Physician-Assisted Suicide

Policy Exchange

Improving the Quality of the Debate

John Keown

Forewords by
Baroness O'Neill of Bengarve CH CBE FBA,
Lord Carlile of Berriew CBE KC
and Rt Hon Lord Sumption OBE PC FSA FRHistS

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Endorsements

"For doctors actively to bring about the termination of life, or for judges to approve it, raises profound ethical questions challenging the traditional respect for the sanctity of life. It is understandable why, in the absence of effective palliative care, assisted dying is seen as a compassionate solution to particular cases of acute suffering where someone is near death. But as Professor Keown's paper shows, this response ignores the wider moral implications of such a solution. For example, he points out that it is logically difficult to limit intervention on such a narrow basis – and experience elsewhere shows that it does not stop at that point. Indeed, why should the right not be given to anyone who, on mature consideration, considers that death is preferable to life? Yet that would profoundly undermine our perception of the sanctity of life. Professor Keown examines these and other ethical issues with considerable skill. It is an important contribution to this vitally important debate."

Sir Patrick Elias, former Lord Justice of Appeal

This Policy Exchange paper provides a careful analysis of the complexities of assisted suicide. It details the extensive evidence from abroad, from which we must learn. Indeed, as I have long spoken of - in countries where assisted dying is legal, palliative care has dwindled, legislation has widened, the safeguards have been seen to fail, and non-assisted violent suicide rates have risen disproportionately. It suggests to terminally ill people that ending your life is something you should consider. Even the strongest are vulnerable to influence when fearful or when their lives are shattered by disease. I urge all Parliamentarians to digest the important lessons contained within this paper.

Baroness Finlay of Llandaff, Crossbench Peer, former Consultant in Palliative Medicine, and former Chair of the Palliative Care Strategy Implementation Board for Wales

"This report from Policy Exchange is a vital contribution to the complex, emotive and often deeply personal debate around assisted suicide. We are continually being asked to vote through the principle of this issue and to think about the detail later, but as this Policy Exchange report lays bare - the devil is in the detail. I urge Parliamentarians to understand the significance of proposed changes to the law and the seismic shift it would cause to the way we choose to care for people at their most vulnerable. Protecting people is something the current prohibition on encouraging or assisting suicide does well. Parliamentarians should be in no doubt that a change to this law would fundamentally alter the political and societal landscape for disabled people and this Policy Exchange report should be required reading as they consider this

latest Private Members Bill."

Baroness Grey-Thompson,Crossbench Peer

"A reading of the Leadbeater Bill to legalise assisted suicide, shows clearly the practical and moral difficulties that this drastic departure from current ethical norms on the sanctity of human life will entail. John Keown's paper examines these issues in great detail and makes a reasoned case against it. Irrespective of one's view on assisted suicide, it should be compulsory reading for anyone with an interest in this legislation."

Rt Hon Dominic Grieve KC, fomer Attorney General for England and Wales

"Public discussion of physician-assisted suicide deserves better than the intemperate exchange of emotionally loaded slogans which has characterised much recent debate. Here, the eminent ethicist and legal scholar John Keown seeks to raise the level of discourse by engaging with the ideas behind the slogans. He confronts the reality of so-called "assisted dying" and subjects it to critical scrutiny. As he shows, many of the safeguards promised by its supporters amount to nothing more than arbitrary restrictions, with no rational foundation. Reason demands their removal, propelling an irreversible expansion of scope that has already taken place in the Netherlands and elsewhere. This process is as logically inexorable as it is empirically inevitable, for the very arguments relied upon to justify physician-assisted suicide would also support the introduction of voluntary and, ultimately, non-voluntary euthanasia.

In this new and updated edition of Professor Keown's paper, the reader will find a thoughtful, accurate and engaging guide to the moral and legal issues raised by current proposals to change the law. It will repay study by legislators and all who follow the debate, whatever their personal views."

His Honour Thomas Teague KC, former Chief Coroner of England and Wales (2020–24)

"Next year will mark 30 years since the passage of the Disability Discrimination Act, the UK's first ever comprehensive civil rights legislation for disabled people. It was a milestone. Another, less happy, milestone for me was being told, also in 1995, that I would be dead within six months unless I had emergency neurosurgery. That most definitely wasn't in the script because, despite my disability, I dreamed of a normal life. My neurosurgeon wouldn't give me odds on survival, but, thanks to her incredible skill, I came through the surgery. What almost killed me was the passive discrimination of the nursing staff, the insidious, soul-destroying preconception that this severely disabled person, who couldn't breathe independently, swallow or speak for months after surgery, couldn't possibly expect to regain his independence or have a successful career and own his own home. I've done all three, but I'll never forget the acute sense of vulnerability because of their attitudes. Disabled people cannot afford to become even more vulnerable than they are now. Yet that is what this timely report shows would happen if the bill proposed by Kim Leadbetter MP were to become law. Precedents in other jurisdictions show that safeguards are quickly

eroded, and disabled people become targets by default. We should not be in any doubt: the stakes could not be higher."

Lord Shinkwin, Conservative Peer

About the Author

John Keown MA (Cantab) DPhil (Oxon) PhD (Cantab) DCL (Oxon) holds the Rose Kennedy Chair in the Kennedy Institute of Ethics at Georgetown University. He was previously a Senior Lecturer in the Faculty of Law at Cambridge. The second edition of his book Euthanasia, Ethics and Public Policy, acclaimed as 'the classic text' on the issue, was published by Cambridge University Press in 2018. (His surname is pronounced like that of the former Arsenal and England footballer.)

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Baroness O'Neill of Bengarve CH CBE FBA
Crossbench Peer and former Reith Lecturer

In 2021, Baroness Meacher introduced an Assisted Dying Bill in the House of Lords that would have made it lawful for physicians to assist those who aimed to kill themselves. The UK had decriminalised suicide over sixty years ago, since when proposals for further change, including legalising 'physician-assisted suicide', have often been advanced, but so far rejected. Some other jurisdictions have moved faster, and now allow physician-assisted suicide in specified circumstances. John Keown discusses some of the arguments used in debating the latest proposal, and concludes that there were good reasons to reject both the arguments and the Bill.

Discussions of assisted suicide have thrown up many points of detailed disagreement. Should physician-assisted suicide be offered only to those with terminal conditions? Or only to those enduring 'unbearable suffering'? Should palliative care be required before patients may opt for physician-assisted suicide? How should those who lack capacity be treated? However, these issues are not the most disputed.

John Keown argues that the most popular reason now offered for decriminalising physician-assisted suicide is that respect for *patient autonomy* requires it. However, this claim builds on a subjective view of autonomy.

Classical conceptions of autonomy were not *subjective*, but *political* or *jurisprudential*. Cities and states that made their own laws were seen as autonomous; colonies and counties were not. This view of autonomy was maintained in Immanuel Kant's well-known claim that autonomy is fundamental to ethics. Kant understood autonomy not as respect for whatever individuals happen to choose, but as respect for standards that *could* in principle be adopted by all, so were lawlike.

In the twentieth century the classical view of autonomy was widely replaced by an *individualistic* and *subjective* understanding of the term, and respect for autonomy is now often seen as a matter of respecting individuals' choices—including any choice to kill oneself. Keown argues that this exaggerates the importance of individual autonomy and overlooks the importance of respecting the sanctity of life. He concludes that seeing appeals to 'personal autonomy' as justifying physician-assisted suicide begs the question, pointing out that "*the absence of autonomy does not cancel the duty of beneficence*". Once respect for autonomy is reinterpreted as respect for individual choice, many standards are likely to be demoted or discarded since they are not chosen by individuals, while others will be promoted because they happen to be chosen.

Many contributors to the debate on the Meacher Bill appealed to

subjective conceptions of autonomy. Lord Neuberger, for example, argued that all important human rights 'can be encapsulated in a single, overriding right…: the right to personal autonomy'. Individual autonomy is popular, and matters, but does not offer a reliable basis for all ethical claims. Personal autonomy matters to each of us, but is not enough to identify just laws or institutions. As the late Bernard Williams warned some decades ago, we should beware of placing too much weight on the fragile structure of the voluntary. A subjective view of autonomy may endorse claims and standards that need further, deeper or wider justification.

