Assisted Dying as the Last Human Right: A Critical Review of the Eligibility Criteria for an Assisted Dying Framework in England and Wales

Thesis submitted for the degree of

Doctor of Philosophy

at the University of Leicester

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September 2017
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Thesis Abstract

Within the vast work that has been done on assisted suicide, this thesis examines how assisted suicide may be legalised in England and Wales if Parliament decides that is necessary in the future. The thesis takes as starting point the three eligibility criteria proposed by the Commission on Assisted Dying, a privately-funded Commission established in 2012 to review the status of the current law in England and Wales. The thesis focuses on the practical side of the assisted suicide debate, and hints that studying how legalisation could take place in the future may hinge on whether it can ever be realised in practice.

In particular, the thesis suggests that if Parliament decides to legalise assisted suicide in England and Wales, it should adopt a medico-legal framework that will respect both the right to life (Article 2) and the right to self-determination (Article 8) and the state obligations arising from these, and attempt to strike a balance. Parliament will then respect the rights of those who choose death over life, and safeguard the lives of those who do not want to die but may be unduly influenced into assisted death. To achieve this balance, the criterion relating to the physical or mental condition of the individual (terminal illness or unbearable suffering) should be abandoned, and a robust approach to safeguards adopted. Individuals should be able to request an assisted death if they have mental capacity, if they make a voluntary and informed decision, and if the Family Division of the High Court approves the assisted death. This is a new proposal that should be considered as an option if, and when Parliament decides that the time is ripe for legalisation. The right to control the manner and timing of death is ‘the last human right’ to which individuals should have access.
This thesis is dedicated to my grandfather Kypros Papadopoulos

who passed away on the 31\textsuperscript{st} of January 2015.

You were the kindest, the most humble.
Acknowledgments

The journey from applying for a position in the Leicester Law School’s doctoral degree programme, to the submission of the completed PhD Thesis in September 2017 has been a challenging, yet transformative life experience. With its lows and highs, successes and failures, it would not have been possible without the support of many people that I would like to acknowledge here.

First and foremost, I would like to thank my mum and dad, Evi and Christos. They have always been next to me supporting me emotionally and practically, and most importantly sharing their love and life experiences. I could not have done any of this without your support and belief in me. I am very grateful. My younger brother Kypros has also always been there to remind me that I should take life easy, and though I rarely listen, I thank him for that. Thank you for all the life lessons.

This project would not have been possible without the academic and personal support and guidance of my two amazing supervisors: Professor Elizabeth Wicks and Dr Tracey Elliott. Liz has been an inspiration for me; her professionalism, knowledge and experience, and the sense of security that she projects are qualities that make up the ideal supervisor. Tracey’s knowledge and experience, intelligence and wit, and insight into every new case and book out there was an absolute gem. To both of you: I am so grateful for the long-hours you spend reading all those drafts, for your encouragement and belief in me and this project. This journey has been an absolute pleasure, and I would not change a thing.

Many thanks to Professor José Miola who has been overseeing my progress since the very beginning. Your knowledge and experience, your professional and personal, and career advice have been wonderful. I will be forever grateful.

I am grateful to all the past and current staff and admin members of the Leicester Law School, but special mention should go to Dr Stelios Andreadakis, Dr Maribel Canto-Lopez, and Teresa Rowe. These lovely people have gone out of their way to support and encourage me over the last four years. Stelios encourages me to fulfil my
potential, and helps me in each step of the way. Maribel, you are a source of positive energy. Thanks for all the support and love. Teresa, I could not wish for a better PGR administration and friend than you. Your honesty, skill, intellect, perseverance has been tremendous. Your cakes are also the epitome of perfection!

A big thank you to Dr Stefano Bertea a unique, kind individual; to Professor Peter Cumper, always willing to have an honest talk; to Dr Albert Sanchez-Graells (now in Bristol) you have been a true inspiration and your advice has been wonderful; to Professor Jill Marshall (now in London) thank you for the opportunities; and to Dr Paolo Vargiu, you are one of a kind! Thanks for your honesty and support. Anthony Berry, Holly Morton, and Jane Sowler (now retired): thanks for all your hard work for everyone in the School. In my last year, I have had the privilege to meet Dr Angus Cameron and Dr Andrea Davies (Leicester Business School). You are the academics I want to be in the future. Thank you for all the advice and fun times in our voice training.

And finally, although they would probably never see this, thanks to Fiona and Emmanuela for keeping my physical, and mental health and wellbeing solid (most of the times!)

I am indebted to all my friends around the world for their love and support. These few pages are not enough to express my gratitude for your support and love.

To all my Leicester-based friends, but especially Eleni L. and Annaliza, thank you for the long talks, advice, and unconditional love; I don’t have enough words to thank you for the time you spent caring for me over the years. Katerina V. thank you for your honestly, help, and love; Valentina for being there; to Christina A. and Antonis for being the most loving people I was lucky to meet recently; to Yiota, Josephina, Giannis K., Manuel, Andreas P., and Savvas P. for being my Leicester family and for all the fun times we had in Leicester; to Maria-Paula (and Simon), Esra, Reza, Bader for always being there to talk to me and advise me; and to all my University friends and colleagues but especially: Katerina K., Aristi, Khalida, Laura, Ewa, and Haward. You
have all taught me something different. These four years have been full of life experiences that I will forever cherish and look back to.

Special mention to all my Cyprus, and non-Leicester-based friends and family. To my cousins, Andria, Polis, Andrea, Elena (and to Christina and Sophia, my nieces, for making me smile!), all my uncles and aunts, and my grandmother. Your support and understanding over the last four years have been amazing. Sorry for missing a lot of things because I needed to work! To my precious ‘filaki’ for her unconditional love and support; my dearest twins Elena and Nicoletta, the most humble and pure creatures you will meet; my sources of positivity Eva and Stavroula; to Melina for the long and life-changing talks; and Pavlos A. for sharing a lot of our common PhD problems and thoughts.

To my friends abroad, thank you for always being there. Kim, Kostas, Andy, Zara, Mert, Shiva; Prahlad, Bam, Kristina; Diana for the Colombian sources and Elco for the Dutch translations! A final thank you to all my ELSA family around the world; you have taught me so much, and Salsa people in Leicester for all the fun times in my last year; George C., Theodoros, and Harris C. for always being there; Rhidi for always sharing a smile; and Omiros and Andreas K. for no particular reason. Thank you for being part of this without even realising!

Finally, a very special thank you must go to my partner in crime and life Constantinos. All credits to him for surviving every single one of the crazy lows of this journey, for sharing his legal knowledge and random, little ideas, his amazing proofreading skills and attention to detail, but most importantly, for his perseverance, unconditional love, and support throughout. I could not have done it without you. Thank you for being caring and so wonderful.

Nataly Papadopoulou

Leicester Law School, 29-09-17
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INTRODUCTION

‘If we were satisfied that national conditions and public opinion in this country were no longer suited to the absolute ban contained in section 2(1) of the 1961 Act, we could go on to consider in some detail the safeguards which might be put in place to balance the individual’s right to self-determination against the community’s interest in upholding the value of life and protecting the vulnerable’.¹

Background of, and motivation for the thesis

This thesis was inspired by my passion for human rights. Human rights allow us to choose how we live, how we express ourselves, who we choose to represent us. Even before going to Law School, I was intrigued by the idea that human beings have rights because of their shared humanity, and that human rights allow us to live life with dignity, autonomy, freedom, equality, and peace. Growing up in a Western culture, I had high expectations as to the rights human beings should have access to. One of the first cases I studied in Law School, however, significantly lowered these expectations. In 2002, Ms Dianne Pretty, a terminally ill woman around the age of 50 asked the English Courts for assistance in dying to alleviate her pain, indignity, and suffering.² The courts rejected her claim. Why did the courts take this decision? Why did they prioritise the rights of others and the need to protect the society and its values over her individual autonomy, dignity, freedom rights? The principles of autonomy, dignity, freedom, were all loosely defined in my head, but coupled with my fascination for Medical Law and the ethical issues arising within the area, including the end-of-life

¹ R (on the application of Pretty) v DPP [2001] EWHC Admin 788 [57] (Tuckey LJ).
² ibid; R (on the application of Pretty) v DPP [2001] UKHL 61; Pretty v the UK (2002) 35 EHRR 1.
issues relating to assisted suicide, I decided that the study of the law on assisted suicide in England and Wales was a fine blend of Human Rights and Medical Law.

While preparing the research proposal for my LLM in Human Rights dissertation in November 2012, I came across the Assisted Dying Bill 2013.³ The Bill was proposing the choice of an assisted suicide to individuals such as Ms Pretty. I studied the Bill as part of my LLM dissertation and concluded that legalising assisted suicide in England and Wales can be compatible with the European Convention on Human Rights (‘ECHR’). However, I also concluded that the proposed Bill had significant, practical shortcomings. Thus, when I decided to pursue a PhD in law, I wanted to investigate beyond the Bill. I found out that the Bill was based on the findings of a privately-funded Commission, the Commission on Assisted Dying (‘CAD’) that produced a public report in 2012.⁴ I decided that my doctoral research would focus on the core of the CAD’s Report: the three eligibility criteria for legalisation of assisted dying in England and Wales. This decision can be attributed to several reasons.

The first reason is that while examining the 2013 Bill I identified significant practical shortcomings, such as the terminal illness eligibility criterion, that I wished to further explore. The second reason is that I have realised that, ultimately, how legalisation will take place in England and Wales may hinge on whether legalisation can ever be realised. In other words, if it is shown that there is a workable framework on which assisted suicide can be given effect in England and Wales then the debate on its legalisation may become less polarised. However, I do acknowledge that in case of legalisation, there is much more to consider than the eligibility criteria examined in this thesis, including for instance, issues relating to palliative care, resource allocation, training of healthcare professionals and judges involved, or the regulation of the substances used in the assisted death. The third reason is that a review of the


literature on assisted suicide at the time revealed abundant materials on whether assisted suicide should be legalised, however, there was limited academic commentary on the eligibility for assisted suicide, in other words, who should be eligible to request an assisted death in case of legalisation. Hence, I decided that my doctoral research would focus on how Parliament could legalise assisted suicide in England and Wales if it decides that legalisation is necessary in the future. The thesis uses primary law sources, including case law (domestic and international), legislation enacted or considered by Parliament, as well as secondary law sources, including parliamentary and other documents and reports, academic law and other scientific and research journals, and data and reports from jurisdictions allowing a form of assisted death. Because of the continuous domestic and international developments, the enactment of legislation abroad, the ever-increasing number of suicide tourism

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cases, as well as the reporting of suicides at home in the UK, media reports are also used extensively to inform the analysis. The journey of researching and writing this thesis has changed over time. At the beginning, the thesis was much more centred on the CAD’s Report. Later, the thesis took a step away from the CAD and used its three eligibility criteria as starting point. Chapter Three is an example of this shift in focus; it considers in depth not just the terminal illness eligibility criterion preferred by the CAD, but also the second mainstream type of eligibility criterion relating to the physical and mental condition of the individual, the suffering-based eligibility criterion.

As to the substance of the research, the CAD does not make a ground-breaking proposal for the legalisation and the means of legalisation for assisted suicide in England and Wales. Put simply, this is not a proposal that has not been previously put before Parliament, or already in place in other jurisdictions. Indeed, it is a very limited, conservative proposal, as evident particularly in Chapter Three of the thesis. Yet, as argued in Chapter One, there is great value in studying the CAD’s findings and its three proposed eligibility criteria. This is not only because there is little commentary on the CAD’s Report and findings per se, but also because of the thousands of pieces of evidence and unexplored themes arising from the research the CAD has carried out.

The study of the CAD’s Report has indeed given rise to a new idea for a debate that is often said has been ‘done to death’. Additionally, since the Pretty case in 2002, several legal cases have grappled with assisted suicide and its legalisation, both in the domestic and the international level (Chapter Two). The cases have given rise to many

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new arguments, mostly relating to human rights, and highlight the conflict between the current prohibition on assisted suicide in England and Wales and human rights law. The enactment of legislation in jurisdictions outside England and Wales also contribute to the study in this thesis, and indeed offer new evidence and facts on how an assisted suicide law may look in a future, domestic legalisation framework.

A word on the scope of this thesis

This thesis deals with assisted suicide that is defined as providing someone with the means to end his or her own life. This definition has been adopted by the two most recent reviews of the assisted suicide law in England and Wales: the CAD, in 2012, and the House of Lords Select Committee (‘HLSC’), in 2005. Nevertheless, I acknowledge the relevance of other related practices, including euthanasia. The word euthanasia originates from the Greek language; the Greek word ‘εὖθανασία’ means good death: ‘εὖ’ (eu) meaning good, and ‘θάνατος’ (thanatos) meaning death. The Oxford English Dictionary defines euthanasia as ‘the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma’. Some fierce euthanasia opponents link the term to the eugenic atrocities carried out by the Nazis during, or shortly before, World War II, a meaning that moves away from the

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12 On the legality of euthanasia see: Law Commission, Murder, Manslaughter and Infanticide (Law Com No 304, 2006). See further: R v Moor [1999] Crim LR 2000 Jul 568-590. A retired GP was charged with the murder of an 85-year old man suffering from terminal bowel cancer after injecting him with diamorphine; and R v Cox (1992) 12 BMLR 38. A rheumatologist was convicted of attempted murder for injecting a 70-year-old woman with potassium chloride. However, the doctor was eventually given a 12-month suspended prison sentence.

etymology of the word (‘good death’).\textsuperscript{14} This is evidence that the meaning of the word ‘euthanasia’ varies greatly, and is given different interpretations, including non-medical connotations.

