have a system which interfered in the autonomy of those who wished to die, than have a system which allowed people to be killed, even though that may not have actually been what they wanted.

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[186] House of Lords Select Committee on Medical Ethics, *Paper No 21* (Hansard 1994), discussed in J Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press 2002) ch 16.

[187] J Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press 2002) ch 5.

[188] J Herring, *Great Debates: Criminal Law* (Palgrave 2014) ch 1.

Being killed against your true wishes is a greater interference in your autonomy than not be allowed to be killed when you would wish to be.

21.89 This last point raises a broader question which is the extent to which a person can, or at least people do, make informed decisions about their death. It has, for example, been argued that many close to death are so confused by pain, anguish, and a rush of varied emotions that they lack the capacity to make an autonomous choice.[189] Another argument is that many people say they want to die because they fear suffering pain,[190] but are unaware of the possibility of effective pain relief[191] and hospice care which can make the reality of the last few weeks far less unpleasant than people predict.[192] Finally, and perhaps most significantly, there is evidence that those seeking death suffer depression and that once the depression is treated the desire for death falls. Indeed in one study it was found that a remarkable 99 per cent of those who were suffering depression and stating they wished to die changed their

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[189] B Gordijn, B Crul, and Z Zylicz, 'Euthanasia and Physician-assisted Suicide', in H ten Have and D Clarke (eds), *The Ethics of Palliative Care* (Open University Press 2002).

[190] E Jackson, *Medical Law* (Oxford University Press 2012) at 948 states that in Oregon the most common reason people seek assisted suicide is not pain, but the loss of autonomy.

[191] F Hicks and E Rees, 'A "Pain-free" Death' (2008) 88 British Medical Bulletin 23.

[192] F Randall and R Downie, *The Philosophy of Palliative Care* (Oxford University Press 2006); H ten Have and D Clarke (eds), *The Ethics of Palliative Care* (Open University Press 2002).

mind following treatment for depression.[193] It is notable that a major concern among medical professionals is whether safeguards can be put in place to ensure that decisions reached are genuinely autonomous.[194]

21.90 Even if one accepted these points[195] they do not provide a 'knock out' blow for the anti-euthanasia camp. It may be argued that these points only demonstrate that if euthanasia is to be permitted we need to have in place a very careful set of procedures to ensure that only those whose decision to die is made in a fully informed way, after due deliberation and with treatment for any depression. But that assumes we can put in place mechanisms which ensure that only fully autonomous choices are respected. The European Parliamentary Assembly, Committee on Legal Affairs and Human Rights had this to say:[196]

> Medical professionals working within the palliative care sector have expressed the fragility of patients' desire for death and the rapid changes that, in their experience, may occur in response to good symptom control of psychological interventions. The dangers of acceding to rare requests

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[193] Royal College of Psychiatrists, Statement from the Royal College of Psychiatrists on Physician Assisted Suicide (RCP 2006).

[194] C Seale, 'Legalisation of Euthanasia or Physician-assisted Suicide: Survey of Doctors' Attitudes' (2007) 33 Journal of Medical Ethics 742.

[195] House of Lords Select Committee, *On The Assisted Dying For The Terminally Ill Bill* (TSO 2005) found however that care could not remove all pain in every case.

[196] European Parliamentary Assembly, Social, Family Affairs and Health Committee, *Euthanasia* (European Parliament 2003), para 1.

for voluntary active euthanasia and physical assisted suicide should not be underestimated.

Certainly it must be accepted that the reasons a person may want to die are complex and may be subject to significant change.[197] Still, supporters of euthanasia may respond that it is not impossible to imagine a case where a person has made a consistent and fully informed choice to die and it is no response to say that others will be less informed or less consistent.

21.91 There is a more theoretical issue here. There is something rather uncomfortable about autonomy being relied upon as the basis of a claim to justify euthanasia. This is because autonomy is all about enabling people to make the most of their lives and to flourish and develop as people.[198] Dying is the very antithesis of autonomy.[199] By dying a person is removing all their future autonomy and it cannot be seen as promoting giving people a range of choices over their life. Sometimes an analogy is drawn with slavery. We do not allow people to exercise their autonomy in order to become slaves. In part that is because in so doing their will robs themselves of their autonomy. There is the same issue in relation to euthanasia. Although Peter Singer has denied the analogy and argued that what makes enforced slavery objectionable is

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[197] H Chochinov, D Tataryn, J Clinch, and D Dudgeon, 'Will to Live in the Terminal Dying' (1999) 354 The Lancet 816.