Foreword

Lord Carlile of Berriew CBE KC
Crossbench Peer

Professor Keown's paper tactfully discloses fault lines in the House of Lords. Rightly, he mentions the need for reform of our unelected House, a view held by many members though possibly with nearly as many reform ideas. Helpfully, he reminds cynics about the Lords that it provides a high quality of debate, given the expertise and experience of many of its members. Viscerally, he dismembers the disproportionate influence that can be deployed by small professional interest groups when they deploy their combined forces in debate. I belong to one such group, the lifelong legal practitioners. Mercifully, we are only occasionally united towards a single view.

In this instance, his targets are four retired senior judges, who spoke in the last major Lords debate on assisted dying. All are superb authorities on black-letter law and its not always crystal-clear meaning. All have been involved in hugely important cases, and are rightly respected for their brilliance and customary clarity. That said, Professor Keown exposes the danger of their authority as lawyers being deployed on matters which, despite strong ethical and legal components, essentially are matters of opinion. There is no evidence that retired judges in the House of Lords are less susceptible to campaigning than any other mortals. As Keown advises, they owe an obligation not to confuse their listeners by seeming to place a legal construction on questions of non-legal conscience and actuality.

The evidence from other countries with laws allowing some level of euthanasia (in my view that honest word removes inappropriate euphemisms from the discussion) is far more mixed than some respected adherents of euthanasia are comfortable to recognise. In Oregon, Canada, and The Netherlands there have been troubling examples of third party involvement in the deaths of those who were not suffering from clearly terminal illnesses, including psychiatric illnesses and co-morbid conditions involving physical and psychological factors. In Oregon, and possibly elsewhere, there emerges as a causative factor the desire to save money of family members including heirs.

Of course, as Keown says, there are profound ethical issues, articulated in some of the reported cases he cites. Deliberately killing another person other than in war or as capital punishment has never been permitted by UK jurisdictions: to permit a third person to end a life with no other physical purpose would be an astonishing departure from our common law and legislative principles.

A further issue is as to who would do the killing. Most doctors would

be unwilling to accept the responsibility. It would hang heavy on their consciences, and would contradict their practising oaths. Almost all medical practitioners, including the vast majority of those who would be willing to take part in the requested form of euthanasia, have as strong an ethical matrix as those opposed to the practice. However, my many years as a practitioner of criminal law, including ten years as a member of the medical profession's disciplinary body, the General Medical Council, as well as a small number of well-publicised cases, leave me regrettably in no doubt that there are some professionals who would abuse a law permitting euthanasia. The risk is small, but the possibility is real and horrific.

Professor Keown makes a strong case, founded on sound legal analysis, for restraint in this controversial legislative area. The House of Commons Select Committee on Health has now embarked on an inquiry into the subject. Thus far, they are asking the right questions to frame the debate. I look forward to their report in due course, and to Keown's critique of it at that time.

Foreword

Rt Hon Lord Sumption OBE PC FSA FRHistS
Former Justice of the Supreme Court of the United Kingdom and Reith Lecturer

The lesson of this paper is that medically assisted suicide arouses strong feelings, and strong feelings make for muddled thinking and moral confusion. Yet the issue matters, because it raises fundamental questions about human life and public morality. If not by ending our life when it no longer has value for us, then how are we to respond to advances in medical science which enable us to live long beyond our mental and physical capacity? In an age which is spiritual without being religious, does our life have value to anyone other than ourselves and perhaps those close to us? Does it have any value at all if it is attended by mental or physical incapacity or intolerable pain? Does our autonomy as moral beings extend to the manner and timing of our death? Are these really moral issues, or are they perhaps no more than questions of pragmatic convenience?

The Suicide Act 1961 prohibits acts calculated to encourage or assist the suicide of another person. These questions therefore raise questions of law. The current campaign to amend the Act has inevitably involved the courts and debates in Parliament in which lawyers have taken a prominent part. Yet lawyers, qua lawyers, have no special qualification to pronounce on these questions. The criminal law is a blunt instrument. It deals in absolutes. It cannot be discretionary in its application, even if the penalties for breach of it are. Like all law, it seeks coherence and consistency. Yet it would be difficult to argue that the interventions of courts and judges have been either coherent or consistent. What is the justification for allowing medically assisted suicide but limiting it to those believed to be close to death or in intolerable pain, actual or prospective? There are so many other reasons why one might want to end one's life. Once the moral barrier has been crossed, what is the logical stopping point?

Professor Keown's paper will not resolve these questions. He would not claim as much himself. It is a contribution to a particular argument about the treatment of terminal illness which happens to be in the ascendant right now. But he will have done a great service if he provokes reflection on the moral basis of the legislative compromises of this kind.

I. Introduction

The distinguished jurist Lord Judge, the former Lord Chief Justice, described physician-assisted suicide as 'the great moral and legal problem of our times'.[1] Parliamentary debates about its legalisation ought, then, to be of a commensurately high quality. Over almost thirty years Parliament - mainly the House of Lords - has considered a series of Bills to permit physician-assisted suicide for the 'terminally ill'. The quality of debate, and of two Lords' select committee reports, has been commendably high.

What of the debate on the latest Bill, introduced by Baroness Meacher? In the day-long second reading debate in October 2021 no fewer than one hundred and thirty peers spoke, illustrating the continuing importance of the issue.[2] Although the Bill fell because of lack of Parliamentary time, the debate merits analysis not only because of the issue's profound moral importance but also because of its continuingly prominent political profile. In February 2024, the House of Commons Health and Social Care Committee published the report of its inquiry into the issue and in November Kim Leadbeater MP introduced a Bill which is to have its second reading on 29 November.[3] Not least given the essential similarity of the Leadbeater Bill to the Meacher Bill, what lessons can MPs in particular learn from the second reading debate on the Meacher Bill? A key lesson is that the case advanced for the Bill was flawed in at least three main respects:

- It was claimed that the Bill's purpose was to prevent suffering, but the Bill did not require that patients be suffering and excluded many patients who were.
- It was asserted, erroneously, that by decriminalising suicide the Suicide Act 1961 condoned suicide and that the Act's ongoing prohibition of assisting suicide was therefore illogical.
- Principled arguments for the Bill were superficial. In particular, the principle of respect for autonomy was exaggerated at the expense of the principle of the sanctity of life, and the obvious implications ignored.

No fewer than four eminent former judges spoke in favour of the Bill: Lord Mance, Lord Etherton, Lord Neuberger and Lord Brown of Eaton-under-Heywood.[4] One would have expected their speeches to have been of a very high calibre, particularly in relation to matters of law and legal principle. Yet, underlining the disappointing quality of the second reading debate, it is upon their speeches this paper will largely draw to illustrate the above three flaws.[5]

1. In the Foreword to John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge: Cambridge University Press, 2nd ed, 2018) ('*Euthanasia*') xiii. The long-used, transparent and legally apt phrase 'physician-assisted suicide' has, regrettably, been increasingly displaced by 'assisted dying', a vague and tendentious euphemism that is variously understood to mean: physician-assisted suicide (the writing of a prescription for lethal drugs later ingested by the patient); voluntary euthanasia (the injection of a lethal drug at the patient's request); the refusal of life-prolonging treatment, and hospice care for the dying. (See footnote 80.) Another euphemism, used to describe the lethal drugs that doctors would be allowed to prescribe, is 'medication'. A medication is a substance that treats, not kills, a patient.
2. Parl Deb HL, vol 815, col 393 (22 October 2021). (Future references are to column numbers.) A video recording of the debate is available at: https://parliamentlive.tv/event/index/fd4f9ba1-c001-4d1f-a30d-52f3ef9ee38c?in=10:08:27 (last accessed 10 January 2023). For an overview of the debate see Christopher M Wojtulewicz, 'Analysing the Assisted Dying Bill [HL] debate 2021' (2021) *The New Bioethics* 1. A copy of the Assisted Dying Bill [HL Bill 13] can be found at: https://bills.parliament.uk/publications/41676/documents/322 (last accessed 10 January 2023).
3. See House of Commons, Assisted Dying/Assisted Suicide (Second Report of Session 2023-24). https://publications.parliament.uk/pa/cm5804/cmselect/cmhealth/321/report.html; Terminally Ill Adults (End of Life) Bill [Bill 012 2024-25]. https://publications.parliament.uk/pa/bills/cbill/59-01/0012/240012.pdf (both accessed 13 November 2024)."
4. 'The four judges'. At the time of writing, Lord Neuberger is listed as a judge in the Hong Kong Court of Final Appeal.
5. This is not to suggest that each of the four judges' speeches exhibited all three flaws, let alone that no peer managed to avoid them.