Euthanasia is often divided in two categories: voluntary and non-voluntary. Voluntary euthanasia is euthanasia that is the result of the individual’s request. Non-voluntary euthanasia is carried out without the individual’s request, whether because consent is not sought after, or because the individual is unable to give consent.\textsuperscript{15} Euthanasia can also be divided in two further categories: active and passive. Active euthanasia means that an active, deliberate act ends life (e.g. a lethal injection). Passive euthanasia often refers to the withdrawal or withholding of life-sustaining treatment and, under certain circumstances, is considered lawful.\textsuperscript{16} The main difference between euthanasia and assisted suicide then is that in the former, the death is caused by a third party, whereas in the latter, death is caused by the individual himself or herself. Assisted suicide highlights, in particular, the right of individuals to self-determination by placing them in control of the dying procedure.

Assisted suicide is referred to in this thesis as assisted dying or, sometimes, as assisted death for clarity purposes. Assisted suicide, which is the legal term used in the Suicide Act 1961 that regulates the law in England and Wales (Chapter One), will be used only when reference is made to the criminal prohibition of the 1961 Act. The use of the term assisted dying or assisted death, I suggest, is justified by the reasons analysed below. Assisted dying, over assisted suicide, is a term that implies death as the result of a procedure (die-ing). This procedure, which as evident in this thesis can involve a number of parties and robust safeguards, will not necessarily lead to an assisted death, allowing the individual to stop at any time. Assisted dying also implies a

\footnotesize{\textsuperscript{14} See further: Ruth Macklin, ‘Which Way Down the Slippery Slope? Nazi Medical Killing and Euthanasia Today’ in John Harris (ed), \textit{Bioethics} (Oxford University Press 2001), 109-130.}

\footnotesize{\textsuperscript{15} N.B. The term ‘involuntary euthanasia’ is sometimes used to describe an expressed desire to live.}

\footnotesize{\textsuperscript{16} \textit{Airedale NHS Trust v Bland} [1993] AC 789 (HL).}
supported, safeguarded dying procedure. On the contrary, the word *suicide*, as discussed in Chapter One of the thesis, has historically negative connotations. Suicide implies an isolated, unsupported, single act, that was until 1961 criminalised in England and Wales, and is still today condemned by individuals and some societies.\(^17\) Dignity in Dying (‘DID’), a group that campaigns for legalisation of assisted dying for terminally ill adults in the UK, indeed highlights that the suffix ‘-cide’ means ‘to kill’ and denotes illegal or egregious, prohibited behaviour such as homicide, genocide, or infanticide.\(^18\) Moreover, a review of the case law relating to the 1961 Act includes deaths outside the medical context and of different moral culpability, from encouraging suicide for inheritance purposes, to assisting death on compassionate grounds.\(^19\) The wide scope of the offence was also highlighted in *R v Hough*: ‘in terms of gravity [the offence] can vary from the borders of cold blooded murder down to the shadowy area of mercy killing or common humanity’.\(^20\) Therefore, the focus of this thesis is the practice of assisted suicide, which is referred to as assisted dying or assisted death throughout the analysis.

\(^{17}\) See, for instance, the following jurisdictions: Cyprus, Lebanon, Malaysia, Oman, Singapore, and Syria. This list is not exhaustive.


\(^{19}\) See, for instance: *A-G v Able* [1983] 3 WLR 845. In the case, the Attorney General sought a declaration as to whether it would be a crime of aiding, abetting, counselling, or procuring suicide to distribute a booklet published to describe ways of committing suicide. The defendants claimed that the booklet aimed to help readers overcome the fear of dying; and *R v Howe* [2014] EWCA Crim 114. The defendant was charged under the 1961 Act for buying and providing the vulnerable victim with petrol which the victim eventually used to set himself on fire.

The structure of the thesis

Chapter One and Chapter Two are the introductory Chapters of the thesis. Chapter One discusses the law relating to assisted suicide in England and Wales. It considers the abolition of the crime of suicide, the Suicide Act 1961, and the domestic assisted suicide reform proposals with a focus on the CAD, which the thesis uses as starting point. Chapter Two deals with the human rights law dimension of assisted suicide. Specifically, the Chapter discusses Article 2, the right to life, and Article 8, the right to respect for private and family life, home and correspondence of the European Convention on Human Rights (‘ECHR’). These two provisions are considered the most relevant for this thesis. Chapter Two also briefly discusses the ethical principles of the sanctity of life and autonomy that underpin Article 2 and Article 8 respectively. This is followed by an analysis of the domestic legal cases relevant to assisted suicide. Chapter Three discusses the two eligibility criteria used in jurisdictions that already allow a form of assisted death that relate to the physical and mental condition of the individual: the terminal illness eligibility criterion, and a suffering-based eligibility criterion. The CAD proposed that only terminally ill, competent adults should have the option of an assisted death. Chapter Three challenges the suitability of both criteria. This is not least because of problems with their identification and practical application, but most importantly because these two characteristics (terminal illness and/or unbearable suffering) should not be the basis for being allowed to request access to an assisted death. The self-determination right under Article 8 of the ECHR is not qualified on this basis. This argument is fully explored in Chapter Six. Chapter Four and Chapter Five of the thesis deal with the CAD’s second and third eligibility criteria, of mental capacity and voluntariness. They conclude that these are essential minimums for a domestic assisted dying framework and propose some changes based on the study of the legal rules in other jurisdictions and academic and other research studies. Chapter Seven proposes that an additional ‘last safeguard’ should be considered in building a robust assisted dying framework for England and Wales, that of judicial oversight.
Potential limitations of the thesis

This brings the discussion to the consideration of the limitations of this research which is by no means exhaustive. A potential limitation lies in the number of jurisdictions used in informing the analysis in Chapter Three, Chapter Four, and Chapter Five. It is not possible in the scope of this thesis to draw upon every jurisdiction that legalises a form of assisted death in the world. Therefore, the three Chapters draw upon the jurisdictions and their legal rules considered most relevant in the context. Similarly, in this thesis I have chosen to focus on Article 2 and Article 8 of the ECHR. Though this was justified on the basis of the relevance and usability of these provisions in domestic and international cases on assisted suicide and euthanasia, one may argue that the analysis would not be complete without the consideration of the other relevant ECHR provisions, including Article 3 (prohibition of torture or inhuman or degrading treatment or punishment), Article 9 (the right to freedom of thought, conscience and religion), and Article 14 (the prohibition of discrimination). The issues arising from these articles in relation to assisted suicide have been explored elsewhere. A final limitation briefly discussed earlier concerns Chapter Seven. The final safeguard for assisted dying proposed in Chapter Seven cannot be fully explored without some input from empirical data and studies. Specifically, the potential involvement of the Family Division of the High Court in a future assisted dying framework in England and Wales requires further research on the procedural delays and costs of court proceedings, to test whether this final safeguard can be accommodated within an assisted dying context. Finally, at the time of the submission of this thesis the Noel Conway judgment\textsuperscript{21} has not been published, while the Omid T case\textsuperscript{22} has not yet had its full

\textsuperscript{21} R (on the application of Noel Douglas Conway) v Secretary of State for Justice and Crown Prosecution Service and A-G [2017] EWHC 640 (Admin); R (Conway) v the Secretary of State for Justice [2017] EWCA Civ 275.

\textsuperscript{22} R (on the application of) Omid T v The Ministry of Justice [2017] (High Court of Justice, Administrative Court - Claimant’s Detailed Statement of Facts and Grounds) [2] available at:
court hearing. This is unfortunate, as the Courts’ view in these two domestic cases, in particular on the impact of Article 2 and Article 8 on the assisted suicide law, is very likely to be relevant to the analysis in this thesis.

The argument of the thesis

Individuals at any stage in their lives may endure loss of autonomy or suffering of any type and duration, or be unable to experience any pleasure in the continuation of their lives. These individuals may believe that their lives should end, and decide that suicide is their only option. Even though suicide is no longer a crime in England and Wales (Chapter One), this is insufficient or physically unattainable as an option to some of these individuals. I do not argue that every suicide should come under the medico-legal framework suggested in this thesis; individuals should be free to decide the means of their suicide. I suggest, however, that if Parliament considers that it is necessary, individuals who do wish to have an assisted death should be allowed to request one. Isolated, unsupported suicides could be prevented when to do so would be appropriate and desirable by the individual concerned. The same applies for suicides using violent, dangerous, and unregulated means. Individuals who wish to end their lives should also be protected against serious and permanent mental and physical injuries or harm arising from unsuccessful suicides. Moreover, individuals who do not have the mental capacity to decide to end their lives or are being unduly influenced by third parties to do so should be protected by the state. Other individuals, such as bystanders, who may accidentally become involved in the suicide, should also be protected.  

The establishment of a medico-legal assisted dying


framework for England and Wales could provide answers to these concerns. It would give the healthcare professionals involved confidence that judges would act as the ‘final safeguard’ to support the ‘last human right’ of individuals who choose to end their lives in a supported, regulated environment. It would give individuals the option of controlling their death, in the same way as they control their life. On the assumption that these individuals have the mental capacity to make an assisted dying decision (Chapter Four), that individuals make a voluntary and informed decision (Chapter Five), and that the Family Division of the High Court approves the assisted death (Chapter Seven), these individuals should be allowed to exercise their right to self-determination recognised under Article 8 (Chapter Six). At the same time, however, under Article 2, the law must also safeguard the lives of those individuals who do not want to die, but may be unduly influenced in seeking an assisted death (Chapter Six).

This thesis does not establish the need for legalisation of assisted suicide. It does not argue in favour or against it, and does not argue that Parliament should legalise assisted suicide in England and Wales in the future. Rather, it aims to contribute to the vast work that will be needed, if Parliament decides that legalisation of assisted suicide in England and Wales is necessary. The conclusion and findings of this thesis also have the potential to influence other jurisdictions that may decide to legalise a form of assisted dying in the future.

Chapter One is the first of two introductory Chapters of this thesis. The aim of Chapter One is to provide the legal context for assisted suicide in England and Wales, and to act as a reference point for the rest of the thesis. In Part 1.1 it discusses the assisted suicide law in England and Wales. Specifically, the analysis covers the abolition of the crime of suicide and explains the key provisions of the Suicide Act 1961, the legislation which governs the law in this area, and specifically Section 2(1) and Section 2(4). Part 1.2 provides an overview of the recent attempts to reform the law on assisted suicide in England and Wales. The analysis places emphasis on the Commission on Assisted Dying (‘CAD’), the most recent review of the law. The CAD’s Report, published in 2012, proposed three eligibility criteria that this thesis uses as starting point. Overall, Part 1.2 argues that despite most of the CAD’s Commissioners having an interest in the legalisation of assisted suicide before joining the CAD, the Report produced is still a credible source of research, and its findings and collected evidence reveal unexplored themes.
1.1 Assisted Suicide Law in England and Wales

1.1.1 Suicide and its Abolition in 1961

The self-killing of St Augustine in the 5th century AD is commonly considered the origin of the law against suicide in Europe.  

Augustine described suicide as a crime in many of his writings, including his book *The City of God*, relying predominantly on the sixth Commandment: ‘thou shalt not kill’.  

The Ecclesiastical cannon law of the Church relied on Augustine’s writings in condemning suicide. Since 563, those who committed suicide were denied religious burial rites; this was incorporated into English canon law in 673.  

For centuries, the bodies of those who committed suicide were mutilated and degraded, buried at crossroads overnight with a stake through the heart to ‘pin the evil spirit down’.  

The execution of the corpse, according to George Minois, was both an exorcism and an example intended to dissuade imitation.  

In the early middle ages, the civil sanction of forfeiture was added to the ecclesiastical cannon law sanction of the denial of religious burial.  

William Blackstone in 1775 explained the rationale of the condemnation of suicide: ‘no man hath a power to destroy life, but by commission

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from God, the author of it’. Other than the religious crime, Blackstone noted ‘a double offence’, ‘one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects’.

Suicide was also a crime at common law, a peculiar species of felony committed upon one’s self (felo de se). In failed suicide attempts, the common law imposed severe sanctions to the individual surviving the suicide. In successful suicides, the common law imposed sanctions directed to what the deceased left behind, namely, reputation (burial rites) and fortune (forfeiture of property). The common law response to successful suicides had a profound impact on the deceased’s loved ones. The procedure was a dreadful trial for the relatives of the deceased who were forced to watch a humiliating and distressing public spectacle. At the same time, the common

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8 ibid.

9 ibid. See also: *R v Mann* (1914) 10 Cr. App. R. 31 (attempted suicide: six months’ imprisonment with hard labour, on appeal hard labour removed); *Beresford v Royal Insurance Company Ltd* [1938] AC 586 [HL] (claim for recovery of life insurance of a man who committed suicide).

10 *R v Mann (John William)* (1914) 10 Cr. App. R. 31 (attempted suicide: six months’ imprisonment with hard labour, on appeal hard labour removed); *R v Saunders (William Thomas)* (1914) 9 Cr. App. R. 119 (attempted suicide: six months’ imprisonment reduced on appeal to immediate release when doctor reported safe to do so); *R v Montgomery (Walter)* (1930) 21 Cr. App. R. 140 (attempted suicide and bigamy: sentence reduced to three months’ imprisonment for showing remorse); *R v Crisp (Henry)* (1912) 7 Cr. App. R. 173 (attempted suicide: sentenced to six months’ imprisonment reduced on appeal to six weeks’ imprisonment); *R v Wilson (Alfred)* (1914) 9 Cr. App. R. 32 (attempted suicide: eight months’ imprisonment with hard labour reduced on appeal to ten weeks’ with hard labour – driven to crime by starvation).