[198] L Gormally, 'Walton, Davies, Boyd and the Legalization of Euthanasia' in J Keown (ed), *Euthanasia Examined* (Cambridge University Press 1995).

[199] C Foster, *Choosing Life, Choosing Death* (Hart 2009) 149.

the enforcement of it.[200] Another response is that the way one dies is an important part of how a person organizes their live. Indeed a good death may be regarded by some people as a central part of their life story. Death will end autonomy in any event; in allowing euthanasia one would be allowing a person to determine when and how their closure would be.

21.92 There is a further potential difficulty in relying on autonomy as the basis for euthanasia and that is this: if autonomy is the key moral principle, would we allow anyone who wishes to be killed to die, even the love-sick teenager, who appears so frequently in the literature? Most supporters of euthanasia would not go that far and would restrict access to euthanasia to those who are suffering from a terminal illness or are in grave pain.[201] The problem is that if we are saying that euthanasia should be regarded as a matter of individual choice, then that should be so whatever the personal characteristics of the individual. Indeed, once access to euthanasia or assisted suicide is limited to those who are in a certain state of health or of a certain age the question is raised whether or not autonomy is the sole principle at play.[202]

2. Sanctity of life

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[200] P Singer, 'Is the Sanctity of Life Ethic Terminally Ill?' (1995) 9 Bioethics 307.

[201] S Frileux, C Lelievre, M Sastre, E Mullet, and P Sorum, 'When is Physician-assisted Suicide or Euthanasia Acceptable?' (2003) 29 Journal of Medical Ethics 330.

[202] J Ackernman, 'Assisted Suicide, Terminal Illness, Severe Disability, and the Double Standard', in M Battin, R Rhodes, and A Silvers (eds), *Physician Assisted Suicide* (Routledge 1988).

21.93 To some ethicists, the sanctity of life is the key principle in the euthanasia debate.[203] However, interestingly, there is little consensus over its correct meaning among commentators or judges. John Keown has suggested that it is useful to separate the following views:[204]

(1) Vitalism. This view holds that human life has an absolute moral value. It can never, therefore, be justifiable to kill a person[205] and indeed all reasonable steps should be taken to keep a person alive. Such a view would firmly reject the idea that there comes a point when a person's life is not worth living. Vitalists would therefore argue that it is never permissible to take steps to shorten a person's life nor to withhold treatment which could keep a person alive.

(2) Sanctity of life. This view holds that human life is a fundamental basic good. It shares many aspects of vitalism in that is also rejects suggestions that a person's life may become not worth living. It holds that a person should never be killed intentionally, be that through an act or an omission. It can, however, be distinguished from vitalism in two ways. First, it

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[203] C Foster, 'What is Man, that the Judges are Mindful of Him? Lessons from the PVS Cases' (2005) Journal of Philosophy, Science and Law 1.

[204] J Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press 2002) ch 4.

[205] Some vitalists would provide an exception where a person kills in self-defence to save their own life. For a general discussion see J McMahan, *The Ethics of Killing* (Oxford University Press 2003).

would permit an act which shortens life if the act was justified under the principle of double effect (see para 21.25). Under that doctrine a doctor would be permitted to give a lethal amount of medication if his or her purpose was to reduce pain, rather than kill the patient. Second, it might accept the withdrawal of treatment if the treatment was not worth providing. It would therefore, under this view, be acceptable to withdraw treatment if the benefit of the treatment was negligible. However, it would not be acceptable to withdraw treatment on the basis that the person's life was not worth living.[206]

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(3) Quality of life. Under this approach it is not life per se that is of value but only the things that one can do, experience and enjoy with life. If, therefore, a person is in such pain that they are unable to appreciate or experience any pleasure then their life will lose its value. In such a case it is permissible to end life.

21.94 The principle of sanctity of life has received some judicial support. In *Airedale NHS Trust v Bland*[207] Lord Hoffmann held:

> I start with the concept of the sanctity of life . . . [W]e have a strong feeling that there is an intrinsic value in human life, irrespective of whether it is valuable to the person concerned or indeed to anyone else.

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[206] Although some are not convinced that the distinction between an act and omission is sufficiently robust to play such a key role in this area of the law (see e.g. J Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press 2002) ch 4).

[207] [1993] AC 789, 826 (HL).