II. The Three Flaws

1. Mischaracterising the scope of the Bill

The first flaw, concerning the scope of the Bill, was showcased by Baroness Meacher's speech opening the debate. The Bill would, she said, afford terminally ill, mentally competent people over 18 the right to choose the timing and manner of their death. Two independent doctors would have to approve the application, certifying that the patient's life expectancy was no more than six months. The application would also require the endorsement of a High Court judge of the Family Division.[6] She said she feared being one of the unlucky 'small minority' of people who suffer a 'traumatic dying process in which our precious palliative care services cannot relieve our suffering and cannot enable us to have a dignified death'.[7] Her 'truly modest' Bill was based on 'tried-and-tested laws from overseas' and its 'sole aim' was 'to reduce unnecessary and unbearable suffering'.[8] Patient choice, she said, meant nothing unless it included the right to decide when one could take no more suffering.[9] Similarly, in an article in *The Times* the previous day she had written that the Bill 'would enable terminally ill, mentally competent adults whose suffering is beyond the reach of palliative care to die on their own terms.'[10]

Her speech was confusing. The Bill did not require that the patient be suffering, or would be likely to suffer, let alone unbearably. Nor did it require that patients who were suffering had consulted a palliative care physician, let alone tried palliative treatment. The Bill merely required that the applicant have a 'terminal illness'.[11] Patients, then, fell within the terms of the Bill if they had a 'terminal illness' but were not suffering. Conversely, patients who had a chronic illness that caused intense and protracted suffering fell outside the Bill. Neither Meacher nor her supporters, including the four judges, explained why the Bill excluded the following three groups of suffering patients:

- those who were not 'terminally ill' and who faced many years of suffering
- those were suffering intensely but who were physically unable to kill themselves, even if provided with a prescription for lethal drugs, and who therefore wanted a lethal injection (euthanasia), and
- suffering patients who lacked the legal capacity to request assistance, such as disabled infants or people with advanced dementia.

Clearly, if the two main ethical principles informing the Bill were respect for patient choice (autonomy) and the duty to alleviate suffering (beneficence), those same principles justified physician-assisted suicide for the chronically ill. They also justified voluntary euthanasia, especially (though not only) for those physically unable to kill themselves. And, if

6. Col 395.
7. Col 393.
8. Col 394.
9. Col 396.
10. Molly Meacher, 'Assisted Dying Bill is a Humane End of Life Insurance Policy' *The Times* 21 October 2021.
11. 'For the purposes of this Act, a person is terminally ill if that person – (a) has been diagnosed by a registered medical practitioner as having an inevitably progressive condition which cannot be reversed by treatment ("a terminal illness"); and (b) as a consequence of that terminal illness, is reasonably expected to die within six months.' Assisted Dying Bill, Clause 2(1). Clause 2(2) added: 'Treatment which only relieves the symptoms of an inevitably progressive condition temporarily is not to be regarded as treatment which can reverse that condition'. The Bill appeared to include many patients who refused a treatment that would extend their life for years, such as patients with diabetes who declined insulin. The 'terminally ill' were not, then, such a 'narrowly defined group of persons', as Lord Mance described them (at col 409).

autonomy and beneficence are thought in combination to justify voluntary euthanasia, then beneficence alone justifies non-voluntary euthanasia to end the suffering of patients lacking capacity: the absence of autonomy does not cancel the duty of beneficence.[12] As we shall see, the failure of the supporters of the Bill to follow the obvious logic of where the principles informing the Bill led was one of the most striking omissions in their speeches.

Turning to jurisdictions with relaxed laws, Baroness Meacher tried to distinguish those laws from her Bill, but unsuccessfully. She said that not a single jurisdiction in the world that had legalised 'assisted dying' for the 'terminally ill' had expanded its laws, apart from Canada. However, she added, the Canadian Parliament had relaxed its law in response to a ruling of the Supreme Court and had decided to enact a limited Bill similar to hers and, if it worked, to expand it. People should not, therefore, point to Canada as an example of a slippery slope.[13]

Her speech was, again, confusing. First, the Supreme Court of Canada did not limit 'assisted dying' to those reasonably expected to die within six months[14] (a fact which illustrates the arbitrariness of any such limit). Second, the subsequent legislation enacted by the Canadian Parliament applied to those whose death was merely 'reasonably foreseeable', and the guidance from Health Canada made it clear that patients need not have a terminal condition to qualify.[15] Third, the legislature did not initially intend to extend that limit if it worked; it extended it in March 2021 in response to a court that ruled (predictably) that the limit was unconstitutional.[16] Another extension made patients whose illness is solely mental eligible for euthanasia (though its coming into force was postponed until March 2023 and the government has announced a further delay).[17] The law in Canada, then, was highly relevant to the debate on her Bill, providing a revealing and ongoing illustration of the slippery slope. Greasing the slope in February 2023, a report by the Canadian Parliamentary Special Joint Committee on Medical Assistance in Dying has supported the extension of the law not only to patients whose mental disorder is the sole condition but also to "mature minors" under 18, and to mentally incapacitated patients such as those with dementia who have made an advance request for euthanasia.[18]

As for the laws in the Netherlands, Belgium and elsewhere, Baroness Meacher hoped they would not be raised as they were more broadly based and any reference to them was therefore irrelevant.[19] But why irrelevant? The Dutch and Belgian laws, by permitting both physician-assisted suicide and euthanasia, and by not being limited to the 'terminally ill', illustrate the arbitrariness of those two limitations in her Bill. Moreover, like Canada, their experiences amply illustrate the reality of the slippery slope.[20]

What of the Oregon Death with Dignity Act? Was it 'tried-and-tested'? For a reality-check into that Act and its operation, readers may wish to consult at least two of several critical scholarly sources. The first is the excellent volume by Dr Neil Gorsuch (now a Justice of the US Supreme Court) containing his searching analysis of that legislation, an analysis

12. See John Keown, 'The Logical Link from Voluntary to Non-Voluntary Euthanasia' [2022] 81(1) *Cambridge Law Journal* 84-108 (Available open access at: https://doi.org/10.1017/S0008197321001057. Last accessed 10 January 2023.)
13. Col 396.
14. *Carter v Canada (Attorney-General)* 2015 SCC 5, [2015] 1 SCR 331.
15. Keown, *Euthanasia* 441.
16. Government of Canada, Ministry of Justice, 'Canada's new medical assistance in dying (MAID) law' https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html (last accessed 10 January 2023)
17. Leyland Checco, 'Canada delays right to physician-assisted death for mentally ill people' *The Guardian* 18 December 2022.
18. Medical Assistance in Dying in Canada: Choices for Canadians. Report of the Special Joint Committee on Medical Assistance in Dying (44th Parliament, 1st Session, February 2023.) https://www.parl.ca/Content/Committee/441/AMAD/Reports/RP12234766/amadrp02/amadrp02-e.pdf (last accessed 23 February 2023).
19. Col 396.
20. Keown, *Euthanasia* parts III to VII.

which poses many of the still unanswered questions raised by the Act and its operation.[21] The second is the examination of the Act by leading US health lawyer Professor Alexander Capron which carefully explains why the Act's safeguards are 'largely illusory'.[22] Their illusory nature has not, however, prevented supporters of 'assisted dying' from suggesting their relaxation on the ground that they are 'burdensome obstacles' because they exclude: patients who are not 'terminally ill' or cannot self-administer; mature minors, and requests made in an advance directive by those who later develop advanced dementia.[23]

None of the four judges corrected Baroness Meacher's remarks about the scope of her Bill (or its allegedly 'truly modest' nature, or the supposed irrelevance of laws permitting physician-assisted suicide and euthanasia abroad). On the contrary. Lord Mance said that the question raised by the Bill, which was limited to a 'narrowly defined group', arose in the tragic context of 'imminent death' where many would wish to determine the hour and manner of their death when their palliative drugs might not provide alleviation.[24] As we have noted, however, the Bill's loose definition of 'terminal illness' merely stated that the patient be reasonably expected to die within six months (an expectation that might, moreover, prove highly inaccurate) and appeared even to include patients with diabetes who declined their life-preserving insulin.[25] Lord Brown said that those physically capable of ending their own lives did not need the Bill - 'they can proceed'- but that there were those – 'and it is to these the Bill is directed' – who were 'so totally disabled, so pitiable and with such a low quality of life, that they need help to achieve early death'. He added: 'It would be quite illogical to deny those in this second category the assistance they need, leaving them alone and utterly powerless, when they understandably want to accelerate death'.[26] However, the Bill made no such distinction between patients. It permitted physician-assisted suicide for 'terminally ill' patients whether or not they were physically capable of ending their own lives. And, one might add, what of those unable to end their lives even with assistance and who wanted a lethal injection? Were they not 'utterly powerless' and was it not 'quite illogical' to leave them so?