12 ibid.
law not only failed to support individuals who attempted suicide but failed, but also forced them to go through trial and sentencing. Closer to 1961 the case law indicates changing attitudes.\textsuperscript{13}

With the introduction of the Suicide Act in 1961, attempted suicide and suicide were no longer regarded as criminal offences under the common law in England and Wales.\textsuperscript{14} In July 1961, Mr Eric Fletcher, a Labour MP, during the Second Reading of the Suicide Bill spoke of the need to show compassion and assist those contemplating suicide: ‘more often than not [those attempting suicide] require the services of a doctor, a psychiatrist, a spiritual adviser, a welfare worker, and in some cases, perhaps, a lawyer, and not the services of a policeman or gaoler’.\textsuperscript{15} Similar views were heard in the House of Lords.\textsuperscript{16} In the case of Pretty in 2002, Lord Bingham indeed noted that the common law offence of suicide did not act as deterrent, and casted ‘an unwanted stigma on innocent members of the suicide’s family’ and ‘led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success’.\textsuperscript{17} The legislative history of the 1961 Act further indicates that the 1961 Bill was not ‘intended to undermine the sanctity of human life or the general view of society’ on suicide.\textsuperscript{18} Rather, the decriminalisation of suicide aimed ‘to protect already distressed relatives from the imposition of additional hardship, and to ensure that people who had unsuccessfully attempted suicide could seek medical [psychiatric] help, without fearing

\textsuperscript{13} R v French (Edward) (1955) 39 Cr. App. R. 192 (attempted suicide and larceny: two years’ imprisonment for each offence – appeal against the former only – reduced to one month). The Lord Chief Justice noted that the sentence was absurd as attempted suicide was not a ‘very serious crime’ and prosecutions are ‘now’ rare.

\textsuperscript{14} Section 1: ‘The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated’.

\textsuperscript{15} HC Deb 14 July 1961, vol644 cols833-845.

\textsuperscript{16} See HL Deb 2 March 1961, vol229 cols246-276, for instance, speech per Lord Bishop of Carlile.

\textsuperscript{17} R (on the application of Pretty) v Director for Public Prosecutions [2002] 1 AC 800 (HL) [35].

\textsuperscript{18} HC Deb 14 July 1961, vol644 cols833-845.
prosecution’. In fact, during the Second Reading of the 1961 Bill reference was made to the services Samaritans are offering to those contemplating suicide, as well as to the need for appropriate treatment of individuals who unsuccessfully attempt suicide. Section 1 of the 1961 Act, that decriminalised attempted suicide and suicide, indeed reflects a degree of compassion towards those attempting suicide and their families, acknowledges human frailty, and recognises the absurdity and insensitivity of the law that criminalised suicide. Section 1, however, created no right to suicide.

1.1.2 The Suicide Act 1961

The Suicide Act 1961, although it decriminalised suicide and attempted suicide, established the offence of encouraging or assisting suicide or attempted suicide that carries a penalty of up to fourteen years of imprisonment. Section 59 of the Coroners and Justice Act 2009 replaced the original ‘aiding and abetting’ wording of the offence. Section 2 currently reads as follows:

(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.

(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.

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22 See, for instance: *Re Z (Local Authority: Duty)* [2004] EWHC 2817 (Fam).
(4) No proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions.\textsuperscript{23}

The 1961 Act initially used the terms of the Accessories and Abettors Act 1861 requiring that the defendant aided, abetted, counselled, or procured suicide or attempted suicide. There was the need to prove intention and that the individual was actually assisted or encouraged as a result of the defendant’s conduct (‘the substantive offence’).\textsuperscript{24} Under Section 1(1) of the Criminal Attempts Act 1981 it was also an offence to attempt to aid, abet, counsel, or procure suicide or attempted suicide (‘the attempt offence’).\textsuperscript{25} A ‘more than merely preparatory’ act and intention were the elements needed for the offence. There was, however, no need for an actual or attempted suicide to take place. Under English law, the liability of secondary parties is derivative and dependant on a principle offence being committed. Following the decriminalisation of suicide and attempted suicide in 1961, an individual committing or attempting suicide committed no actual crime, therefore, ‘aiding and abetting’ suicide was an unusual offence.\textsuperscript{26}

Therefore, in 2009, Section 59 of the Coroners and Justice Act replaced ‘the substantive offence’ and ‘the attempt offence’ with one single offence.\textsuperscript{27} The aims of the reform were to improve public understanding of the law, ensure that the law also


\textsuperscript{25} ibid [emphasis added].

\textsuperscript{26} HL Deb 02 March 1961, vol229 cols246-76 speech per Lord Denning.

\textsuperscript{27} Law Commission, Inchoate Liability for Assisting and Encouraging Crime (Law Com. No. 300, 2006) B27.
applied to online actions, and modernise the language of the offence. The amendment shifted the offence from one of aiding and abetting and attempting to an inchoate offence as defined in Part 2 of the Serious Crime Act 2007. The inchoate offence is committed by an act capable of encouraging or assisting suicide regardless of whether suicide is actually committed or attempted. Therefore, the new offence applies when ‘a person does an act which is capable of encouraging or assisting another person to commit or attempt to commit suicide, and intends his act to so encourage or assist. The person committing the offence need not know the other person or even be able to identify them’.

Section 2(4) of the 1961 Act requires the consent of the Director of Public Prosecutions (‘DPP’) to initiate criminal proceedings under Section 2(1). Crown Prosecutors assess the cases reported according to the Full Code Test. The Code establishes a two-stage procedure, the evidential test and the public interest test,

28 Maria Eagle, Ministerial Statement, 17th September 2008 (Hansard col142WS).


which Prosecutors must apply.\textsuperscript{32} If sufficient evidence exists to justify a prosecution, prosecutors must consider whether prosecution is in the interest of the public. Assisted suicide cases are recorded by the Crown Prosecution Service (‘CPS’) headquarters and dealt with by the Special Crime and Counter Terrorism Division.\textsuperscript{33} The DPP consents to a prosecution only if the Full Code Test is satisfied.

In 2009, the House of Lords ordered the DPP to issue an offence-specific Policy for assisted suicide cases ‘to clarify what his position is as to the factors that he regards as relevant for and against prosecution’.\textsuperscript{34} Two months following the House of Lords decision, an Interim Policy was published followed by a 12-week public consultation process.\textsuperscript{35} The final Policy was released ten weeks later.\textsuperscript{36} The Policy identifies the facts and circumstances Crown Prosecutors need to consider when deciding whether or not to initiate proceedings under Section 2(1). The Policy enlists factors favouring prosecution, for instance, the victim being under 18, questionable mental capacity of the victim, or a malicious motivation by the assister;\textsuperscript{37} and factors against prosecution, for instance, the victim taking a voluntary, clear, settled and informed decision, or the


\textsuperscript{34} R (on the application of Purdy) v DPP [2009] UKHL 45 [55].


\textsuperscript{36} The Final Policy was published on the 25\textsuperscript{th} of February 2010, available at: \url{http://www.cps.gov.uk/publications/prosecution/assisted_suicide_Policy.pdf} accessed 27 September 2017.

\textsuperscript{37} ibid para 43.
assister been wholly motivated by compassion.\textsuperscript{38} The Policy does not decriminalise assisted suicide and does not grant prosecutorial immunity for assisting or encouraging the suicide or attempted suicide of another individual under Section 2(1). Overall, Part 1.1 discussed the assisted suicide law in England and Wales to set the legal context for the discussion that follows.

1.2 Assisted Suicide Law Reform in England and Wales

Several unsuccessful attempts, mostly by means of Private Members’ Bills in Parliament,\textsuperscript{39} have been made in order to reform the assisted suicide law in England and Wales.\textsuperscript{40} Part 1.2 provides a brief overview of these attempts with an emphasis on the CAD. This overview is deemed necessary because it will act as referencing point for the analysis throughout this thesis. The emphasis of the analysis is on the CAD as the CAD’s three eligibility criteria and the findings of the CAD’s Report, as such, are used as starting point for the analysis in this thesis.

1.2.1 Patient (Assisted Dying) Bill 2003

\textsuperscript{38} ibid para 45.

\textsuperscript{39} See also, the two failed amendments to the Coroners and Justice Bill in 2008-2009 by Lord Falconer and Patricia Hewitt MP who envisaged protection for those who assist a loved one to travel abroad to receive assistance in dying.

\textsuperscript{40} However, see also attempts to legalise voluntary euthanasia: The Voluntary Euthanasia (Legalisation) Bill introduced to the House of Lords by Arthur Ponsonby (HL Deb 1 December 1936, vol103, cols465-505); a euthanasia motion introduced by Lord Chorley of Kendal in 1950 to the House of Lords that was withdrawn following heavy criticism (HL Deb 28 November 1950, vol169 cols552-598); and in 1967, Mary Rose Barrington drafted a Bill on voluntary euthanasia, however, it wasn’t until 1969 that Lord Raglan agreed to introduce it to the Lords following unsuccessful attempts to find an MP willing to present it to the House of Commons (HL Deb 25 March 1969, vol300 cols1143-1254).
The Patient (Assisted Dying) Bill 2003 (‘PADB’), a Private Members’ Bill, was introduced by Lord Joffe, a life peer, to the House of Lords in 2003.\(^{41}\) It aimed to enable a competent adult suffering unbearably as a result of a terminal or a serious and progressive physical illness to receive medical help to die at his own considered and persistent request. The Bill also made provisions for the individual to receive pain relief medication. It did not proceed further than the Second Reading stage, which took place on the 6\(^{th}\) of June 2003.\(^{42}\)

### 1.2.2 Assisted Dying for the Terminally Ill Bill 2004-2006

The Assisted Dying for the Terminally Ill Bill 2004 (‘ADTIB 2004’) was a revised version of the PADB. It was introduced by Lord Joffe to the House of Lords on the 8\(^{th}\) of January 2004.\(^{43}\) The Bill aimed to enable a competent adult suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request. The Bill also made provisions for the individual to receive pain relief medication. The Bill had its Second Reading on the 10\(^{th}\) of March 2004,\(^{44}\) and was subsequently referred to a House of Lords Select Committee (‘HLSC’).\(^{45}\)

The HLSC reported on the 4\(^{th}\) of April 2005.\(^{46}\) Based on its recommendation, the revised ADTIB 2005 was introduced to the House of Lords on the 9\(^{th}\) of November 2005. The Bill aimed to enable an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his

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\(^{41}\) Patient (Assisted Dying) HL Bill (2002-03) 37.  
\(^{42}\) HL Deb 6 June 2003, vol648, cols1585-1690.  
\(^{43}\) Assisted Dying for the Terminally Ill HL Bill (2003-04) 17.  
\(^{44}\) HL Deb 10 March 2004, vol658, cols1317-1324.  
\(^{45}\) The three official reports that the HLSC produced are available at: <http://www.publications.parliament.uk/pa/ld/ldasdy.htm> accessed 27 September 2017.  
own considered and persistent request; and for connected purposes. The Bill again did not proceed further than the Second Reading debate, which took place in the House of Lords on the 12th of May 2006. The HLCS’s investigation was significant. Some of its findings and conclusions, as well as the evidence collected and used in its investigation are used throughout this thesis to inform its analysis.

1.2.3 Assisted Dying Bill 2013-2017

The Assisted Dying Bill 2013 (‘ADB 2013’) was a Private Members’ Bill first introduced to the House of Lords by Lord Falconer of Thornton on the 15th of May 2013. It was based on the findings of the CAD, which is separately examined below. The Bill aimed to enable competent terminally ill adults to be provided at their request with specified assistance to end their own life; and for connected purposes. The Bill ran out of time as the 2013-2014 parliamentary session was prorogued, and the Bill made no automatic progress to the next session. The Bill was re-tabled with the new parliamentary session and had its first reading again on the 5th of June 2014. There was consensus amongst the Lords during the Bill’s Second Reading debate on the 18th of July 2014 that Parliament had to consider the issue. Therefore, the ADB 2014 proceeded to Committee, the first time that such a Bill proceeded beyond the Second Reading stage in Parliament. The Bill had two days of Committee debate on the 7th of November 2014, and on the 16th of January 2015. There was no further debate in

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the House of Lords. However, some amendments discussed during the Committee debates, most importantly the judicial oversight of the assisted dying procedure, were used to draft the ADB No.2 that was introduced by Labour MP Rob Marris on the 24th of June 2015, this time to the House of Commons. Rob Marris topped the ballot for Private Members' Bills, with Lord Falconer only securing the 21st place. The Bill aimed to enable terminally ill competent adults to choose to be provided with medically supervised assistance to end their own life. The Bill was rejected by the Commons at its Second Reading on the 11th of September 2015. It was the first time in 20 years that the Commons had an opportunity to debate the issue. Lord Hayward has introduced an identical Bill ('ADB 2016') in the House of Lords on the 9th of June 2016. At the time of writing, there is no scheduled Second Reading. The Bill aims to enable competent terminally ill adults to be provided at their request with specified assistance to end their own life; and for connected purposes.

1.2.4 The Commission on Assisted Dying 2010-2012

The CAD was established in September 2010 following an initiative and funding by two individuals: Sir Terry Pratchett, the celebrated British novelist, and Mr Bernard Lewis, a businessman. It was publicly launched in November 2010 to consider the legal and policy approach on assisted dying in England and Wales. The CAD was self-professed as: ‘an independent body that will reach conclusions based upon the evidence brought before it [and will] act entirely independently and [...] alone will be responsible for its

52 HL Deb 16 January 2015, vol758, cols1001-1070.

53 Assisted Dying (No.2) HC Bill (2015-16) 7.

54 HC Deb 11 September 2015, vol599, cols656-728.

55 Assisted Dying HL Bill (2016-17) 42.

conclusions [...] independent from DEMOS and the funders’. DEMOS, a leading cross-party think-tank pursued secretariat and administrative support. Dignity in Dying (‘DID’), a national campaign and membership organisation supporting the legalisation of assisted dying for competent terminally ill adults, ‘brokered the relationship’ between DEMOS and the funders. DEMOS agreed to host the investigation on the understanding that neither DID, nor the two funders, will be further involved.