Those who adhere to religious faiths which believe in the sanctity of all God's creation and in particular that human life was created in the image of God himself will have no difficulty with the concept of the intrinsic value of human life. But even those without any religious belief think in the same way. In a case like this we should not try to analyse the rationality of such feelings. What matters is that, in one form or another, they form part of almost everyone's intuitive values. No law which ignores them can possibly hope to be acceptable.

Our belief in the sanctity of life explains why we think it is almost always wrong to cause the death of another human being, even one who is terminally ill or so disabled that we think that if we were in his position we would rather be dead. Still less do we tolerate laws such as existed in Nazi Germany, by which handicapped people or inferior races could be put to death because someone else thought that their lives were useless.

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But the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person. The fact that the dignity of an individual is an intrinsic value is shown by the

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> fact that we feel embarrassed and think it wrong when someone behaves in a way which we think demeaning to himself, which does not show sufficient respect for himself as a person.

Lord Goff in *Airedale NHS Trust v Bland* also referred to the principle:

> . . . the fundamental principle is the principle of the sanctity of human life—a principle long recognised not only in our own society but also in most, if not all, civilised societies throughout the modern world, as indeed evidenced by its recognition both in article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (Cmd 8969) and in article 6 of the International Covenant of Civil and Political Rights 1966.
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> But this principle, fundamental as it is, is not absolute . . . We are concerned with circumstances in which it may be lawful to withhold from a patient medical treatment or care by means of which his life may be prolonged. But here too there is no absolute rule that the patient's life must be prolonged by such treatment or care, if available, regardless of the circumstances.[208]

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Lord Wilson in *R (on the application of Nicklinson) v Ministry of Justice*[209] claimed that the principle 'is hard-wired into the minds of every living person. It lies at the heart of the common law and of international human rights and it is also an ethical principle of the first magnitude.'

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[208] [1993] AC 789 (HL).

[209] [2014] UKSC 38 at [199].

21.95 John Keown has complained that such judicial comments, holding that the principle of sanctity of life is not an absolute one in English law, are based on a misunderstanding of what the doctrine teaches.[210] He argues that these statements have wrongly equated sanctity of life with vitalism. He argues that if the notion of sanctity of life was properly understood it would be regarded as an absolute principle in English law.

21.96 Supporters of the doctrine of sanctity of life argue that we must recognize that every life has value in itself. Many of those supporting this view write from a religious perspective, arguing that everyone's life is equally precious in God's eyes. However, the principle has been supported from a non-religious viewpoint. Somerville writes of the 'deeply intuitive sense of relatedness or connectedness to other people and to the world and the universe in which we live'. She sees the prohibition on euthanasia and assisted suicide reflecting an acceptance of the mysteries of life and death.[211] By contrast, Emily Jackson has argued that the sanctity of life doctrine has 'no coherent secular basis' and that 'the sanctity principle, with its commitment to the intrinsic value of lives which have ceased to contain anything of value, does not make sense, other than as an article of religious faith'. She rejects the view that 'human life is always intrinsically valuable, and that its deliberate destruction is always necessarily

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[210] J Keown, 'Restoring the Moral and Intellectual Shape to the Law after Bland' (1997) 113 Law Quarterly Review 418.

[211] M Sommerville, *Death Talk* (McGill Queen's University Press 2001) 134.

a bad thing'.[212] She, and other supporters of euthanasia, tend to argue that although life is precious and valuable, that does not mean that all life must be valued for its own sake.[213] To keep a person alive when they long for death and are wracked with pain is not to treasure life, but to demean it.[214]

21.97 Critics of the sanctity of life principle argue that although supporters of it are entitled to their views, they should not impose them on others who reject the view that life has inherent value.[215] They insist that respect should also be shown to those who hold the view that for them life only has value in the experiences of the person whose life it is. Ronald Dworkin has written of a person suffering Alzheimer's:

> [He] is no longer capable of the acts or attachment that can give [life] value. Value cannot be poured into a life from the outside; it must be generated by the person whose life it is, and this is no longer possible for him.[216]

Contrast that view with the following comment of John Finnis who supports the sanctity of life view:

> Human Life is indeed the concrete reality of the human person. In sustaining human bodily life, in however impaired a condition, one is

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[212] E Jackson, 'Secularism, Sanctity and the Wrongness of Killing' (2008) 3 Biosocieties 125, 126.

[213] J Harris, *The Value of Life* (Oxford University Press 1984).

[214] J Rachels, *The End of Life* (Oxford University Press 1986).