In sum, the debate disclosed no little confusion about the scope and purpose of the Bill. Let us now turn to a second flaw in the debate.

2. Misunderstanding the decriminalisation of suicide

The debate reflected the all too common belief that when Parliament enacted the Suicide Act 1961 to decriminalise suicide it thereby condoned suicide. As the legislative history demonstrates, any such belief is mistaken. Suicide was decriminalised for other reasons, including the enlightened understanding that a more promising and humane way of dealing with the problem of suicide was by treating the causes of suicide, not least mental illness, rather than by subjecting those who attempted suicide to the criminal process.

Responding to contemporary concerns that decriminalisation might be

21. Neil M Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton University Press, 2006).

22. Alexander M Capron, 'Legalizing Physician-Aided Death' (1996) 5(1) *Cambridge Quarterly of Healthcare Ethics* 10. Lest it be thought that the last two sources are out of date, Professor Capron's analysis of the Act's lax safeguards remains valid. So too do Dr Gorsuch's questions about the Act's operation: there has still been no comprehensive analysis of operation of the Oregon law of the sort carried out by the Dutch in relation to the operation of their euthanasia legislation. For a more recent analysis of the Oregon experience, see Keown, *Euthanasia*, chapter 21.

23. Thaddeus Mason Pope, 'Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles' https://ascopost.com/issues/december-25-2017/medical-aid-in-dying-when-legal-safeguards-become-burdensome-obstacles/ (last accessed 10 January 2023).

24. Cols 408-409.

25. See footnote 11. As just noted in the text, predicting life-expectancy is notoriously difficult: 'Deciding who should be counted as "terminally ill" will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide.' Joanne Lynn et al, 'Defining the "Terminally Ill": Insights from SUPPORT' (1996) 35(1) *Duquesne Law Review* 311, 314. Lord Mackay, the former Lord Chancellor, questioned (at col 500) the basis of the Bill's limitation to those with six months to live and predicted that, if the Bill were passed, an attempt would soon be made to drop the limitation.

26. Col 480.

perceived as condonation, the Joint Under-Secretary of State for the Home Department repeated a warning he had made during the Second Reading debate on the Suicide Bill:

> *Because we have taken the view, as Parliament and the Government have taken, that the treatment of people who attempt to commit suicide should no longer be through the criminal courts, it in no way lessens, nor should it lessen, the respect for the sanctity of human life which we all share. It must not be thought that because we are changing the method of treatment for those unfortunate people we seek to depreciate the gravity of the action of anyone who tries to commit suicide.*[27]

Similarly, he emphasised:

> *I should like to state as solemnly as I can that that is certainly not the view of the Government, that we wish to give no encouragement whatever to suicide…I hope that nothing that I have said will give the impression that the act of self-murder, or self-destruction, is regarded at all lightly by the Home Office or the Government.*[28]

Lord Bingham, the distinguished Law Lord, would later confirm in the *Pretty* case that suicide, while no longer a criminal offence, remained contrary to the policy of the law. His Lordship observed:

> *The law confers no right to commit suicide. Suicide was always, as a crime, anomalous, since it was the only crime with which no defendant could ever be charged. The main effect of the criminalisation of suicide was to penalise those who attempted to take their own lives and failed, and secondary parties. Suicide itself (and with it attempted suicide) was decriminalised because recognition of the common law offence was not thought to act as a deterrent, because it cast an unwarranted stigma on innocent members of the suicide's family and because it led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success.*

He continued:

> *But while the 1961 Act abrogated the rule of law whereby it was a crime for a person to commit (or attempt to commit) suicide, it conferred no right on anyone to do so. Had that been its object there would have been no justification for penalising by a potentially very long term of imprisonment one who aided, abetted, counselled or procured the exercise or attempted exercise by another of that right. The policy of the law remained firmly adverse to suicide, as [that penalty] makes clear.*[29]

One might reasonably have expected, then, that in the debate on the Meacher Bill at least one of the four judges would have made clear to the House (i) that the decriminalisation of suicide was not intended to condone suicide, let alone establish a right to commit suicide (ii) that suicide, while no longer a crime, remained contrary to the policy of the law and (iii) that this was why the Suicide Act maintained the criminal

27. Parl Deb HC, vol 645, cols 822-823 (1960-1961).
28. Parl Deb HC, vol 644, cols 1425-1426.
29. *R(Pretty) v DPP* [2001] UKHL 61 at [35].

prohibition on assistance or encouragement.[30] None did so.

On the contrary, Lord Brown went so far as to assert that by the Suicide Act 1961 'suicide was accepted as a lawful right in the interests of dignity and so forth' and that therefore it became 'illogical to deny those with the very lowest quality of life and the strongest justification for wanting to accelerate death the power to achieve it.'[31] Lord Etherton stated that 'as suicide is no longer a crime, I suggest that it defies logic to preclude a patient, with appropriate safeguards, from seeking assistance to terminate his or her life'.[32] Lord Mance asked: 'If a person may choose freely to commit suicide, what justifies a refusal to allow them to obtain willing assistance?'[33] These remarks echoed Lord Neuberger's misguided observation in the *Nicklinson* case, namely, that arguments based on the sanctity of the lives of those who sought physician-assisted suicide had been 'substantially undermined' by the decriminalisation of suicide. He had reasoned: 'I find it hard to see how a life can be said to be sacred if it is lawful for the person whose life it is to end it', adding 'if the primacy of human life does not prevent a person committing suicide, it is difficult to see why it should prevent that person seeking assistance in committing suicide'.[34]

Not only is the belief that by decriminalisation Parliament intended to condone suicide seriously mistaken but it paves the way to another, no less mistaken, belief. This is that the prohibition on assisting suicide can be justified only as a way of protecting the 'vulnerable' from being unduly influenced to request assistance in suicide, and that the central question for consideration is therefore whether a blanket prohibition is 'overbroad' to achieve that purpose.[35] It was this erroneous belief, among others, that led the Supreme Court of Canada egregiously to invent a right to voluntary euthanasia and physician-assisted suicide in 2015.[36] The true legal position is that the blanket prohibition of assisting suicide is no more designed to protect only the 'vulnerable' than is the blanket prohibition on murder. Both criminal prohibitions aim to protect *everyone*, whether 'vulnerable' or not, and whether or not they autonomously want to be assisted in suicide or to be killed.

3. The superficiality of the ethical debate: exaggerating autonomy, ignoring the sanctity of life

Many of those who spoke for the Bill claimed, often drawing on personal stories of distressing deaths, that it was needed to prevent people from dying in agony.[37] Anecdote is not, however, argument. Distressing deaths, while a matter of the utmost importance - not least to those who suffer them and to their loved ones - are by themselves no more an argument for legalising physician-assisted suicide than for improving access to palliative care. Although the UK is world-leader in palliative care, it remains, indefensibly, unavailable to many patients. Why was the solution to distressing deaths so widely and readily assumed to be helping suffering patients kill themselves rather than providing adequate resources to ensure the palliation of their suffering? Moreover, as we shall see in section 4,

30. The prohibition was updated by the Coroners and Justice Act 2009, section 59.
31. Col 481. The perduring myth that the Suicide Act created a 'right to suicide' has also been given credence in the courts: see *JK v A Local Health Board* [2019] EWHC 67 (Fam) at [28].
32. Col 428.
33. Col 408. While he did observe that 'some' regarded suicide as a breach of the sanctity of life and its decriminalisation as a pragmatic recognition of the incongruity of punishing those whose attempts failed, he left that observation hanging and proceeded to talk about the need to 'balance' the sanctity of life with 'autonomy' and 'dignity'. Peers might well have mistakenly inferred that the 1961 Act was the product of such a balance. Fortunately one peer, Lord Dannatt, correctly noted (at col 484) that although the 1961 Act decriminalised suicide, it sought to discourage it by prohibiting assisting suicide.
34. *R(Nicklinson) v Ministry of Justice* [2014] UKSC 38, [2015] AC 657 at [90].
35. See ibid at [90] – [91].
36. See Keown, *Euthanasia* chapter 23.
37. See, for example: cols 394 ('intolerable or unbearable suffering'); 403 ('slow, agonising deaths'); 412 ('appalling deaths'); 425 ('acute and intractable pain…intolerable suffering'); 432 ('horrific conditions'); 445 ('fearful of a truly horrible death…terrible terminal pain'); 451 ('intolerable pain and misery').

the evidence from Oregon concerning the reasons people seek a hastened death shows that inadequate pain control is one of the *least* common, quite some way behind 'losing autonomy' and being 'less able to engage in activities making life enjoyable'.