The CAD’s investigation involved a public call for evidence producing over 1200 responses by practitioners, professional bodies, and the public; six public meetings producing specialist evidence by health and social care professionals, practitioners, academics, the police, and by individuals affected by the current law; and research founded upon the study of four jurisdictions: the Netherlands, Belgium, Oregon in the US, and Switzerland. These international visits produced new evidence on the link between suicide and serious physical illness; the attitudes of ‘vulnerable groups’ towards assisted dying; and the efficiency of safeguards and quality of palliative care. The CAD’s Commissioners carried out Interviews and meetings with practitioners, policy-makers, and regulators to assess professional and other views on the law and its functionality. Some of the resulting evidence is used throughout the thesis to inform the analysis. The CAD recognised some limitations on the evidence collected as some organisations and individuals declined to submit evidence, including


58 Ibid.


63 All the evidence collected and produced by the CAD is available on the CAD’s official website.
the British Medical Association, and the pro-life organisation Care Not Killing.\textsuperscript{64} This is also remarked by the Justices of the Supreme Court in the case of \textit{Nicklinson}.\textsuperscript{65} Even so, the investigation is deemed to be measured and thorough, drawing upon wide-ranging and authentic sources. The CAD’s Report is indeed referenced in several parts of the \textit{Nicklinson} judgment, and the Justices of the Supreme Court place significant emphasis on it.\textsuperscript{66} It is also evident that many organisations opposing legalisation have indeed submitted evidence; including, most importantly, the Royal College of General Practitioners (‘RCGP’).\textsuperscript{67}

The CAD presented its findings on the 5\textsuperscript{th} of January 2012 by means of a 400-page Report concluding that the current status of the law is ‘inadequate and incoherent and should not continue’.\textsuperscript{68} The Report evaluates the status of the current law, examines the potential form of a legalisation framework, and investigates which approach would be most acceptable by the majority of health and social care professionals and the general public.\textsuperscript{69} The investigation was carried out against the following terms of reference:

- \textit{to investigate the circumstances under which it should be possible for people to be assisted to die}

\textsuperscript{64} CAD’s Report, p. 39.

\textsuperscript{65} \textit{R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) v The Director of Public Prosecutions; R (on the application of AM) v The Director of Public Prosecutions} [2014] UKSC 38 [175] (Lord Mance) and [224] (Lord Sumption).

\textsuperscript{66} ibid. [14], [53]-[54], [88], [121]-[123] (Lord Neuberger), [175], [185] (Lord Mance), and [224]-[225] (Lord Sumption).

\textsuperscript{67} Evidence from the RCGP

\textsuperscript{68} CAD’s Report, pp. 1, 19, 416.

\textsuperscript{69} ibid p. 2.
• to recommend what system, if any, should exist to allow people to be assisted to die
• to identify who should be entitled to be assisted to die
• to determine what safeguards should be put in place to ensure that vulnerable people are neither abused nor pressured to choose an assisted death
• to recommend what changes in the law, if any, should be introduced.  

The CAD concluded that the choice of assisted dying should be given to terminally ill adults only who experience ‘a degree of suffering towards the end of their life’ that cannot be alleviated by ‘skilled end-of-life care’. The CAD suggested that a legal framework should be devised that would set out ‘strictly defined circumstances’ under which terminally ill people will be assisted to die by means of the support of health and care professions and by means of robust upfront safeguards to prevent ‘inappropriate requests falling outside the eligibility criteria’. Some ‘key elements’, for instance, clearly defined eligibility criteria, a good level of care and support services, and properly trained health and social care staff, were also deemed essential. This thesis examines the core of the CAD’s Report, namely, the three eligibility criteria proposed:

- **The person concerned is aged 18 or over and has a diagnosis of terminal illness.**
- **The person is making a voluntary choice that is an expression of his or her own wishes and is not unduly influenced by others.**
- **The person has the mental capacity to make a voluntary and informed choice, and the person’s decision-making is not significantly impaired as a result of mental health problems such as depression.**

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70 ibid pp. 1, 19.

71 ibid pp. 19 and 24.


73 For a complete list see: CAD’s Report, pp. 19-20.

The study of, specifically, the CAD’s three eligibility criteria is justified because of my previous study of the Assisted Dying Bill 2013 (‘ADB’). In this study of the Bill, which was based on the CAD’s findings, I identified significant practical shortcomings, such as the terminal illness eligibility criterion, that I wished to further explore. Moreover, because I suggest that ultimately, how legalisation will take place may hinge on whether it can ever be realised. In other words, if it is shown that there is a workable framework on which assisted suicide can be given effect in England and Wales then the debate on its legalisation may become less polarised. And, finally, because a review of the literature on assisted suicide, as also highlighted in the Introduction of this thesis, revealed abundant materials on whether assisted suicide should be legalised, but limited commentary on who should be eligible to request an assisted death in case of legalisation.

Similar to the approach adopted by the CAD, this thesis concentrates not on whether the law should change, but how the law could change if Parliament decides that such change is necessary. The relevant passage from the CAD’s Report is worth quoting in its entirety:

‘The ethical perspectives on assisted dying at both ends of the spectrum remain polarised, and indeed they may be fundamentally irreconcilable. The Commission has not sought to resolve this ongoing ethical debate, which is a matter for Parliament to decide on behalf of the British public. Instead, the Commissioners have set out to understand the perspectives of all of those with a firm ethical position on assisted dying [...] while focusing on collecting evidence that can provide insights into the practical issues that are at the heart of the debate’.  

Hence, the CAD’s investigation assumes that if Parliament in the future considers that the time is right for legalisation, and if the ethical arguments in both ‘ends of the spectrum’ can be reconciled, then the CAD’s findings should be considered.

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76 CAD’s Report, pp. 37-38.
1.2.5 The CAD’s Composition

A significant point to consider in relation to the CAD is the criticism it received on its composition or membership. This is not a unique criticism. The Commission on the Bill of Rights (‘CBR’), for example, which formed around the same time as the CAD, received similar criticism. This criticism cannot be ignored given that this thesis examines the core of the CAD’s Report, the three eligibility criteria proposed in case of legalisation. Section 1.2.5 argues that, despite the fact that the majority of those involved with the CAD had a previous interest in the legalisation debate before joining the CAD, the CAD’s Report is still a credible source of research. In particular, this

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80 See also: James Woodward website <https://jameswoodward.info/?s=commission+on+assisted+dying> accessed 28 September 2017. The Reverend Canon Dr James Woodward, the only dissenting Commissioner, praised the CAD’s
refers to the Chairman and coordinator of the CAD, Lord Charles Falconer, the majority of the Commissioners (that Lord Falconer personally invited to join the CAD), as well as other parties involved. The background of each of the parties involved in the CAD’s investigation and subsequent Report is examined below.

Prior to his involvement with the CAD, Lord Falconer proposed an amendment to the Coroners and Justice Bill in an attempt to lessen the effects of Section 2(1) of the Suicide Act 1961. The amendment was voted down in the House of Lords by 194 to 141. He has made his views in favour of legalisation of assisted dying known in numerous occasions. Professor Sam H. Ahmedzai, Head of the Academic Unit of Supportive Care at the School of Medicine and Biomedical Sciences at the University of Sheffield, and one of the CAD’s Commissioners, has experience in palliative investigation on its quality, expertise, and ‘significant contribution to the on-going debate’, and described it as ‘a substantial piece of work’ that should not be dismissed by critics.

For instance, the late Sir Terry Pratchett, the British celebrated novelist who funded the CAD, was a vocal proponent of the legalisation of assisted dying. See: ‘Assisted suicide report causes mixed reaction among campaigners’ The Guardian (January 5, 2012) <http://www.theguardian.com/society/2012/jan/05/assisted-suicide-report-mixed-reactions> accessed 25 September 2017; and Pratchett’s television documentary ‘Terry Pratchett: Choosing to Die’ (2001). The CAD’s funding was also an issue discussed in the Supreme Court in R (on the application of Nickinson and another) v Ministry of Justice; R (on the application of AM) v The Director of Public Prosecutions; R (on the application of AM) v The Director of Public Prosecutions [2014] UKSC 38 [53].


medicine and was involved with the research and treatment of cancer patients.\textsuperscript{84} Professor Ahmedzai has written in the British Medical Journal in 2012 indicating that his involvement with the CAD, as well as his regular professional visits to the Netherlands, changed his views on assisted dying in favour of legalisation.\textsuperscript{85} Lord Ian Blair of Boughton, a Cross Bench Peer and former Commissioner of the Metropolitan Police, is another Commissioner who has a well-founded opinion in favour of assisted dying.\textsuperscript{86} Sir Graeme Catto, a CAD Commissioner, is the President of the College of Medicine, and former President of the General Medical Council. He was a Chairman of DID, therefore his interest in the legalisation of assisted dying cannot be disputed.\textsuperscript{87} Dr Carole Dacombe was a CAD’s Commissioner and a Medical Director at St Peter’s Hospice. She has extensive practical experience of hospice care and she is heavily involved with palliative care. Dr Dacombe has expressed her views in favour of the legalisation of assisted dying in the House of Lords.\textsuperscript{88} Penny Mordaunt is a Conservative Party MP for Portsmouth North. She was the founding Chairman of the All-Party Parliamentary Group (‘APPG’) on Choice at the End of Life that is concerned

\textsuperscript{84} CAD website <http://www.commissiononassisteddying.co.uk/commissioners/> accessed 26 September 2017.


\textsuperscript{88} HL Deb 10 October 2005, vol674, col50.
with issues such as how to ‘ensure that dying adults have more control over where, when and how they die.’ 89 The group is composed of MPs and Peers and DID is the group’s secretariat. 90 There is no doubt that she is a proponent of assisted dying. The APPG is in fact responsible for the drafting of the ADB 2013, 91 which was based on the CAD’s findings. 92 Baroness Elaine Murphy of Aldgate is an independent crossbench life peer, Secretary to the APPG on Mental Health, and a vice-president of the Alzheimer’s Society with considerable psychiatric medical expertise. Similar to Lord Blair, she expressed her views in favour of assisted dying in the House of Lords in 2013. 93 She argues that everyone, regardless of disability or terminal illness, should access the same rights, including a right to an assisted death. 94 Baroness Barbara Young of Old Scone is a life peer at the House of Lords, and Chancellor of Cranfield University. She submitted evidence to the House of Lords Select Committee (‘HLSC’) in 2005 proclaiming her support towards the legalisation of assisted dying and stated that palliative care is sometimes not adequate at the end of life. 95 Baroness Young is therefore another Commissioner with an established view on the legalisation debate. It is evident, therefore, that the CAD has been predominantly formed by parties with direct interest, or previous involvement in the legalisation debate. Hence, it is now to


90 Note the involvement of DID with the CAD’s establishment discussed earlier.


93 HL Deb 12 December 2013, vol750, col901.


95 HL Deb 10 October 2005, vol674, col126.
be examined whether there is value in using the CAD’s Report in this thesis. Two main arguments are advanced to support the argument that the CAD’s Report is indeed a credible source of research.

The first argument refers to the Commissioners’ expertise and diversity. A closer look at the information presented for each Commissioner points towards individuals with significant and relevant experience and knowledge. Examples include Professor Ahmedzai, palliative medicine and cancer specialist with special interest in patients’ quality of life, Sir Catto, medical professional concerned with end-of-life care, and Dr Dacombe, who has broad hospice care experience and deals extensively with patients and families facing terminal illnesses. Reverend Dr Woodward, the dissenting Commissioner, offers the ethical and religious prospective on issues such as ageing, death, and loss and the end-of-life. Lord Falconer, Baroness Murphy, and Baroness Young, who were previously involved with the reform of the law on assisted suicide, can make (and indeed have made) a positive contribution to the review of the assisted suicide law by means of the CAD’s investigation. In terms of the diversity argument, the CBR and the criticism it received in relation to its composition are relevant. The CAD is equally comprised of both genders, six males and five females, of a diverse age range, background, and professional qualification. In contrast, the CBR was formed by individuals in their late 60s, all Queen’s Counsels, and only one female. The CAD’s Commissioners come from varying occupations and are not just involved with politics; examples include a law enforcement officer, healthcare professionals, and individuals involved with the law. Thus, the CAD’s investigation is backed by a well-informed and diverse panel of individuals.


97 See a similar argument in R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) v The Director of Public Prosecutions; R (on the application of AM) v The Director of Public Prosecutions [2014] UKSC 38 [53] (Lord Neuberger).
Secondly, the amount and quality of evidence collected by the CAD point towards an informed and detailed investigation. Briefly, the evidence consisted of 1200 responses by professional bodies and the public; specialist evidence by health/social care professionals, practitioners, academics, the police, and individuals affected by the current law; and evidence collected as a result of four international visits to jurisdictions that permit a form of assisted death. The CAD acknowledged that certain ‘prominent individuals and organisations’ opposing all forms of assisted suicide have denied DEMOS’ call for evidence including, the British Medical Association and the pro-life organisation Care Not Killing. The CAD emphasised, however, that it is ‘confident that the evidence they have received is of a high quality and sufficiently varied and detailed to enable the Commissioners to tackle the issues under consideration’. The CAD’s Report is indeed referenced in several parts of the Nicklinson judgment, indicating that the Justices of the Supreme Court place considerable attention on it. In addition, the collected evidence indicate that despite prominent organisations such as the British Medical Association declining to

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100 CAD’s Report, p. 39.
101 R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) v The Director of Public Prosecutions; R (on the application of AM) v The Director of Public Prosecutions [2014] UKSC 38 [14], [53]-[54], [88], [121]-[123] (Lord Neuberger), [175], [185] (Lord Mance), and [224]-[225] (Lord Sumption).
102 It is interesting to note that the British Medical Journal, a subsidiary of the BMA, is reportedly supporting assisted dying using its editorial independence. This raises questions as to whether the BMA members agree with the official stand of the organisation. See, for instance, ‘Terminally ill people should have choice to end their lives, BMJ argues’ The Guardian (July 2, 2014) <http://www.theguardian.com/society/2014/jul/02/terminally-ill-choice-end-lives-bmj-assisted-dying> accessed 28 September 2017; and Fiona Godlee, ‘Why the Assisted Dying Bill should become law in England and Wales’ (2014) 349 BMJ g4349, available at <http://www.bmj.com/content/349/bmj.g4349> accessed 28 September 2017.
submit evidence, several organisations which likewise oppose legalisation have submitted evidence, including the Royal College of General Practitioners (‘RCGP’). Therefore, it can be argued that the assumed ‘gap’ in the evidence is filled and that the arguments of both sides of the debate are represented. As noted by the dissenting Commissioner Reverend Dr James Woodward, the legitimacy of the CAD’s research should not be ignored, neither its coherence, rigour, nor its quality of work. Therefore, based on these two arguments, the diversity of the panel and the breadth of the evidence gathered, it is argued that the CAD’s Report is indeed a credible source of research despite most parties involved with the investigation having a previous interest in the legalisation debate.