[215] E Jackson, n 212, 125.

[216] R Dworkin, *Life's Dominion* (Harper Collins 1993), 230.

> sustaining the person whose life it is. In refusing to choose to violate it, one respects the person in the most fundamental and indispensable way.[217]

The contrast between the two views is notable. To Finnis, sustaining life is important and valuable in itself, but for Dworkin, the value is only found if the life is so valued by the person themselves.

3. Dignity

21.98 This is a concept which is used by those on both sides of the debate. For supporters of euthanasia it is crucial that we support euthanasia in order to protect the dignity of the dying. As a person dies they gradually lose control of physical and mental functions. This can increase the degree of helplessness and dependence. This can lead to a person's inability to care for themselves or others. Richard Tur cites the following description of a prolonged painful death:

> . . . death is dreadful to watch. The skin and mucosa dry out: the blood thickens; the kidneys no longer produce urine and gradually die. The eyes become damaged for the lack of tears; the mouth is infested by fungal infections because the natural cleaning by saliva is lost. The body is gradually poisoned by the breakdown of products which can no longer be excreted. In the airways crusts of dried mucus develop which makes breathing steadily more difficult and so the unconscious patient fades away under the eyes of doctors, nurses and family. It can well take ten

[217] J Finnis, 'Bland: Crossing the Rubicon?' (1993) 109 Law Quarterly Review 329.

> days or more before death arrives and in dying the patient becomes a monument to medical and judicial cowardice and hypocrisy.[218]

The argument is then made that it is more dignified to allow a person to die at a time and in a manner of their choosing than to go through such an undignified death.

21.99 The importance of the notion of dignity has even received judicial support. Munby J in *R (on the application of A, B, X and Y) v East Sussex CC and the Disability Rights Commission (No 2)*[219] stated:

> The recognition and protection of human dignity is one of the core values——in truth the core value—of our society and, indeed, of all the societies which are part of the European family of nations and which have embraced the principles of the Convention. It is a core value of the common law, long pre-dating the Convention . . . The invocation of the dignity of the patient in the form of declaration habitually used when the court is exercising its inherent declaratory jurisdiction in relation to the gravely ill or dying is not some meaningless incantation designed to comfort the living or to assuage the consciences of those involved in making life and death decisions: it is a solemn affirmation of the law's and

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[218] Dr B Smalhout, quoted in R Tur, 'Special Defence Based on the Ethics of Doctors: "The Doctor's Defence and Professional Ethics"' (2002) 13 King's College Law Journal 75, 95. No doubt some experts in palliative care would deny that such a death could occur with good care.

[219] [2003] EWHC 167 (Admin) at [86].

> of society's recognition of our humanity and of human dignity as something fundamental.

21.100 It is not clear what dignity adds to autonomy-based arguments.[220] Presumably, the claim is not that a person who is dependent on others lacks dignity. That would mean a person who was perfectly happy in their state of dependency was automatically undignified which would be problematic. It might mean that many disabled people were automatically undignified. In the light of that, if what is meant is that dignity is in its nature undignified, then only a very extreme state of illness where a person's body was so invaded by medical procedures that their humanity has been stripped away. That would apply to few cases. It may, therefore, be better to see dignity as an argument to bolster an autonomy-based argument, rather than being an argument in its own right. Where a person feels they lack dignity then there is a particularly strong case for allowing them to exercise their autonomy to avoid it.

21.101 The argument against euthanasia also seeks to rely on the notion of dignity. Amarasekara and Bagaric argue:

> It could be suggested that allowing a patient to die in pain against his or her wish is undignified. But killing a person hardly seems to be according him or her much concern or respect or placing much valued on the person's life—it would seem to be the antithesis of respecting one's dignity.[221]

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[220] C Foster, *Human Dignity in Bioethics and the Law* (Hart 2013).

[221] K Amarakekara and M Bagaric, *Euthanasia, Morality and the Law* (Peter Lang 2002).

Indeed, opponents of euthanasia argue that good palliative care and effective pain relief can mean that death does not need to be undignified.[222] But, again, that may depend on who is deciding what dignity means.