Peers, and spectators, would reasonably have expected the speeches by the four judges to have demonstrated an impressive command of the key relevant legal and ethical principles. Yet their speeches reflected, rather than rose above, the average, not least by tending to exaggerate the principle of autonomy and to ignore the principle of the sanctity of life.

(i) an exaggerated respect for autonomy

The case advanced for legalisation reflected the assumption that respect for autonomy was a, if not the, paramount ethical principle. For Lord Etherton, the Bill rested on the principle of personal autonomy which was 'an inseparable aspect of human dignity, which has been at the heart of the western concept of human rights since the United Nations Declaration of Human Rights in 1948'. He pointed out that a competent person who had not been unduly influenced by others had an 'absolute' right at common law to insist on the withdrawal of treatment.[38] Lord Neuberger went so far as to assert: 'There are many important human rights but, in the end, they can all be encapsulated in a single, overriding right…: the right to personal autonomy.' He too thought that the case for the Bill was supported by the legal right to refuse treatment.[39] As we shall now see, such remarks suggest a failure to appreciate (i) the proper limits to respect for autonomy (ii) the logical implications of attaching an inflated importance to autonomy and (iii) the questionable relevance to the case for PAS of the right to refuse treatment.

(a) limits to autonomy

Autonomy is not a moral absolute; it has limits. The basis of the rights enumerated in the UN Declaration of Human Rights is not autonomy but, as its preamble affirms, dignity.[40] Indeed, the Declaration nowhere mentions a right to autonomy. While respect for autonomy is an important moral principle, and is an aspect of human dignity, it requires careful definition and application. Also, autonomy may be trumped by other principles,[41] as well as by human dignity, whether one's own or another's.[42] It is right, for example, to prohibit an autonomous choice to sell another person into slavery (even with that person's free consent), or an autonomous choice to sell oneself into slavery, because such choices are radically inconsistent with human dignity. Indeed, what is the criminal law but an extensive web of restrictions on our choices, however autonomous?

Many of the criminal law's restrictions seek to prevent harm to others. Some aim to protect us from harming ourselves: it is, for example, a crime to drive a car without a seatbelt. It is an offence to cause actual bodily harm even with the victim's consent (absent a limited number of justifications accepted by the courts), let alone to kill.[43] In short, simply to invoke 'personal autonomy' as a justification for the abolition of the

38. Col 428.

39. Col 462. Lord Mance also mentioned (at col 409) the refusal of treatment by competent patients, and the withdrawal of treatment from incompetent patients, as instances of striking a balance between sanctity, autonomy and dignity.

40. The Preamble begins: 'Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world…'. The first sentence of Article 1 reads: 'All human beings are born free and equal in dignity and rights'. 'The Universal Declaration of Human Rights' (1948) https://www.un.org/en/about-us/universal-declaration-of-human-rights (last accessed 10 January 2023).

41. The rights and freedoms articulated in the UN Declaration are not all absolute. Article 29(2) provides that in the exercise of rights and freedoms everyone shall be subject to such limitations as are determined by law solely for the purpose of due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

42. For a helpful account of the long-established understanding of human dignity in terms of the intrinsic and ineliminable worth of all human beings see Daniel Sulmasy, 'Dignity and Bioethics: History, Theory and Selected Applications' in The President's Council on Bioethics, *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics* (Washington DC, 2008) chapter 18.

43. *R v Brown* [1994] 1 AC 212; *R v McCarthy* [2019] EWCA Crim 2202.

historic criminal prohibition on physician-assisted suicide is to beg the question. The criminal law has always rejected the victim's request or consent as a defence to the charge.

As we shall observe later, the judges not only appeared, explicitly or implicitly, to attach an inflated importance to autonomy but they almost completely ignored a legal and moral principle that is at least as important: the sanctity or inviolability of human life. From the dawn of the common law that principle has underpinned the criminal prohibition on intentionally killing the innocent and on helping them to kill themselves, however autonomously they may wish for a hastened death.

(b) the logical implications of exaggerating autonomy

Although Lords Etherton and Neuberger appeared to attach paramount importance to autonomy, they did not follow through the logical implications of so doing. Lord Neuberger claimed:

> *Personal autonomy has no more important aspect than the right to control your very existence. It is your life to deal with as you see fit. If you want to end your life, you are entitled to do so, and if you have a fundamental right to end your life, you must require very powerful reasons why you should be denied assistance if you need to exercise that right and cannot do it without assistance.*[44]

As we have seen, however, the Bill limited the exercise of this supposed 'right to control your very existence' and 'fundamental right to end your life' to the 'terminally ill' and to the method of ingesting lethal drugs obtained on prescription. What 'very powerful reasons' were there for denying a hastened death to autonomous people who were not 'terminally ill' or who were, perhaps because of total paralysis, unable to take their own lives even with assistance?

Indeed, Lord Neuberger, presiding in the Supreme Court in *Nicklinson*, had questioned a proposal to allow physician-assisted suicide for only the 'terminally ill'. Quite apart from the 'notorious difficultly' in assessing life expectancy, he thought there was 'significantly more justification' for assisting the suicide of those who had the prospect of living 'for many years' a life they regarded as 'valueless, miserable and often painful'.[45] Such was, indeed, the situation of Tony Nicklinson, who had been paralysed by a stroke.

Moreover, Tony sought euthanasia, not merely assistance in suicide. Lord Neuberger suggested that in law and morality a 'satisfactory boundary' between euthanasia and assisted suicide could be found in 'personal autonomy': in assisted suicide, the patient had not been killed by anyone and had ended their own life pursuant to a voluntary and settled intention.[46] His Lordship appeared to confuse autonomy with agency. A death by lethal injection may respect personal autonomy as much as death by lethal prescription, not least because when a patient swallows the drugs there need be no doctor present to check that decision to do so is (still) autonomous. And a law that denies lethal injections clearly frustrates the

44. Col 462.

45. *R(Nicklinson) v Ministry of Justice* [2014] UKSC 38, [2015] AC 657 at [122].

46. Ibid at [95].

autonomy of those who want them, who are likely to be many. Indeed, the overwhelming majority of cases of 'assisted dying' in Canada and the Netherlands involve euthanasia. In Canada in 2021 virtually all the 10,064 cases involved euthanasia; fewer than 7 (0.07%) were cases of physician-assisted suicide.[47] Similarly, in the Netherlands that year only 2.5% of cases involved physician-assisted suicide.[48] Why should the law in England and Wales frustrate the autonomy of patients, who might also form the vast majority of those seeking a hastened death, who would want an injection?

In short, if Lord Neuberger thinks there is no more important aspect to autonomy than the right to control one's very existence, and that one has a fundamental right to end one's life, on what sensible basis can the exercise of that right be limited (as by the Meacher Bill) to those who are 'terminally ill' and to those who are physically able to end their lives with assistance? Indeed, why would the paramountcy he evidently affords to autonomy not justify euthanasia for *any* person who autonomously wanted it?

(c) the relevance of refusing/withdrawing treatment

We will recall that Lord Etherton, echoed by Lord Neuberger, pointed out that a competent person who had not been unduly influenced by others had an 'absolute' right at common law to insist on the withdrawal of treatment. This invites three responses.

First, judicial and extrajudicial *dicta* that the right to refuse treatment is 'absolute' are more controversial than many judges and practising and academic lawyers seem to appreciate. For example, non-consensual treatment of capacitous patients is permitted under the mental health legislation.[49]

Second, even if the right to refuse treatment were 'absolute', its relevance to the case for PAS would not be obvious. In *Vacco v Quill* the proponents of a constitutional right to physician-assisted suicide argued before the US Supreme Court that there was no significant difference between withdrawing life-prolonging treatment at the patient's request and prescribing a lethal drug at the patient's request. The submission failed. Chief Justice Rehnquist rightly noted an important distinction: in the former case there need be no *intent* to shorten life, either by the patient or by the physician.[50]

Third, if a competent patient's 'absolute' right to refuse treatment, for whatever reason, is thought to support the case for physician-assisted suicide, why should a competent patient's right to access physician-assisted suicide (or euthanasia) not also be 'absolute'? Why is the argument from autonomy advanced by Lords Etherton and Neuberger not an argument for euthanasia on request?