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103 Evidence by Professor Amanda Howe, Honorary Secretary of Council, Royal College of General Practitioners (‘RCGP’)

1.3 Concluding Remarks

Part 1.1 discussed the assisted suicide law in England and Wales. Part 1.2 provided an overview of the recent attempts to reform the law on assisted suicide in England and Wales. Emphasis was placed on the CAD, the most recent review of the law, because of its significance for this thesis. Overall, the analysis highlighted not only the link of the CAD to this thesis but also that, despite the criticism with regards to its composition or membership, that it is a credible source of research. The CAD’s Commissioners have relevant and significant expertise on issues relevant to assisted dying, and come from diverse backgrounds and occupations; hence they are able to offer a diverse stand and expertise on the investigation. The CAD’s Report and findings, as well as the quality and range of its collected evidence reveal unexplored themes on the assisted suicide debate. This thesis, therefore, is justified in using its three proposed eligibility criteria as a starting point in its investigation of how an assisted dying framework could look like in the future in England and Wales.
Chapter Two: Assisted Dying and Human Rights

Chapter Two is the second introductory Chapter of the thesis. It is concerned with assisted dying and the European Convention on Human Rights (‘ECHR’).\(^1\) Other international human rights treaties, such as the UN International Covenant on Civil and Political Rights of 1966,\(^2\) or the EU Charter of Fundamental Rights of 2000,\(^3\) are also potentially relevant to this area. However, the direct applicability of the ECHR in UK law by means of the Human Rights Act (‘HRA’), the right of individual petition under Article 34, as well as its rich jurisprudence on assisted dying and related questions as a result, makes the ECHR the most relevant human rights treaty for our purposes.

The ECHR is a binding international human rights treaty drafted by the Council of Europe, a regional intergovernmental organisation formed after World War II. It was signed on the 4\(^{th}\) of November 1950 and came into force on the 3\(^{rd}\) of September 1953. It was the first treaty to give effect to some rights found in the Universal Declaration of Human Rights of 1948 and turn them into practical and enforceable rights. It has since been ratified by all forty-seven Members States of the Council of Europe. In 1959, the European Court of Human Rights (‘ECtHR’) was established in Strasbourg, France. It is an international, permanent court of full-time judges, which hears state and individual applications alleging violations of the rights guaranteed by

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\(^1\) Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR).


\(^3\) Charter of Fundamental Rights of the European Union 2000/C 364/01.
the ECHR. The judgments of the ECtHR are binding in international law (Article 46(1)) but States are not under an obligation to give them direct effect. The execution of the judgments is overseen by the Committee of Ministers of the Council of Europe, which is formed by government representatives of the forty-seven Members States (Article 46(2)).

The UK played a vital role in the drafting of the ECHR in 1949 and was one of the first states to ratify it on the 8th of March 1951. It was however incorporated into domestic law much later, by the Human Rights Act 1998 (‘HRA’) which came into force in 2000. Section 1 of the HRA defines ‘the Convention rights’ as the fundamental rights and freedoms in Articles 2-12 and 14 of the ECHR. Section 3(1) provides that, ‘so far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the Convention rights’. Section 4 provides that a statutory provision can be declared incompatible with the ECHR by means of a declaration of incompatibility by senior courts. Section 6 provides that it is ‘unlawful for a public authority to act in a way which is incompatible with a Convention right’. The enactment of the HRA had, and to this day continues to have, enormous impact on the development of domestic law including healthcare law,

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regulation, and relevant policies\(^7\) and despite on-going governmental and other proposals for its repeal and possible replacement by a British Bill of Rights.\(^8\)

For assisted dying, the most relevant ECHR provisions are Article 2, which guarantees the right to life subject to the exceptions in subsection 2, and Article 8, the right to respect for private and family life, home and correspondence. It is important to note that other ECHR provisions are also relevant, and have indeed been used in legal cases concerning assisted dying. Examples include Article 3 (prohibition on torture and inhuman or degrading treatment or punishment), Article 9 (freedom of thought, conscience and religion), and Article 14 (prohibition of discrimination).\(^9\) This thesis focuses on Article 2 and Article 8. This is because these two provisions have been mostly used, and are currently used, in the legal challenges of the criminal prohibition on assisted suicide in England and Wales. Most importantly, it is under Article 8 that the right to self-determination in issues of life and death has been recognised by the

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ECtHR, and it is Article 2 that is mostly used to argue against legalisation of assisted dying because of the need to protect health and life. Accordingly, Part 2.1 of this Chapter discusses Article 2, and Part 2.2 discusses Article 8. In addition, the analysis in both Parts briefly discusses the ethical principles of the sanctity of life and autonomy that underpin Article 2 and Article 8 respectively. This analysis is followed by Part 2.3 which analyses the human rights legal cases in England and Wales that relate to assisted dying. Overall, Chapter Two reveals the conflict between human rights law and the current prohibition on assisted suicide. Chapter Two aims to provide the human rights context relating to assisted dying, and to act as a reference point for the rest of the thesis.
2.1 Article 2: The Right to Life

ARTICLE 2 - Right to life

1. Everyone’s right to 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.

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

The ECHR is the first international human rights treaty to give detailed protection and legal enforcement to the ‘right to life’. Article 2 is the most basic, fundamental human right because if individuals are arbitrarily deprived of life, or from their right to life, all other rights become illusory. Some commentators argue that Article 2 protects human existence and the biological process, the starting point and precondition of rights recognition. As a general rule, Article 2 cannot be derogated

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10 See, in contrast, Article 3 of the UN Universal Declaration of Human Rights: ‘Everyone has the right to life, liberty and security of person’ [emphasis added].


from in times of war or other public emergency. Together with Article 3 it ‘enshrines one of the basic values of the democratic societies making up the Council of Europe’ and so, according to the ECtHR, its provisions ‘must be strictly construed’. Article 2 creates a positive obligation to protect the right to life (Article 2(1)), as well as a negative obligation not to deprive individuals from their life, subject to the exceptions set in Article 2(2). Chapter Six explores the state obligations under Article 2 in the context of assisted dying and the argument of the thesis. Although there can be no doubt on the fundamental nature of the provision, its interpretation by the ECtHR and enforcement by states has emerged only recently.

2.1.1 The Language of Article 2

The first sentence of Article 2(1) states that ‘everyone’s’ right to ‘life’ shall be protected by law. ‘Life’ means human life: neither the right to life of animals, nor the right to existence of ‘legal persons’ is protected by Article 2. The ECHR does not otherwise define ‘life’, neither specifies the circumstances when ‘life’ should be protected, or when it begins, or ends. Elizabeth Wicks argues that human consciousness and the sanctity of human life are two considerations that may justify the special value placed on human life and its special protection by the ECHR and

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13 But see: Article 15(2) of the ECHR: ‘No derogation from Article 2, except in respect of deaths resulting from lawful acts of war’ [emphasis added].

14 McCann and others v the UK (1996) 21 EHRR 97 [147].


18 ibid.
other treaties.\textsuperscript{19} The debate on what makes human life valuable, thus in need of special protection, is vast. The principle of the sanctity of human life, however, is considered below as the principle that underpins Article 2. The second question in relation to the language of Article 2 is the meaning of ‘everyone’. As Douwe Korff notes, animals are not ‘persons’ therefore are not protected under the term ‘everyone’ (\textit{toute personne}).\textsuperscript{20} In the text of the ECHR, ‘everyone’ is used by Article 2 and ‘no one’ by Article 3. The ECHR refers to ‘a person’ only in relation to Article 7(2),\textsuperscript{21} and to ‘men and women’ in Article 12.\textsuperscript{22}

\textsuperscript{19} See further details: Elizabeth Wicks, \textit{The Right to Life and Conflicting Interests} (Oxford University Press 2010) Chapters 1 and 2.


\textsuperscript{21} But see: \textit{Vo v France} [2004] ECHR 326, and the use of ‘persons’ by the ECtHR in the context of Article 2.

2.1.2 Article 2 and the Sanctity of Human Life

Article 2 protects a principle, an idea most sacred for some individuals: the inherent value of human life. The debate in relation to the value of human life is usually expressed by two competing, mutually exclusive approaches: the sanctity of life and the quality of life; however, John Keown, the leading authority for the former approach, argues that there is also a third approach. An overview of the three approaches in relation to the valuation of human life, alongside a discussion on how Article 2 fits into these, follows below.

The Vitalism Approach

John Keown’s third approach is called ‘Vitalism’. According to this approach, human life has an absolute moral value and is the supreme good; therefore, it should never be taken, shortened, or not prolonged. In a healthcare context, Vitalism demands that patients’ lives be maintained and preserved at all costs, and doubtless prohibits the active shortening of life regardless of pain, suffering, or other considerations. Vitalism can become exhausting for the healthcare system and its available, yet

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limited, means as it would require a great deal of resources, financial and other, to preserve life indefinitely. Keown himself notes that Vitalism is absolute and impractical, giving the examples of an anencephalic new-born and a dying centenarian; ‘[vitalism] is as ethically untenable as its attempt to maintain life indefinitely is physically impossible’. Other commentators agree: for instance, Jonathan Glover notes that the argument that taking life is always wrong is ‘absolute pacifism’, and David Price highlights its impractical nature. Moreover, Vitalism received judicial criticism for being too extreme, for example, in Re A (Children) (Conjoined Twins: Separation). In the case, the conjoined twins had to be surgically separated; otherwise, the weaker twin’s continued existence would have led to the death of the stronger twin, who oxygenated blood for them both, within a few months. The application of Vitalism in that case would mean that the

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27 See further: Shaun D. Pattinson, Medical Law and Ethics (4th edn, Sweet and Maxwell 2014) 18.


31 [2000] 4 All ER 961. The hospital sought, and was eventually granted, a declaration from the Family Division to carry out the operation. The parents appealed to the Court of Appeal which upheld the lower court’s decision.

surgery/separation should not have been performed; in which case both babies would have died. With regards to Vitalism, the General Medical Council (‘GMC’) guidance on Treatment and Care at the End of Life suggests that, although there is a presumption in favour of life which requires healthcare professionals to take all reasonable steps to prolong life, there is no absolute obligation to prolong life disregarding the consequences and any views by the patient.33 The very fact that human life itself cannot be preserved indefinitely, and all human and other beings will eventually die, indeed shows the problematic nature of the approach.

It is evident from the language, interpretation, and application of Article 2 that Article 2 does not endorse the Vitalism approach. Specifically, Article 2(2) qualifies the ‘right to life’ by listing circumstances in which the protection of life does not apply.34 Article 2(2) creates three exceptions when ‘use of lethal force’ may be used: in defence of any person from unlawful violence, to effect a lawful arrest, or to prevent the escape of a person lawfully detained, and in action lawfully taken for the purpose of quelling a riot or insurrection.35 These exceptions apply only when ‘absolutely necessary’, which differentiates the application of Article 2 from other ECHR provisions.36 The jurisprudence of the ECtHR establishes that the use of the term ‘absolutely necessary’ indicates a stricter and more compelling ‘test of necessity’, as opposed to ‘necessary in


35 Article 2(1) creates one further exception which reads as follows: ‘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 death penalty was, however, abolished by Protocols 6 and 13 of the ECHR.

a democratic society’ requirement found in Articles 8-11.37 None of the Article 2(2) exceptions relate directly to medico-legal matters, including assisted dying.38 In essence, what Article 2(2) says is that the ECHR treats human life as not of absolute moral value, thus in some circumstances allowing its deprivation, even its intentional deprivation in specified circumstances.

The Quality of Life Approach39

The Quality of Life approach maintains that life has no inherent or supreme value in itself; rather, life is valuable because it allows us to do things which make life valuable.40 In other words, the Quality of Life approach depends on the ‘utility’ of life and on a certain threshold of quality.41 For some individual patients, for instance, because of disease, injury, or disability, this threshold will not be met; therefore allowing even for the intentional termination of life by an act or an omission.42 Since

37 McCann and Others v the UK (1996) 21 EHRR 97 [149].
the Quality of Life approach focuses on the utility of life, if this is diminished then the right to end one’s life should be granted. Proponents of the Quality of Life approach would, for instance, support abortion, assisted suicide, and euthanasia. John Keown does not endorse the Quality of Life approach because of its absolute character; it denies the ‘ineliminable value of each patient’ and produces discriminatory judgments especially when judging what type of disability and to what degree this makes or does not make life worth living. This means that individuals may be judged to have a different, or lesser, ‘value of life’ and as such, be discriminated in relation to the protection offered under Article 2 or other international human rights treaties. John Keown does not support this approach also because it is not concerned with the assessment of the worthwhileness of the patients’ proposed treatment, but with the worthwhileness of the patients’ life, focusing on things such as mental or physical disabilities. The Catholic Church’s stand, reflected in the Archbishop of Westminster’ submission in the Conjoined Twins case, is firmly against the Quality of Life approach: ‘it is seriously unreasonable to seek to justify the ending of someone’s life on the grounds that that human being’s life lacks value or worth, so that he or she would be better off dead.’ L.J. Ward in the same case remarked that in light of international treaties protecting the right to life ‘it is impermissible to deny that every


45 ibid. 487.