21.102 For a long time deaths have taken place in the medical context in a largely unregulated way. It is perhaps understandable that people had rather looked the other way than addressed what happened. As John Robertson has noted:

> As long as we can dress the choice to take life in other clothes, such as refusing treatment or relieving pain, then we can acknowledge it. But naked decisions to take life as such are, to paraphrase T.S. Eliot, too much 'reality' to bear openly. We must hide the reality of how we made end of life decisions for fear of what we will find. Yet in doing so, society risks even greater harm. Many persons who need assisted suicide to relieve their suffering will not receive it. Some persons may still receive such assistance covertly, but without the advantages of openly following medical protocols that can assure efficacy and prevent arbitrary and abusive practices . . . If we practice and tolerate assisted suicide and euthanasia, we certainly need to do it openly to reassure the public and prevent abuse. At the same time, as T.S. Eliot reminds us, 'humankind cannot bear very much reality.' We also cannot tolerate the notion that doctors will openly take life, even with proper reporting and bureaucratic

[222] S Woods, *Death's Dominion—Ethics at the End of Life* (Open University Press 2007) ch 1.

> oversight. We are caught in the dilemma that we can permit assisted suicide only by not admitting it . . . [223]

We have probably reached the stage in our history where turning the other way is no longer an option in relation to legal regulation of ending life in the medical context. Hence we have seen an increase in calls to reform the law. In a recent study, 80 per cent of members of the public questioned would support doctors assisting patients to die if requested.[224] Lady Hale in *R (on the application of Nicklinson) v Ministry of Justice)*:[225]

> It would not be beyond the wit of a legal system to devise a process for identifying those people, those few people, who should be allowed help to end their own lives. There would be four essential requirements. They would firstly have to have the capacity to make the decision for themselves. They would secondly have to have reached the decision freely without undue influence from any quarter. They would thirdly have had to reach it with full knowledge of their situation, the options available to them, and the consequences of their decision: that is not the same, as Dame Elizabeth pointed out in *Re B (Treatment)*, as having first-hand experience of those options. And they would fourthly have to be unable, because of physical incapacity or frailty, to put that decision into effect

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[223] J Robertson, 'Respect of Life in Bioethical Dilemmas' (1997) Santa Clara Law Review 329, 342–43.

[224] D Price, 'What Shape to Euthanasia after Bland?' (2009) 125 Law Quarterly Review 125, 145.

[225] [2014] UKSC 38, at [314].

without some help from others. I do not pretend that such cases would always be easy to decide, but the nature of the judgments involved would be no more difficult than those regularly required in the Court of Protection or the Family Division . . .

21.103 There has been a trickle of private members bills which have been introduced to amend the law in this area, none of which have been passed. The latest is the Assisted Dying Bill 2014, the first clause of which states:

(1) A person who is terminally ill may request and lawfully be provided with assistance to end his or her own life.

(2) Subsection (1) only applies where the person—

(a) has a clear and settled intention to end his or her own life;

(b) has made a declaration to that effect in accordance with section 3; and

(c) on the day the declaration is made—

(i) is aged 18 or over; and

(ii) has been ordinarily resident in England and Wales for not less than one year.

There was not time to pass the before the 2015 general election. It is clearly drafted with a significant number of safeguards which are designed to mitigate fears about the impact on vulnerable people. However, these restrictions mean that someone facing years of a painful illness would not fall under its remit because it only applies to a person who has six months or less to live.

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21.104 By contrast the Medical Treatment (Prevention of Euthanasia) Bill proposed in 1999 stated in clause 1:

It shall be unlawful for any person responsible for the care of a patient to withdraw or withhold from the patient medical treatment or sustenance if

> his purpose or one of his purposes in doing so is to hasten or otherwise cause the death of the patient.

This Bill attempted to tighten the law in that it prevents a doctor withholding treatment from a patient if the purpose is to hasten death. It would have outlawed the present treatment of patients suffering from PVS, unless doctors could claim that the treatment is withheld not to produce death, but because the treatment is not producing any benefit to the patient. The use of the word 'purpose' rather than 'intend' was designed to make it clear that a doctor who foresaw death being the result of her or his treatment or non-treatment would not be breaking the law if death was not her or his purpose. However, some commentators felt the Bill (if enacted) would have placed doctors in a difficult position.[226]

21.105 Of course, a strong case can be made for leaving the law as it is. McCall Smith accepts the present law as a satisfactory, if a little untidy, compromise between the different arguments.[227] He even finds the uncertainty in the present law a benefit:

> Doctors know full well what they are doing when they increase a dose of diamorphine, but they need not describe their act, to themselves or to others as an act of killing. This approach has been described as hypocritical, but it accords with a moral distinction which is meaningful for doctors, then why should they be denied the comfort it affords them?