Turning to the withdrawal of treatment from incapacitated patients, Lord Etherton commented that difficult decisions had already been made 'in relation to termination of the life of incapacitated individuals' where the overriding principle was the patient's best interests, which included what the patient would have wanted. He said that many withdrawal of

47. 'Self-administration of MAID [Medical Assistance In Dying] is permitted in all jurisdictions in Canada, except for Québec. There were fewer than seven deaths from self-administered MAID in 2021 across Canada, a trend consistent with previous years'. Health Canada, *Third Annual Report on Medical Assistance in Dying in Canada 2021* (2022) 20.

48. Regionale Toetsingscommissies Euthanasie, *Jaaverslag 2021* (2022) 9. https://www.euthanasiecommissie.nl/de-toetsingscommissies/uitspraken/jaarverslagen/2021/maart/31/jaarverslag-2021 (last accessed 10 January 2023).

49. See Mental Health Act 1983 sections 58, 63 and 145(4). The courts have also yet adequately to address the argument that a refusal of treatment has no right to be respected if it is clearly suicidal. See John Keown, 'The Case of Ms B: Suicide's Slippery Slope?' (2002) 28 *Journal of Medical Ethics* 238-239. (This is not necessarily an argument in favour of forcing treatment on competent patients who refuse it but rather that the law should not recognise a right to suicide or to be assisted to execute a suicidal plan. The right to refuse provides a shield, not a sword.)

50. *Vacco v Quill* 512 US 702 at 800-804.

treatment cases, such as the *Bland* case and the *Conjoined Twins* case, raised difficult issues. (We may leave aside the fact that the latter was not a withdrawal of treatment case and that the former was so only by an extended interpretation of 'treatment'.) He added:

> *I suggest that there is an obvious flaw in logic and consistency in making such early termination of life possible for incapacitous people but not permitting a person of full capacity, free from undue influence and properly informed, to request assistance in dying. Inconsistency in the application of the law heralds injustice, and I therefore support the Bill.*[51]

Unless Lord Etherton was simply making the uncontroversial point that there is a risk of decisions being improperly influenced in cases of treatment withdrawal as well as in cases of physician-assisted suicide, a comparison between withdrawal of treatment from the incapacitated and physician-assisted suicide is, like the comparison with the right to refuse treatment, questionable. Withdrawing treatment from the incapacitated need involve no intent to hasten death, either by the physician or (in advance of incompetence) by the patient. It is, therefore, problematic even to categorise such cases as involving the 'termination of life' as opposed to the 'termination of treatment'. Indeed, the Mental Capacity Act 2005 expressly provides[52] that in determining what is in an incapacitated patient's 'best interests', where the determination relates to life-sustaining treatment, the person making the determination must *not* be motivated by a desire to bring about death. Moreover, if his Lordship thought that cases such as *Bland* and the *Conjoined Twins* involved the intentional 'termination of life' of incapacitated patients, and are relevant precedents that support legalising physician-assisted suicide, why do those precedents not also support lethal injections for incapacitated patients?[53]

To summarise: it was odd that the judges seemed largely to assume that the prohibition on physician-assisted suicide was an unjustified breach of the principle of respect for autonomy. It was no less odd, if that principle was – as Lords Etherton and Neuberger seemed to think – of paramount importance, that they did not question the significant limits placed on autonomy by the Bill. Odder still for it to be suggested that cases such as *Bland* and the *Conjoined Twins* case, and the right to refuse treatment, militated in favour of the Bill. The withdrawal of tube-feeding from a patient in a 'persistent vegetative state' or the separation of conjoined twins need involve no intent to kill, and respecting a patient's refusal of treatment need not involve assisting suicide. Withdrawing treatment from the incapacitated, and separating conjoined twins, surely prove either too little (not involving an intent to hasten death) or too much (involving an intent to kill the incapacitous). It was, finally, noteworthy that three of the four judges did not even *mention* a relevant and indeed fundamental legal principle to which we shall now turn: the sanctity of life, a principle whose importance was, moreover, reaffirmed (albeit unsatisfactorily grasped or applied) in both *Bland* and the *Conjoined Twins* case.

51. Col 429.
52. Section 4(5).
53. Yet again there appears to be a failure to follow an argument to its logical conclusion.

(ii) rejecting the sanctity of life and overlooking the implications

The principle of the 'sanctity' or 'inviolability' of life is of foundational importance to English law.[54] The principle does not, as many think, require the preservation of life at all costs: that is sheer 'vitalism'. At the heart of the inviolability principle is *an opposition to intentionally killing the innocent or assisting them to kill themselves*. The principle has long shaped the criminal law. A main reason the US Supreme Court in 1997 rejected the argument for a constitutional right to physician-assisted suicide was that the Anglo-American common law tradition had either punished or otherwise disapproved of both suicide and assisting suicide for over 700 years.[55]

Lord Goff, commenting on the principle in *Bland*, said:

> *[The] fundamental principle [in this case] 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 is indeed evidenced by its recognition both in article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1953…and in article 6 of the International Covenant of Civil and Political Rights 1966.*[56]

Article 2(1) of the European Convention on Human Rights provides:

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

The core of the principle was neatly captured in an impressive report produced by a House of Lords Select Committee in 1994. The Select Committee on Medical Ethics closely considered, and rejected, the arguments for legalising voluntary euthanasia or physician-assisted suicide. Its report observed that the law's prohibition on intentional killing was 'the cornerstone of law and of social relationships' that 'protects each one of us impartially, embodying the belief that all are equal'.[57] In his extensive judgment in the *Conjoined Twins* case, Lord Justice Ward quoted that statement, adding: 'What the sanctity of life doctrine compels me to accept is that each life has inherent value in itself and the right to life, being universal, is equal for all of us.'[58]

In *Inglis* a mother appealed against her conviction for murdering her adult son, Thomas, who was in a 'persistent vegetative state' following an accident. The Lord Chief Justice, Lord Judge, observed that in the eyes of the law against intentional killing 'a disabled life, even a life lived at the extremes of disability, is not one jot less precious than the life of an able-bodied person'. Until Parliament decided otherwise the law recognised a distinction between the withdrawal of treatment, which might be lawful, and the active termination of life, which was unlawful.[59] Moreover, he added, the law of murder drew no distinction between malevolent and benevolent motives.[60]

It is this understanding of radical human equality that the principle

54. See John Keown, *The Law and Ethics of Medicine: Essays on the Inviolability of Human Life* (Oxford: Oxford University Press, 2012) especially chapter 1.
55. *Washington v Glucksberg* 521 US 702 (1997) at 710-716.
56. *Airedale NHS Trust v Bland* [1993] AC 789 at 863-864.
57. *Report of the Select Committee on Medical Ethics* (HL Paper 21-I of 1993-94) paragraph 237.
58. *Re A* [2001]1 Fam 147, IV, 7.4. Here is not the place to explore the complex cases of *Bland* and the *Conjoined Twins* except to say that to the extent that judges in either case may have condoned intentional killing they were laying down bad law, clearly incompatible with the principle of the inviolability of life and leaving the law, to adopt the apt observation of one Law Lord in *Bland* (who nevertheless agreed with the decision), 'morally and intellectually misshapen'.Nor is this the place to explore the jurisprudence of the European Court of Human Rights in *Pretty* ((2002) 35 EHRR 1) and later cases. Suffice it to say that in *Pretty* the Law Lords and the European Court rejected the argument that English law's prohibition on assisting suicide breached the European Convention. The key point made in the text stands: only one of the four judges in the Meacher debate even mentioned the inviolability of life, a legal and ethical principle that should be acknowledged as central.
59. *R v Inglis* [2011] 1 WLR 1110 at [38].
60. Ibid at [37].

of the sanctity or inviolability of life upholds. The lives of *all* patients, however disabled, are of equal, intrinsic worth and merit protection. The value of Thomas' life lay not in his autonomy, for he no longer had any, nor in Thomas' or anyone else's valuation of his life, but in his intrinsic dignity as a member of the human family, a fundamental worth he retained despite his profound intellectual disability. It is a 'golden thread' of English criminal law that it is for the Crown to prove a defendant's guilt beyond all reasonable doubt.[61] The principle of the inviolability of life could reasonably be described as a 'golden chain' of English criminal law. A law that were to allow certain people to be killed or helped to kill themselves, whether on account of their illness or disability, would rupture that chain. It is quite remarkable that none of the four judges pointed out that the Meacher Bill was, then, anything but 'truly modest'.[62] In *Conway*, Sir Terence Etherton (as he then was), delivering as Master of the Rolls the careful judgment of the Court of Appeal, had identified the ethical debate as being between the sanctity of life and personal autonomy,[63] and he noted that the (no less careful) judgment of the Divisional Court had identified the sanctity of life as a purpose of the Suicide Act's prohibition on assisting suicide.[64] It is surprising, then, that the sanctity of life did not merit a mention in his speech in the debate. Nor was it mentioned by Lord Neuberger or by Lord Brown.