46 Re A (Children) (Conjoined Twins: Separation) [2000] 4 All ER 961 (CA).

life has an equal inherent value’. The judge in particular noted that life is worthwhile in itself notwithstanding ‘the diminution in one’s capacity to enjoy it and however gravely impaired some of one’s vital functions of speech, deliberation and choice may be’. The Quality of Life approach, however, has many proponents. For instance, Richard Huxtable endorses a self-determined value of life. According to this principle, which prioritises the autonomous agent’s assessment, life has the value that the autonomous individual determines life has. Peter Singer is another proponent of the Quality of Life approach. In his influential book, *Rethinking Life and Death: The Collapse of Our Traditional Values*, for instance, he argues that western society has embraced the Quality of Life approach in its actions and decisions. However, the emphasis by some on the Sanctity of Life approach that is analysed below, leads modern medicine to some incoherent and illogical decisions.

Article 2, its language and interpretation also do not endorse the Quality of Life approach. Article 2 guarantees to *everyone* the ‘right to life’. There is no reference to any ‘threshold of quality’ affected by disease, injury, or disability. The provision guarantees to *everyone* an inherent, equal value of life. John Keown confirms that the Quality of Life approach goes against national and international human rights

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48 *Re A (Children) (Conjoined Twins: Separation)* [2000] 4 All ER 961 (CA).

49 Ibid.


53 Ibid.

54 *Re A (Children) (Conjoined Twins: Separation)* [2000] 4 All ER 961 (CA) 1000 (Ward LJ): ‘each life has inherent value in itself and the right to life, being universal, is equal for all of us’.
treaties.\textsuperscript{55} Most significantly, the approach fails to recognise the most fundamental human rights concept: that rights are enjoyed by \textit{all} human beings by reason of their shared humanity, and that \textit{all} humans should be treated as valuable and deserving respect.\textsuperscript{56} Elizabeth Wicks indeed remarks that ‘the principle of equality is at the heart of human rights law and the idea of excluding a category of human beings, for whatever reason, cannot be compatible with this body of law. All living human beings are entitled to the protection afforded by a right to life’.\textsuperscript{57} The right to life is protected by law ‘regardless of life expectancy, regardless of quality of life, and regardless of the conflicting needs of healthier, younger and more viable individuals’.\textsuperscript{58} Ronald Dworkin, along similar lines, also argued that everyone has an equal right to life; ‘the murder of a depressive handicapped octogenarian misanthrope is as heinous, and must be punished as seriously, as the murder of anyone younger or healthier or more valuable to others’.\textsuperscript{59}

\textbf{The Sanctity of Life Approach}

The Sanctity of Life approach states that human life is an intrinsic, basic good.\textsuperscript{60} Human life is not merely an instrumental good\textsuperscript{61} but ‘a fundamental constituent of


\textsuperscript{56} ibid.


\textsuperscript{60} John Keown, \textit{The Law and Ethics of Medicine: Essays on the Inviolability of Human Life} (Oxford University Press 2012) 4-6; and Ronald Dworkin, ‘What is Sacred?’ in John Harris (ed), \textit{Bioethics} (Oxford
human flourishing’. Put simply, life is not merely good as a means to an end but something worthwhile in itself, like friendship or knowledge. Human life under this approach is however not an absolute good; i.e. not every other good needs to be sacrificed for life to be preserved, similar to the demands of the Vitalism approach. Life should never be intentionally taken, but at the same time, it should not always be extended or preserved. For John Keown, the Sanctity of Life approach would, for instance, allow withholding or withdrawing life-sustaining treatment as there is no moral obligation to administer or undergo treatment which is not worthwhile or is burdensome. The essence of the Sanctity of Life approach is therefore the prohibition on intentional killing, which makes this approach incompatible with assisted dying.

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University Press 2001) 160. Dworkin notes that something is intrinsically valuable if its value is independent of what people happen to enjoy or want or need or what is good for them.

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61 Ronald Dworkin, ‘What is Sacred?’ in John Harris (ed), Bioethics (Oxford University Press 2001) 160. Dworkin notes that something is instrumentally important if its value depends on its usefulness, its capacity to help people get something else they want.

62 John Finnis, Natural Law and Natural Rights (Oxford University Press 1980), 85-90. Finnis identifies seven basic, fundamental goods that make life worth having. These are: life, knowledge, friendship and sociability, play, aesthetic experience, practical reasonableness, and religion.

63 Ibid.


65 John Keown, ‘Restoring Moral and Intellectual Shape to the Law After Bland’ (1997) 113 Law Quarterly Review 482, 485; and Peter Singer, Practical Ethics (3rd edn, Cambridge University Press 2011) 72. Singer notes that it is not always wrong to take human life (pacifism). See also: Re J (A Minor) (Wardship: Medical Treatment) [1990] 3 All ER 930 (CA). It was held that there was no obligation to give treatment which was futile or burdensome to a baby born prematurely with severe, life-threatening problems.

66 However, not all end-of-life practices are proscribed by the Sanctity of Life approach, for instance, the Doctrine of Double Effect (‘DDE’). See further: R v Adams (unreported), 8 April 1957 (Devlin J); Re J
A basic characteristic of the Sanctity of Life approach is its focus on the treatment rather than the value of the patient’s life (Quality of Life approach). An example that is useful to distinguish between the two approaches is the case of *W v M.* In the case, there was disagreement on whether life-sustaining treatment should be withdrawn from a patient in a minimally conscious state (‘MCS’) that doctors supported would not be in her best interests (Sanctity of Life), whereas the patient’s family argued that M’s experiences were predominantly negative (Quality of Life) and argued in favour of the withdrawal of the treatment. The Sanctity of Life approach asks whether the patient’s proposed treatment is worthwhile, that is if it satisfies the ‘purposes of medicine’ to restore the patient to a condition of health and well-functioning (or some approximation), or alternatively, to palliate the symptoms. If the treatment does not satisfy any of these goals, the Sanctity of Life approach allows treatment to be withdrawn or withheld, or not be provided.

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67 [2011] EWHC 2443 (Fam) [6], [7]-[9], [39], [174], [221], [249] (Baker J).


these goals then it should be provided as it will be *worthwhile*.\(^7^1\) The patient’s medical condition is called by John Keown ‘quality of life’\(^7^2\) and is used to assess the worthwhileness of the treatment by looking at its burdens and benefits, and comparing the patient’s present and possible future condition.\(^7^3\) The GMC guidance on Treatment and Care at the End of Life confirms that when assessing the overall benefits of a treatment, healthcare providers must weigh the benefits of the life-prolonging treatment against its burdens and risks.\(^7^4\) There may not, for instance, be any benefit in providing life-prolonging, burdensome treatment to a dying patient because the purpose has moved from treating to symptom-management and keeping the patient comfortable.\(^7^5\) In the Conjoined Twins case, the worthwhileness of the treatment (the surgery) was considered for each twin taking into account their present condition and the burdens and benefits of the surgery.\(^7^6\) The surgery would be required under both the Quality of Life and the Sanctity of Life approaches; however

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\(^7^1\) *ibid.*


\(^7^5\) *ibid.*

\(^7^6\) *Re A (Children) (Conjoined Twins: Separation)* [2000] 4 All ER 961 (CA) (Ward LJ).
some would argue that the former would devalue the weaker twin’s life, whereas the latter would not.\textsuperscript{77}

The Sanctity of Life approach is the most compatible with, and is reflected and protected in secular terms under Article 2.\textsuperscript{78} The core of the ‘right to life’ under Article 2 is essentially a right not to be intentionally killed by the state and its state agents. The Sanctity of Life approach, as earlier discussed, notes that human life is not an absolute good, that is, not every other good needs to be sacrificed for its preservation. This is reflected in Article 2(2) which qualifies ‘the right to life’. Therefore, although human life should never be intentionally taken (Sanctity of Life approach and Article 2(1)), life cannot be protected in all circumstances (Sanctity of Life approach and Article 2(2)). The right of innocent human beings not to be intentionally killed under the Sanctity of Life approach also comes into stark contrast to the Quality of Life approach as it is enjoyed regardless of any inabilities or disabilities. The Sanctity of Life approach is therefore compatible with the principle of equality in human rights law, and with the principle that human beings are entitled to rights because of their shared humanity.\textsuperscript{79}

\textsuperscript{77} The case was subject to extensive criticism, and extensive literature was produced as a result.


\textsuperscript{79} See further: Ronald Dworkin, \textit{Taking Rights Seriously} (Duckworth 1977) Chapter 7.
2.1.3 Concluding Remarks

Part 2.1 was concerned with Article 2 of the ECHR. The discussion highlighted the fundamental role of the provision within the ECHR, and examined its language. Most of the discussion concentrated on the idea behind Article 2: the inherent value of human life. The three dominant approaches to the valuation of human life were examined, namely the Vitalism approach, the Quality of Life approach, and the Sanctity of Life approach, and the link of these approaches to Article 2 was drawn. It was concluded that the Sanctity of Life approach is the most compatible with Article 2. In essence, the Sanctity of Life approach, as well as Article 2, provides that life should not be intentionally taken, but at the same time life should not always be extended or preserved (Article 2(2)).
2.2 Article 8: The Right to Respect for Private and Family Life, Home, and Correspondence

ARTICLE 8 - Right to respect for private and family life

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

2.2.1 The Language of Article 8

The protection of the rights of individuals, particularly in a human rights context, depends on the exercise of state obligations.\(^{80}\) Article 8, as well as Article 2 examined earlier, is one of the few provisions in the ECHR that expressly establishes substantive positive state obligations.\(^{81}\) Article 2 provides that the right to life ‘shall be protected by law’, and Article 8 provides that states ‘respect’ the four protected interests of paragraph 1. The notion of ‘respect’ in Article 8 is not clear, so the standard of protection varies considerably from case to case.\(^{82}\) Article 8 places a positive obligation on Member States of the Council of Europe ‘to respect for’ a wide range of...
A state measure may interfere with more than one of the protected interests. The four personal interests are broadly defined on a case-by-case basis by the ECtHR, which does not provide specific rules for their interpretation. This flexible approach has allowed the jurisprudence of the ECtHR to develop in line with social, legal, and technological developments across the Member States of the Council of Europe. As a result, the ECHR, drafted almost 70 years ago, remains relevant today. Article 8 further places a negative obligation on states to refrain from arbitrary interference with the four protected interests. The protection is however not absolute. Public authorities may interfere with the protected interests if one of the legitimate aims specified in Article 8(2) is pursued, if the interference is prescribed by law, and if it is necessary in a democratic society or proportionate to the pursuit of the legitimate aim (Article 8(2)). To be consistent with the ECHR, any interference with Article 8(1) must fulfil all the criteria in Article 8(2).

In particular, the interference with the four protected interests must first be prescribed or be in accordance with the law (legality requirement). In *Sunday Times v the UK* it was held that laws allowing interference must have a domestic or international basis, be publicly and adequately accessible (quality of law), and be sufficiently precise to allow citizens to foresee, to a degree reasonable in the circumstances, that their conduct might be illegal. If the interference is found to be prescribed or in accordance with the law, the ECtHR examines whether the

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83 *Marckx v Belgium* (1979) 2 ECHR 330; *Kroon v the Netherlands* [1994] ECHR 35 [31]; and *X and Y v the Netherlands* (1985) 8 EHR 235.


85 Ibid.

interference pursued any of the legitimate aims specified in Article 8(2). It is the responding state that needs to identify the aim/s pursued by the interference. The ECtHR then proceeds to the final stage of Article 8(2). It is not entirely clear in the jurisprudence of the ECtHR but ‘necessary in a democratic society’ is interpreted to mean that the interference must correspond to a ‘pressing social need’ and be proportionate to the ‘legitimate aim’ invoked.\textsuperscript{87} A democratic society means pluralism, tolerance, and broadmindedness.\textsuperscript{88} The principle of proportionality recognises that human rights are not absolute and that the exercise of individual rights must be measured against the broader public interest.\textsuperscript{89} The ECtHR often emphasises that ‘inherent in the whole of the Convention is a search for a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual’s fundamental rights’.\textsuperscript{90}

The principle of the ‘margin of appreciation’ is used by the ECtHR in balancing society’s interests against individuals’ interests to find whether interference by states was proportionate.\textsuperscript{91} There is no fixed formula in its application. The margin of

\textsuperscript{87} Olsson v Sweden [1988] 11 EHRR 259 [67].

\textsuperscript{88} Dudgeon v the UK [1981] 4 EHRR 149 [53].


\textsuperscript{90} Soering v the UK (1989) 11 EHRR 439 [89].

appreciation is a Strasbourg-developed notion. The principle was considered in *Handyside v the UK* in the context of Article 10:

> ‘[b]y reason of their direct and continuous contact with the vital forces of their countries, state authorities are in principle in a better position than the international judge to give an opinion on the [...] “necessity” of a “restriction” or “penalty” [...] it is for the national authorities to make the initial assessment of the reality of the pressing social need implied by the notion of “necessity” in this context.

> Consequently, Article 10 (2) leaves to the contracting states a margin of appreciation. This margin is given both to the domestic legislator ... and to the bodies, judicial amongst others, that are called upon to interpret and apply the laws in force.’

The ECtHR, however, does not allow states unlimited discretion; ‘the domestic margin of appreciation goes hand in hand with European supervision’. The ECtHR’s role remains ‘subsidiary’ to allow for different types of human rights protection and ‘different conceptions of rights themselves’. The margin of appreciation afforded to states varies according to the circumstances, the subject matter, and its background.

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94 *Handyside v the UK* [1976] 1 EHRR 73 [48]-[49].

95 ibid.

96 *Muller v Switzerland* [1988] 13 EHRR 212 [35].

Many factors, including, for instance, a common ground between, or consensus in the laws of states, determine the scope of the margin of appreciation.  

### 2.2.2 Article 8 and Autonomy

To decide on the applicability of Article 8 the ECtHR, based on its jurisprudence, assesses what constitutes private life, family life, home, and correspondence and whether the alleged complain falls under any of these interests. In *Pretty v the UK*, which is discussed below, the ECtHR expanded the meaning of private life and held, for the first time, that Article 8(1) protects the right to self-determination, which includes the right to choose when and how to die. The Court held that, although the principle of the sanctity of life remains relevant for the ECHR, the quality of life, human freedom and dignity, and personal autonomy are principles protected by Article 8. Specifically, the principle of autonomy is implicit in the language of the ECHR. Most of the rights protected in the ECHR—freedom of expression and religion, freedom from torture, right to life and liberty of the person, respect for private life— are ‘aspects of a broader freedom to determine how to live one’s own life’. This is despite the fact that autonomy, as a term, does not appear anywhere in the language of the ECHR or in any of its Protocols.