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[226] A Morris, 'Easing the Passing: End of Life Decisions and the Medical Treatment (Prevention of Euthanasia) Bill' (2000) 8 Medical Law Review 300.

[227] <IBT>A McCall Smith, 'Euthanasia: The Strength of the Middle Ground' (1999) 7 Medical Law Review 194</IBT>.

> The moral life is possibly more subtly nuanced than some of the proponents of euthanasia would have us believe. We live by more metaphor, and the metaphor of helping rather than killing, may be a valuable one to those whose duty it is to look after the terminally ill.[228]

Hazel Biggs,[229] however, finds the uncertainty and complexity of the law problematic: 'Sophistry and creative legalism may be effective in the court room, but medical practice cannot always be tailored to take advantage of them.'[230] She is particularly critical of the failure of the law to provide clear guidance to those working day-to-day in the area. But to some commentators this uncertainty is a benefit. Martha Minow writes:

> I think the most honest statement of the issues presented in the physician-assisted suicide cases is this: the Court faced a choice of two lies to countenance. By lie I mean knowing misrepresentation; by countenance to extend approval or toleration. The first lie is that physicians do not already, and regularly, participate in assisting dying patients to end their lives. Every physician I have encountered acknowledges as much; many have written about it . . . The second lie is that permitting such assistance would not systematically and routinely be used to push dying people into death. The problem is not merely risks of abuse; the problem arises from the inauguration of a regime in which people would have to justify

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228 ibid, 206–07.

229 <IBT>H Biggs, *Euthanasia* (Hart 2001)</IBT>.

230 ibid, 5.

> continuing to live . . . It is better to live with the lie that prohibition works so that, at the margin, those who engage in it do so with trembling.[231]

Minow's quotation issues a challenge to those on both sides of the debate. To those who support the current law she asks whether we can be sure the current system of unregulated unacknowledged killing adequately protects patients, while to those who support liberalizing legislation she asks whether we can be entirely confident that any reform will not inevitably involve the killing of at least a few people who are not genuinely consenting to die. Whether and when reform comes may depend on which side of the debate is more effective in answering these challenges.

H. Conclusion

21.106 This chapter has sought to outline the current law on issues relating to euthanasia and assisted suicide. A helpful summary was provided by Lord Sumption *R (on the application of Nicklinson) v Ministry of Justice)*:[232]

> (1) In law, the state is not entitled to intervene to prevent a person of full capacity who has arrived at a settled decision to take his own life from doing so. However, such a person does not have a right to call on a third party to help him to end his life.
>
> (2) A person who is legally and mentally competent is entitled to refuse food and water, and to reject any invasive manipulation of his body or

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[231] M Minow, 'Which Question? Which Lie? Reflections on the Physician Assisted Suicide Cases' (1997) 1 Supreme Court Review 1, 20–22, 30.

[232] [2014] UKSC 38 at [225].

other form of treatment, including artificial feeding, even though without it he will die. If he refuses, medical practitioners must comply with his wishes. . . . A patient (or prospective patient) may express his wishes on these points by an advance decision (or 'living will').

(3) A doctor may not advise a patient how to kill himself. But a doctor may give objective advice about the clinical options (such as sedation and other palliative care) which would be available if a patient were to reach a settled decision to kill himself. The doctor is in no danger of incurring criminal liability merely because he agrees in advance to palliate the pain and discomfort involved should the need for it arise. This kind of advice is no more or less than his duty. The law does not countenance assisted suicide, but it does not require medical practitioners to keep a patient in ignorance of the truth lest the truth should encourage him to kill himself. The right to give and receive information is guaranteed by article 10 of the Convention. If the law were not as I have summarised it, I have difficulty in seeing how it could comply.

(4) Medical treatment intended to palliate pain and discomfort is not unlawful only because it has the incidental consequence, however foreseeable, of shortening the patient's life . . .

(5) Whatever may be said about the clarity or lack of it in the Director's published policy, the fact is that prosecutions for encouraging or assisting suicide are rare. . . .

However, even that summary is not uncontroversial. The very first point appears to overlook the fact that there can be a duty on the state to stop people committing suicide (see para 21.44).

21.107 The law is being subject to powerful human rights challenges and it is likely that it will continue to face such challenges in the future. *R (on the application of Nicklinson) v Ministry of Justice)*[233] has clearly put the ball in Parliament's court. Some kind of reform seems almost inevitable in the not too distant future.

[233] [2014] UKSC 38.