Moreover, none of the four judges adverted to the profound implications of rejecting the inviolability of life, in particular that the law would, ineluctably, enter a discriminatory moral world where some lives were arbitrarily judged worthwhile but others not. The judges' focus on autonomy may well have distracted them, and their listeners, from the reality that laws permitting physician-assisted suicide and voluntary euthanasia do not merely permit certain 'private' exercises of personal choice. For one thing, the decision that the patient should be helped to take their own life is not made by the patient: the Bill required the patient's request to be approved by two physicians and by a judge. For another, the Bill would embody the moral judgment that it is entirely reasonable for some people to put an end to their lives because death would benefit them, and that it would benefit them precisely because their lives were no longer 'worth living'. The Bill did not seek to grant just anyone a right to access physician-assisted suicide. It contained conditions which marked out (however vaguely) a category of people who, it was thought, would be justified in obtaining assistance to kill themselves. Legalising 'assisted dying', then, instantiates a moral judgment that *some* people (such as the 'terminally ill') but not *other* people would be justified in thinking themselves 'better off dead' and in acting upon that judgment. The claimant in *Nicklinson*, who had sadly lost sight of his worth, thought his life 'demeaning' and 'undignified'. A law granting his request to be euthanised or assisted in suicide would endorse his tragically mistaken judgement.

Not only would the belief that certain lives were not 'worth living' be a highly contentious (and erroneous) moral judgment for the law to

61. *Woolmington v DPP* [1935] AC 432 [HL].

62. Lord Mance did mention (col 409) the sanctity of life as an important principle, though he did not explain what it meant. He said a 'balance' had to be struck between it and autonomy and dignity. Properly understood, the historic prohibition on intentionally killing the innocent, or helping them kill themselves, can no more be compromised by a 'balancing' exercise than the prohibition on torture. And sanctity seemed to disappear from his balancing exercise which he framed as between autonomy and dignity versus the risks of abuse.

63. *R(Conway) v Secretary of State for Justice* [2018] EWCA Civ 1431 at [189].

64. Ibid at [201] - [204].

endorse but it could (and sooner or later surely would) be extended to many other patients, including the frail elderly and people with a range of disabilities. Such vulnerable folk would be prime candidates to be thought of (as they already are by many in a modern society which prizes youth, appearance and productivity) as leading lives that are 'pitiable' and of 'low quality' (to borrow the candid if not chilling description by Lord Brown of those who would be eligible under the Bill). Small wonder that leading disability voices Baroness Campbell, Baroness Grey-Thompson and Lord Shinkwin spoke against the Bill.[65]

Lord Brown was much closer to the mark than his judicial brethren in expressing that it is pity and compassion that do the real work, or *at least* as much work as autonomy, in justifying physician-assisted suicide and voluntary euthanasia. Once this is appreciated, why should the law *not* extend its pity and compassion to embrace those who are not 'terminally ill' but who are nevertheless suffering; those who are suffering but incapable of requesting death, such as infants with physical disabilities, or those who are not suffering but who have, say, profound intellectual disabilities? Why should Bills like the Meacher Bill discriminate against *them* by denying them a hastened exit from *their* lives, lives that might easily be judged 'pitiable' and of 'low quality'? As we noted earlier,[66] *the absence of autonomy does not cancel the duty of beneficence*. Once the criminal law abandons its historic, bright-line prohibition on intentionally killing the innocent which, as the Select Committee on Medical Ethics pointed out, guarantees everyone's right to life, everyone's equality-in-dignity, many more people than the competent and 'terminally ill' would, sooner or later, come to be regarded as justified in thinking themselves 'better off dead'.

Moreover, if, as Lord Neuberger sweepingly claimed, all important human rights 'can be encapsulated in a single, overriding right…: the right to personal autonomy', where does this leave those many people who lack autonomy, such as those with profound intellectual disabilities? There is no shortage of bioethicists and others who think that people lacking rationality and self-awareness are 'non-persons', mere 'biological organisms'.

The logical or conceptual slippery slope on which the law would set foot once it embraced the notion that certain people would be 'better off dead' is not merely theoretical; it is demonstrably real. Take the Netherlands. It is no accident that its euthanasia law is, unlike the Meacher Bill, limited neither to the 'terminally ill' nor to physician-assisted suicide. Nor that the Dutch courts, applying the principle of beneficence, slid effortlessly from endorsing lethal injections for competent patients in 1984 to permitting lethal injections for disabled infants in 1996. Nor that the Dutch government proposed in 2016 the extension of 'assisted dying' to the elderly who felt their life was 'completed'. Nor that in 2020 it decided to permit euthanasia for children between 1 and 12.[67]

65. See cols 418, 498 and 502 respectively.
66. See footnote 12.
67. On the Dutch experience see Keown, *Euthanasia* chapters 7-17.

4. Some additional questions

Three of the main flaws in the second reading debate have been identified above, but it is worth briefly mentioning a number of additional questions prompted by the speech of Lord Neuberger. The first concerns the porousness of the line as drawn by the Bill between physician-assisted suicide and euthanasia.

His Lordship said that he did not read the Bill[68] as 'as permitting a third party to administer the killing medicine'.[69] However, it allowed the 'assisting health professional' to assist in the self-administration of the lethal poison, and it is not difficult to imagine circumstances in which that assistance might be substantial. Presumably the professional could help the patient pour the poison ('medication') down his or her throat. Would this not be tantamount to euthanasia? Lord Carlile QC (as he then was)[70] took the view that the Bill would permit euthanasia.[71] In short, the legal line between physician-assisted suicide and voluntary euthanasia is not always clear. Moreover, even if one sought to justify drawing that line, one would have to produce a sound reason. What is the moral difference between pouring a poison and helping to pour a poison?[72]

As for the case against the Bill, Lord Neuberger said that the only argument that resonated with him was the risk of abuse and 'The fact that there will be occasional abuses, as there always are in a free society, is far outweighed by the enormous amount of suffering, relatively speaking, that will be ended if the Bill becomes law'.[73] As we have noted, however, the Bill did not require that patients be suffering at all. In the list of seven reasons for seeking a lethal prescription in Oregon, inadequate pain control, or fear thereof, ranks sixth, cited by around a quarter of patients. The two most common reasons, cited by over 90% of patients, are 'losing autonomy' and being 'less able to engage in activities making life enjoyable'. The majority of patients in 2021 cited being a burden on family, friends and caregivers, and almost one in ten the financial implications of treatment.[74] The data did not, however, prevent Lord O'Donnell, the former Cabinet Secretary, from citing 'the evidence from Oregon' as the basis for his assertion that 'Those who choose assisted dying do so primarily because they are fearful of a truly horrible death'.[75] The judges were far from alone in suggesting that the Bill would reduce intolerable suffering. While no-one should deny the sad and serious reality of painful and distressing deaths, it is quite an intellectual leap to conclude that the answer to the problem is to assist the killing of the sufferers rather than to palliate their suffering.