For Gerald Dworkin, professor of moral, political and legal philosophy, autonomy can be expressed in ‘an exceedingly broad fashion’. Autonomy in moral and political

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98 ibid.

99 *Pretty v the UK* (2002) 35 EHRR 1 [17], [62]-[64].

100 ibid [65].


102 ibid.

philosophy is the equivalent of liberty, an equivalent of self-rule or sovereignty and is associated with freedom of will. Autonomy is equated with dignity, integrity, individuality, independence, responsibility, self-knowledge. Autonomy is associated with qualities of self-assertion, with critical reflection, with freedom from obligation, with absence of external causation, with knowledge of one’s own interests. It relates to actions, beliefs, reasons for acting, to rules, to the will of other persons, to thought, and to principles. For Dworkin, autonomy is however not absolute; other values are equally of fundamental moral value including dignity, health, well-being, integrity, and security. In fact, the exercise of autonomy often needs to be sacrificed in the interests of other moral values. For Dworkin, an individual who pursues autonomy shapes his or her own life and constructs its meaning; in other words, autonomy makes the individual the individual he or she is, that includes his or her life plans or projects.

Dworkin argues that autonomy acts as a moral, political, and social ideal. As a political ideal, autonomy can be used as a basis to argue against political institutions imposing ends, values, and attitudes upon the citizens. Autonomy as a political ideal is also used to promote equal respect in the sense that, institutions must treat their citizens equally so the interests of some individuals are not prioritised over the

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\[ \text{idbid 60.} \]

On political theory and the notion of autonomy see further: Richard Lindley, Autonomy: Issues in Political Theory (Macmillan 1986). The author discusses three conceptions of autonomy put forward by Immanuel Kant, David Hume, and John Stuart Mill.
interests of others. Indeed, a number of commentators treat the political ideal of autonomy as their starting point in their analysis of the notion. Dworkin, for instance, uses the Greek etymology of the word to highlight that autonomy means ‘self-rule’ or ‘self-governance’: αὐτονομία means autonomy, and in particular, αὐτό-means ‘self’ and νόμος means ‘law’ or ‘governance’ or ‘rule’. Autonomy as a notion was first applied to the Greek city state. A city state in Ancient Greece had ‘αὐτονομία’ if its citizens were able to make their own laws as opposed to being under the control or oversight of more powerful city states. If this political notion of autonomy is applied to individuals, individuals will be perceived as being autonomous if their decisions and actions are their own, in other words, when individuals are self-determining. Even though autonomy is a broad concept, Catriona MacKenzie and Natalie Stoljar argue that there is ‘a conceptual thread’ which links the different uses of autonomy in the different disciplines and interpretations: self-determination or self-government, the defining characteristic of free moral agents.

Gerald Dworkin’s conception of autonomy is most influential in the literature. It describes the capacity of autonomous persons to critically reflect upon their preferences, desires, wishes, and the capacity to change these in light of other

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115 ibid.


preferences, desires, and wishes. This is better illustrated in the following extract which is worth quoting in its entirety:

‘[.] autonomy is conceived of as a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes, and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values. By exercising such a capacity, persons define their nature, give meaning and coherence to their lives, and take responsibility for the kind of person they are’. ¹¹⁸

Dworkin considers that autonomy has instrumental value, that is, autonomy is good as it may lead us to something that will also be good; autonomy, however, also has an intrinsic value, that is, autonomy is good in itself. ¹¹⁹ In terms of autonomy as an instrumental good, Dworkin argues that even the process of autonomous decision-making gives autonomous individuals satisfaction. ¹²⁰ It is significant, he argues, not to overlook the fact that ‘the process of thinking about, reflecting upon, choosing among preferences is a source of satisfaction to individuals’. ¹²¹ In terms of autonomy as an intrinsic good, Dworkin argues that ‘the intrinsic desirability of exercising the capacity for self-determination’ is a value in itself. ¹²² This is because individuals seek recognition by other individuals as ‘creatures capable of determining their own destiny’. ¹²³ Autonomy is also a capacity that individuals ought to exercise and which grounds the ‘notion of having a character’. Dworkin, most significantly, notes that;


¹¹⁹ ibid 111.

¹²⁰ ibid 112.

¹²¹ ibid.

¹²² ibid.

¹²³ ibid.
'Our notion of who we are, of self-identity, of being this person is linked to our capacity to find and re-fine oneself. The exercise of the capacity is what makes a life mine. And, if I am to recognize others as persons, as independent centers of consciousness, as them, then there is a requirement that I give weight to the way they define and value the world in deciding how I should act'.

Hence, Dworkin’s conception of autonomy states that autonomous individuals have the capacity for exercising autonomy if they are able to critically reflect on their first order-preferences and form second-order preferences about their first-order preferences. This is often perceived as the concurrence, the ‘line up’, of a first-order and a second-order desire or preference.125 Stephen W. Smith gives an example to illustrate his own understanding of Dworkin’s conception of autonomy. The example is based on a baseball game and gambling. The author remarks that his own decision to stay up late to watch a baseball game is a straightforward case of an individual exercising his autonomy. Nonetheless, he recognises (second-order) that his decision is probably influenced by numerous factors, including his ‘cultural heritage’ as an American. In his second example, the author describes a ‘compulsive gambler’ who finds himself in a casino unable to stop spending money. In the gambling example, there is probably no desire to gamble. Thus, there is no second-order capacity of critical reflection not to gamble upon the first-order desire to gamble. A second-order desire includes opinions, beliefs and attitudes linked to the first-order desire; it is, the author notes, ‘what I feel about my first-order desires’.126

Dworkin’s conception of autonomy is not without its critics. A criticism recognised by Dworkin himself is that there can be more than two orders of preferences or desires.127 This is because if an individual has opinions, beliefs and attitudes on his or

124 ibid 20, 32.
126 ibid 97.
her first-order desires or preferences, the individual must also have opinions, beliefs and attitudes on his or her second-order desires or preferences. Tom L. Beauchamp and James F. Childress also critique Dworkin’s conception of autonomy and in their influential book Principles of Biomedical Ethics offer an alternative conception of what makes an autonomous decision, examined below. The authors argue that Dworkin’s conception of autonomy suffers from numerous problems, including the fact that many everyday actions will not be classified as autonomous as these are carried out without ‘higher reflection’. A similar criticism comes from Charles Foster who argues that hardly anyone can reach Dworkin’s ‘high standard of autonomous living’. Put simply, Dworkin’s conception of autonomy would not regard the fact that one is having coffee or tea in the morning before leaving the house as an autonomous desire or preference because there is, most likely, no ‘higher reflection’ when the decision is taken. Beauchamp and Childress suggest a different conception of autonomy which forms part of their ‘principlist approach’. Their principlist approach is formed by four fundamental principles for bioethics: autonomy, beneficence, non-maleficence, and justice. For Beauchamp and Childress, an autonomous individual must act intentionally, with understanding, and without controlling influences.

An intentional act is defined as an act which requires ‘plans in the form of representations of the series of events proposed for the execution of an action’. In other words, an act is intentional if it corresponds to the actor’s conception of the act,

128 Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics (7th edn, Oxford University Press 2009).
129 ibid 103.
130 Charles Foster, Choosing Life, Choosing Death: The Tyranny of Autonomy in Medical Ethics and Law (Hart Publishing 2009) 8.
131 Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics (7th edn, Oxford University Press 2009) 104-105.
132 ibid.
133 ibid.
even if the action or project ‘might not materialize as projected’. The first criterion that makes an individual autonomous, according to Beauchamp and Childress, is not a matter of degree: an action is either intentional or non-intentional.

The second criterion requires the autonomous actor to adequately understand his or her actions and decisions. Illness, irrationality, or immaturity may influence the actor’s understanding. Lack of communication, for instance between a patient and a healthcare provider, or indeed an ineffective communication may also negatively impact the actor’s understanding. The criterion can be a matter of degree as there are different levels of understanding for autonomous actors. In fact, an autonomous act needs only ‘a substantial degree of understanding and freedom from constraint, not a full understanding or a complete absence of influence’. Therefore, it is enough if individuals have appropriate information, and have some views and beliefs about the nature and consequences of their actions and decisions. In a healthcare context, understanding is a most crucial factor for decision-making as decision-making usually concerns diagnoses, prognoses, risks, benefits, and so on. In the case of Montgomery v Lanarkshire Health Board, for instance, the UK Supreme Court highlighted the increasing importance of personal autonomy that is reflected in patients’ informed consent. Mrs Montgomery in the case was not informed by her doctors of the risk of shoulder dystocia during vaginal delivery for diabetic mothers. The claimant argued that, had she been informed of the risk she would have chosen a caesarean section. The case clarified that healthcare providers have a legal duty to

\[\text{134} \text{ ibid.}\]

\[\text{135} \text{ ibid 131.}\]

\[\text{136} \text{ ibid.}\]


\[\text{138} \text{ Montgomery (Appellant) v Lanarkshire Health Board (Respondent) [2015] UKSC 11.}\]

\[\text{139} \text{ ibid.}\]
take reasonable care to warn patients of any material risk inherent in any proposed treatment, as well as the alternatives available.\textsuperscript{140}

The third and final criterion concerns the lack of controlling influences. An autonomous actor (‘self-rule’) must be ‘free of controls exerted either by external sources or by internal states that rob the person of self-directedness’.\textsuperscript{141} Both external influences, for instance caused by another individual or an event, and internal influences, for instance caused by illness or injury, may limit or completely destroy the voluntariness of a decision.\textsuperscript{142} The criterion is therefore a matter of degree as diseases have variable effects, and threats or external influences or events can be more or less severe.\textsuperscript{143} In \textit{Kings College Hospital NHS Foundation Trust v C and Another}\textsuperscript{144}, for example, the Court of Protection held that C had sufficient capacity to refuse life-sustaining dialysis despite concerns about her lifestyle and a suicide attempt. On the contrary, in \textit{Re T}, the Court found that the mother of a critically ill woman influenced her decision to refuse blood transfusion based on her religious beliefs (Jehovah’s Witness).\textsuperscript{145} On the third criterion, Beauchamp and Childress argue that not all

\begin{footnotesize}
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\item \textsuperscript{141} Tom L. Beauchamp and James F. Childress, \textit{Principles of Biomedical Ethics} (7th edn, Oxford University Press 2009) 138.
\item \textsuperscript{142} Ibid.
\item \textsuperscript{143} Ibid.
\item \textsuperscript{144} [2015] EWCOP 80.
\item \textsuperscript{145} \textit{Re T (Adult: Refusal of Treatment)} [1993] Fam 95.
\end{itemize}
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influences are ‘controlling’.\textsuperscript{146} In the context of the doctor-patient relationship, for example, some influence is welcomed.\textsuperscript{147} This may be advice or guidance on the availability of alternatives or care and treatment options. Furthermore, the authors argue that, an autonomous actor can still make an autonomous decision notwithstanding influences by family, environment, health care providers, and so on.

Beauchamp and Childress’s conception of autonomy is subject to criticism. One such criticism concerns the fact that their conception of autonomy is process-oriented.\textsuperscript{148} A process-oriented conception of autonomy is one which is not concerned with the contents or results of the autonomous decision; rather, it merely describes a process by which an autonomous decision is reached. Therefore, if the decision-making process is ‘right’, the contents or results of the process are ‘autonomous’ however unpopular or wrong. Both Gerald Dworkin’s and Beauchamp and Childress’s conceptions of autonomy are not concerned with the contents or results of the autonomous decision and therefore can be labelled as ‘procedural’, ‘process-oriented’, or ‘content-neutral’. Onora O’Neill criticises ‘process-oriented’ conceptions of autonomy because they sometimes allow individuals to make decisions which are selfish or wrong.\textsuperscript{149} O’Neill argues that instead of focusing on individual autonomy (influenced by Mill), one should focus on ‘principled autonomy’, a non-individualistic conception of autonomy based on a universal moral law (influenced by Kant).\textsuperscript{150} Principled autonomy, O’Neill argues, leads to ethical decision-making with emphasis placed on the contents or results of decisions and their consequences which are

\textsuperscript{146} Tom L. Beauchamp and James F. Childress, \textit{Principles of Biomedical Ethics} (7th edn, Oxford University Press 2009) 138.

\textsuperscript{147} See Chapter Five, Part. 5.1.


\textsuperscript{149} ibid 29.

\textsuperscript{150} ibid.
worthy of protection.\textsuperscript{151} The author acknowledges, however, that today autonomy is seen more as individualistic as opposed to a conception of autonomy relating to a ‘universal moral law’.\textsuperscript{152}

Only recently, a less individualistic approach to autonomy has emerged in the literature, that of ‘relational autonomy’. Relational autonomy suggests that individuals are not self-made, neither self-sufficient, nor exist in isolation from others, and that personal autonomy as self-sufficient independence in western societies is deeply problematic.\textsuperscript{153} Relational autonomy, according to Beauchamp and Childress, claims that, ‘a person’s identity is shaped through social interactions and complex intersecting social determinants, such as race, class, gender, ethnicity, and authority structures’.\textsuperscript{154} Charles Foster notes that relational autonomy recognises that ‘no man is an island’ as we all exist and grow within a network of relationships.\textsuperscript{155} Indeed, Foster argues that most individuals seem to define themselves in terms of family relationships, religious relationships, and so on.\textsuperscript{156} For instance, if an individual is asked to describe himself or herself, one of the first things that will be mentioned will be relational information, for instance, marital status or job status, or nationality. Catriona MacKenzie and Natalie Stoljar have also provided an influential feminist account of relational autonomy.\textsuperscript{157} The authors understand individual autonomy as

\textsuperscript{151} ibid.
\textsuperscript{152} ibid.
\textsuperscript{154} Tom L. Beauchamp and James F. Childress, \textit{Principles of Biomedical Ethics} (7th edn, Oxford University Press 2009) 106.
\textsuperscript{156} ibid.
‘inherently masculinist’ yet crucial for attempts ‘to understand oppression, subjection, and agency’. They see ‘relational autonomy’ as an umbrella term that includes all accounts of autonomy, which assumes that individuals are ‘socially embedded’ and that their identity is formed ‘within the context of social relationships’ and shaped by ‘a complex of intersecting social determinants’ including race, class, gender, and ethnicity. Marilyn Friedman puts forward the argument that individuals are autonomous because of their relationships with others. Each individual exists within a social context, typically a family, itself located in a wider social network. In fact, individuals throughout their lives are involved in social relationships and communities which define their identities and ground their values. Susan Dodds further argues that in bioethics, healthcare providers are required to respect autonomy by not interfering with the ‘self-regarding choices of rational adults’. Dodds argues that this is a ‘rationalistic, atomistic, and individualistic’ conception of autonomy; it assumes that individuals choose wholly for themselves and ignores the social circumstances and power relations that affect choice. In practice, a majority of medical decisions are taken in a state of confusion with the individual choosing

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161 ibid.