How, one wonders, did Lord Neuberger go about 'weighing' the 'occasional abuses' he anticipated (abuses that would include people being induced or pressured to kill themselves, or being killed under the guise of being 'assisted', or killing themselves under the influence of undiagnosed depression or other mental illness) against the amount of suffering he thought the Bill would prevent?[76] Why did he think the abuses would be merely 'occasional'? And what of studies suggesting an *increase* in suicides, both with and without physician assistance, in jurisdictions where the law

68. Clause 4(4)(c).
69. Col 462.
70. Col 416.
71. Lord Mance (at col 409), citing *Kennedy*, thought the Bill adopted an important distinction between providing the lethal means and causing the patient's death. This is, with respect, questionable. *Kennedy* was a case on unlawful act manslaughter, not assisting suicide. It held that handing a loaded syringe to another who died after voluntary self-injection was not a cause of death. But why could assisting a patient to ingest lethal drugs not be a cause of death? Indeed, the court in *Kennedy* regarded 'holding a glass containing the noxious thing' to a victim's lips (which is precisely what physicians assisting suicide might do) as an 'administration' of the substance contrary to section 23 of the Offences against the Person Act 1861. *R v Kennedy* [2007] EWCA Crim 38 at [10].
72. This is yet another moral question advocates of physician-assisted suicide regularly evade.
73. Col 462.
74. Oregon Death with Dignity Act 2021 Data Summary, Table 1. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf (last accessed 10 January 2013).
75. Col 445.
76. Would it be a good argument in favour of capital punishment that the 'occasional abuses' of innocent people being hanged would be outweighed by the amount of crime that would or might be prevented?

has been relaxed?[77]

Lord Neuberger made some additional points in favour of the Bill that should not pass unchallenged. He said that rich people could travel abroad to access 'assisted dying'. True, but rich people can fly to countries where hard drugs or child sex or female genital mutilation are available. Moreover, only 23 British people were accompanied to Switzerland to be assisted in suicide by *Dignitas* in 2021; hardly a flood.[78] Further, several suicide tourists have not been 'terminally ill', even on a loose interpretation, such as Daniel James.[79] Daniel was a 23 year-old who was paralysed from the chest down in a rugby accident and he would not have been eligible for physician-assisted suicide under the Bill. If the fact of 'terminally ill' people flying to Switzerland is thought to be a good argument for the Bill, is the fact of non -'terminally ill' people flying there a good argument for a wider Bill? Yet again, an argument is advanced with its logical implication left unaddressed.

Lord Neuberger also said the Bill was supported by the way we deal with suffering animals. However, that involves euthanasia and, indeed, of the non-voluntary variety. He also commended as 'excellent' a point made by Lady Davidson concerning the autonomous choices people were allowed to make in relation to artificial reproduction, including choosing donor materials 'sifted by everything from eye colour to family medical history'. However, if consumerism at the beginning of life is to be applauded, why not consumerism at the end of life? Why not allow people to opt for a hastened death because they feel old and 'tired of life', as the Dutch government proposed in 2016?

Lord Neuberger also invoked public opinion, but how reliable are opinion polls on an issue like 'assisted dying', not least given that 'assisted dying' is a fuzzy euphemism? In a 2021 poll no fewer than 42% of respondents thought it meant the right to refuse life-prolonging treatment and a further 10% the provision of hospice care to the dying.[80] Even if people polled understand that their opinion is being sought on physician-assisted suicide, how many responses are based on an informed understanding of the issues as opposed to emotion, perhaps influenced by the 'human interest' stories regularly reported by the mass media? In any event, polls are a poor guide to ethics.

A final comment. Lord Neuberger thought it fitting that judges should be involved in cases of physician-assisted suicide as they were used to deciding on 'difficult, sensitive cases'. Judges are indeed involved in difficult and sensitive cases, such as the withdrawal of life-prolonging treatment, but those cases need have nothing to do with assisting people to kill themselves. If the Bill were enacted, the role of judges would switch overnight from one of sentencing others for assisting suicide to one of assisting suicide themselves, by playing a key role in the process of approval.[81] This would, on any reckoning, be a radical transformation of the judicial role. Suicide has been contrary to the policy of the law for over 700 years, yet the Bill would render judges deeply complicit in it.

77. Theo Boer, 'Does Euthanasia Have a Dampening Effect on Suicide Rates? Recent Experiences from the Netherlands' (2017) 10 *Journal of Ethics in Mental Health* 1; David Albert Jones, 'Euthanasia, Assisted Suicide and Suicide Rates in Europe' (2022) 11 *Journal of Ethics in Mental Health* 1; Sourafel Girma and David Paton, 'Is Assisted Suicide a Substitute for Unassisted Suicide?' (2022) 145 (June) *European Economic Review* 104113.

78. A total of 498 from 1998-2021: DIGNITAS, 'Accompanied suicide of members of DIGNITAS, by year and by country of residency 1998–2021', http://www.dignitas.ch/index.php?option=com_content&view=article&id=32&Itemid=72&lang=en (last accessed 10 January 2023).

79. 'Parents of rugby player in Dignitas assisted suicide will not face charges', *The Daily Telegraph* 9 December 2008.

80. Survation APPG for Dying Well Survey, July 2021, https://www.dyingwell.co.uk/survation-appg-for-dying-well-survey-july-2021/ (last accessed 10 January 2023).

81. Lord Carlile QC (as he then was) said the Bill would ask a judge to approve something that no judge has been asked to approve since the abolition of the death penalty; wondered whether the judges of the Family Division, who have a daunting workload, had been consulted, and predicted they could be swamped by the likely number of cases. Cols 416-147.

III. Conclusions

Happily, the British courts have hitherto (unlike the Canadian courts) properly declined to trespass on Parliament's right to decide whether or not to legalise physician-assisted suicide or euthanasia.[82] As Sir Terence Etherton MR (as he then was) rightly said in his extensive judgment in *Conway*: 'There can be no doubt that Parliament is a far better body for determining the difficult policy issue in relation to assisted suicide in view of the conflicting, and highly contested, view within our society on the ethical and moral issues and the risks and potential consequences of a change in the law....'[83] He also noted that, unlike Parliament, the courts could not conduct public consultations or engage experts and advisors.[84]

Probably no legislative body in the world has debated 'assisted dying' more thoroughly, especially over the past quarter of a century, than the House of Lords. The quality of debate on the issue, a comprehensive grasp of which calls for input from disciplines including medicine, ethics, social science and law has, on the whole, been quite high. This is not unconnected with the range of expertise available in the Lords, including that of senior judges. Although the House is clearly ripe for reform, its track-record in debating issues such as physician-assisted suicide helps the case for its retention, at least in some form.

The overall quality of the second reading debate on the Meacher Bill was, however, below par, despite making allowance for the fact that, because so many peers wanted to speak, each was advised to speak for only a few minutes. Even the contributions of the four judges fell short of the high standard one would expect from jurists of such eminence.[85] In short, the debate disclosed several flaws in the case made for the Bill:

- It was claimed that the purpose of the Bill, and a key justification for it, was the prevention of suffering, yet the Bill did not require that patients be suffering at all, merely that they be 'terminally ill' (a vaguely defined condition).
- It was mistakenly asserted that by decriminalising suicide the Suicide Act 1961 condoned suicide and that the Act's continuing prohibition on assisting suicide was illogical.
- There was inadequate attention to the fundamental legal and ethical principle of the sanctity of life, which has historically informed the law against killing patients or helping them to kill themselves, and to the fact that by undermining that principle the Bill was anything but 'truly modest'.

82. See *R(Conway) v The Secretary of State for Justice* " [2018] EWCA Civ 1431.
83. Ibid at [186].
84. Ibid at [189].
85. It was left largely to non-judicial members of the House to point out the implications of accepting the principles underlying the Bill. See, for example, the impressive speech by Lord Herbert (the Prime Minister's special envoy on LGBT+ rights) at cols 473-474.

- There was a failure to recognise the logical implications of supporting the Bill. If respect for patient choice, and the relief of suffering, justified lethal prescriptions for the 'terminally ill', why exclude the chronically ill; suffering patients unable to request a hastened death, and lethal injections? Why (to borrow Lord Etherton's terminology) would introducing such inconsistencies in the law not herald injustice?
- There was a failure to acknowledge the relevance of permissive laws in other jurisdictions, not least the Netherlands and Canada, and to engage with the substantial body of evidence indicating (to put it at its lowest) that concerns about the slippery slope are far from fanciful.

Given that physician-assisted suicide is indeed 'the great moral and legal problem of our times', it is to be hoped that future debates will not exhibit the same flaws.[86] The stakes are too high

86. The recently-published Parliamentary briefing on the subject is not without merit: Devyani Gajjar and Abbi Hobbs, *Assisted Dying* (UK Parliament POSTbrief 47, September, 2022) https://researchbriefings.files.parliament.uk/documents/POST-PB-0047/POST-PB-0047.pdf (last accessed 10 January 2023). Whether it will enhance the quality of debate is doubtful. Its (2-3 page) summary of the 'Key ethical debates' is thin, and it does not even cite the leading scholarly texts on the issue.

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