162 ibid 41.


164 ibid 216.
influenced by internal and external factors, including pain, discomfort, worry, and concern for others.\textsuperscript{165} John Christman sees relational autonomy as the way to describe ‘a free, self-governing agent who is also socially constituted and who possibly defines her basic value commitments in terms of interpersonal relations and mutual dependencies’.\textsuperscript{166} Christman argues that individuals are not simply related to other individuals but also to groups, institutions, histories, and experiences.\textsuperscript{167} Most individuals experience life as part of ‘ongoing narratives and long traditions’ and are motivated by interests and reasons that ‘can only be fully defined with reference to other people and things’.\textsuperscript{168} Relational autonomy is prominent in discussions in relation to the family involvement in medical decision-making. Anita Ho, for instance, argues that family involvement and the consideration of family interests are integral in promoting the patient’s agency and maintaining his/her dignity.\textsuperscript{169} The author highlights the importance of recognising that patients come from families with different structures, backgrounds, and preferences but at the same time acknowledges that in practice, this places a huge burden on healthcare providers.\textsuperscript{170} In his empirical work, Roy Gilbar found that family involvement in the decision-making process of competent adult patients is sometimes ignored.\textsuperscript{171} Gilbar claims that the law mostly concentrates on the dominant principle of individual autonomy, which often concentrates on the patient and excludes the

\textsuperscript{165} ibid 217.


\textsuperscript{167} ibid.

\textsuperscript{168} ibid 144.


\textsuperscript{170} ibid 134.

family. Gilbar, by means of a qualitative study, examined the English law approach towards family involvement in medical decision-making, and considered the views and experiences of patients and their relatives. The study found that most relatives were not only involved in decision-making, but also helped the patient reach an informed decision. The patient was however the one to take the final decision. Only few samples in the study indicated that the law needs to protect patients’ interests. The findings of the study, the author argues, reflect a relational approach to patient autonomy. Gilbar nevertheless identifies certain problems with the application of relational autonomy; for instance, finding the means to resolve conflicts between patients and dominant relatives and dealing with ‘coalitions’ between healthcare providers and relatives which take away the patient’s control and independence. The author prefers a compromise between the predominant individualistic conception of autonomy and a relational conception of autonomy because ‘individual autonomy does not ignore the social implications of a decision, and relational autonomy does not deny the importance of personal freedom’.

Relational autonomy is hard to enforce from a traditional human rights perspective. This is because traditionally human rights focus on the individual. Human rights are typically used to protect the fundamental rights and dignity of individuals against the state and its agents. The right to self-determination established in the case of Pretty under Article 8, for instance, is deemed to go against the ‘relational person’ by

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172 ibid.
173 ibid 232.
174 ibid 202.
175 In Katherine O’Donovan and Roy Gilbar, ‘The Loved Ones: Families, Intimates and Patient Autonomy’ (2003) 23(2) Legal Studies 332 the authors further argue that the individualistic conception of autonomy in medical ethics and law sometimes overlooks the patients’ relationships and can be ‘too narrow to face the complexities of human lives’.

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prioritising the individual and his/her wishes.\textsuperscript{176} This is not the case however with every provision in the ECHR. Some rights, such as Article 9, include a reference to ‘community’ and to the manifestation of religion or belief in worship, teaching, practice, and observance, or Article 11, which provides for freedom of peaceful assembly and association with others. Hence, there is perhaps scope for relational autonomy to function within a human rights framework. Nevertheless, Article 8 seems to protect the individualistic notion of autonomy, that which renders the individual as a self-governing, self-ruling being. On a more practical note, though suicide does not require that a third party is involved, assisted suicide will always require that a third party sacrifices some of his/her own autonomy to facilitate the exercise of the individual’s autonomy. Any assisted dying framework in England and Wales, however, must include a conscientious clause that will permit individuals to opt out from the procedure. As also highlighted by Jeff Sapiro and Angie Ungoed-Thomas, ‘it is inconceivable that [Article 8] would extend to a right to force others, such as doctors, to assist since this would conflict rather fundamentally with a number of rights held by those others’.\textsuperscript{177}

\subsection*{2.2.3 Concluding Remarks}

Part 2.2. was concerned with Article 8 of the ECHR. The discussion emphasised the ECtHR’s interpretation of ‘private life’ in the case of \textit{Pretty} to include a right to self-determination: the right to choose when and how to die.\textsuperscript{178} The analysis also attempted an overview of autonomy as a theoretical concept. What follows now is an

\begin{itemize}
\item \textsuperscript{176} Jonathan Herring, ‘Forging A Relational Approach: Best Interests or Human Rights?’ (2013) 13(1) Medical Law International, 32.
\item \textsuperscript{178} \textit{Pretty v the UK} (2002) 35 EHRR 1.
\end{itemize}
analysis of the legal cases that challenged the prohibition on assisted suicide in England and Wales.
2.3 The Assisted Dying Cases in England and Wales

The incorporation of the ECHR into domestic law led to several legal challenges to the prohibition of assisted suicide and voluntary euthanasia. The five major English cases focused on different aspects of the debate: some were more rights-centred like Pretty, and some more technical in nature like Purdy. Yet, all cases expose the conflict between the law and human rights, highlight the human rights dimension of the legalisation debate, and contribute to the development of the relevant domestic and international jurisprudence. Overall, the message from the case law is that Section 2(1) of the Suicide Act 1961 and the prohibition on assisted suicide interfere with Article 8(1), but English Courts use the need to protect and preserve the sanctity and value of life (Article 2), and the need to protect the vulnerable from harm and abuse (Article 8(2)) to justify the interference with Article 8(1).

2.3.1 Diane Pretty

The Diane Pretty case was the first of its kind to reach the House of Lords. The case was extensively analysed over the years and attracted public and media attention. Since 1999, Mrs Pretty, a 43-year-old woman, suffered from motor neuron disease, a progressive, neurodegenerative, terminal disease which causes progressive muscle weakness. Her condition deteriorated rapidly. In 2000, she was confined to a

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wheelchair, totally dependent on others, her speech and swallowing affected, and with no movement in her arms or legs.

Mrs Pretty, her mental capacity unimpaired, expressed the wish for ‘a peaceful end’ to avoid suffering and degradation.\(^{183}\) She was physically unable to end her own life but her husband was willing to assist.\(^{184}\) Because of Section 2(1) of the Suicide Act 1961, Mrs Pretty requested for prosecutorial immunity for her husband.\(^{185}\) The DPP essentially argued that he had no statutory or other power to ‘grant an advance pardon’ for the commission of a future or proposed criminal conduct.\(^{186}\) The Court emphasised that all the duties and functions of the DPP arise after an offence is committed.\(^{187}\) Mrs Pretty’s counsel pursued a judicial review of the decision. Mrs Pretty’s counsel asked that Section 2(1) is interpreted in accordance with Section 3(1) of the HRA, alternatively Section 2(1) to be declared incompatible under Section 4(2) of the HRA. In 2001, the judicial review failed.\(^{188}\) The Court held that despite the strength of the human rights arguments advanced, the DPP cannot be compelled to grant immunity to a criminal offence.\(^{189}\) The House of Lords also found no violation of

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\(^{183}\) R (on the application of Pretty) v DPP [2001] UKHL 61 [1] (Lord Bingham), [43] (Lord Steyn).

\(^{184}\) R (on the application of Pretty) v DPP [2001] EWHC Admin 788 [5]-[6] (Tuckey LJ). Her counsel claimed that his client required ‘active assistance by a third party’, but that the last steps will be carried out by Mrs Pretty herself. At the time of the House of Lords hearing her physical condition was, however, so bad that questions arose as to whether she could sufficiently contribute to her death in a manner which would trigger assisted suicide and not euthanasia. See, for instance, comments by: Antje Pedain, ‘The Human Rights Dimension of the Diane Pretty Case’ (2003) 62(1) Cambridge Law Journal 181.

\(^{185}\) R (on the application of Pretty) v DPP [2001] EWHC Admin 788, [1] [7]-[8] (Lord Bingham).

\(^{186}\) ibid [2], [8]-[9], [33] (Lord Bingham). The Divisional Court spent a considerable part of the judgment clarifying the DPP’s powers, role, and obligations in Pretty [10]-[24].

\(^{187}\) R (on the application of Pretty) v DPP [2001] EWHC Admin 788 [16], [23].

\(^{188}\) ibid [25], [28], [67].

\(^{189}\) ibid [33] (Tuckey LJ).
the ECHR.\textsuperscript{190} Lord Bingham, who delivered the leading judgment, noted that the House was not a legislative body, therefore not able to make ethical and moral decisions but only ‘ascertain and apply the law of the land’.\textsuperscript{191} The ECtHR appeal was heard in April 2002.

In the House of Lords, Mrs Pretty argued that Article 2 protected not life itself, but the right to life.\textsuperscript{192} It was contested that Article 2 protects the right to choose whether to live or die, i.e. the right to self-determination.\textsuperscript{193} Mrs Pretty argued that the right to die is not the antithesis of the right to life but the corollary of it, and states have positive obligations to protect both.\textsuperscript{194} The Secretary of State, responding to Mrs Pretty’s arguments, referred to the narrow language of Article 2 and the sanctity of life that prevent the deliberate taking of life, subject to exceptions.\textsuperscript{195} The ECtHR confirmed that Article 2 could not ‘without a distortion of language’ be interpreted as conferring ‘the diametrically opposite right’, namely a right to die, or create a right to self-determination.\textsuperscript{196} Strasbourg jurisprudence shows that it is not enough for Member States of the Council of Europe to refrain from intentionally and unlawfully taking life (negative obligation), but that they must also take steps to safeguard life

\textsuperscript{190} R (on the application of Pretty) v DPP [2001] UKHL 61.

\textsuperscript{191} ibid [2] (Lord Bingham).

\textsuperscript{192} R (on the application of Pretty) v DPP [2001] UKHL 61 [4] (Lord Bingham).

\textsuperscript{193} ibid.


\textsuperscript{195} R (on the application of Pretty) v DPP [2001] UKHL 61 [5] (Lord Bingham), [109] (Lord Hobhouse).

\textsuperscript{196} Pretty v the UK (2002) 35 EHRR 1 [39]-[40].
(positive obligation). This translates into the obligation of states to put in place effective criminal laws - in this case the Suicide Act - to prevent criminal conduct.\textsuperscript{197}

Her next key claim was made under Article 8. As noted earlier in the Chapter, the most important aspect of the judgment is that the ECtHR established for the first time that Article 8(1), specifically the right to private life, protects the right to self-determination with regards to choosing how and when to die. Mrs Pretty’s counsel contested that Section 2(1) interferes with Mrs Pretty’s right to self-determination\textsuperscript{198} and that to justify the interference with such intimate aspect of life ‘particularly serious reasons’ are needed.\textsuperscript{199} The UK’s representatives argued that Article 8 was not engaged as it ‘relates to the manner in which a person conducts his life, not the manner in which he departs from it’ and even if it was engaged the wide margin of appreciation justifies its restriction.\textsuperscript{200} The ECtHR, however, held that Article 8(1) was engaged as a result of the prohibition of assisted suicide in England and Wales, and specifically that Mrs Pretty was prevented ‘from exercising her choice to avoid what she considers will be an undignified and distressing end to her life’.\textsuperscript{201} The Court’s reasoning is worth quoting in its entirety:

\begin{quote}
Without in any way negating the principle of sanctity of life protected under the ECHR, 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
\end{quote}

\textsuperscript{197} Keenan v the UK App no 27229/95 (ECHR, 3 April 2001) (unreported).


\textsuperscript{199} Pretty v the UK (2002) 35 EHRR 1 [58]-[59].

\textsuperscript{200} R (on the application of Pretty) v DPP [2001] UKHL 61 [18] (Lord Bingham).

\textsuperscript{201} Pretty v the UK (2002) 35 EHRR 1 [62]-[64], [67].
decrepitude which conflict with strongly held ideas of self and personal identity.\textsuperscript{202}

On account of the wide margin of appreciation, the UK was however held not to have violated Article 8(1). The ECtHR considered that states can regulate, by means of the criminal law, ‘activities which are detrimental to the life and safety of other individuals’; the more serious the harm involved the more appropriate the consideration of public health and safety against the individual’s personal autonomy.\textsuperscript{203} The ECtHR accepted that Section 2(1) was designed to protect the lives of the weak and the vulnerable, even if the applicant in the case was not deemed to be one.

Mrs Pretty died shortly after the ECtHR’s ruling. As well summarised by Andrew Ashworth, the ‘procedural outcome’ of the case was that the DPP is not obliged, and has indeed no power, to grant immunity under Section 2(1), whereas the ‘substantive holding’ was that Section 2(1) was compatible with the UK’s obligations under the ECHR.\textsuperscript{204} John Keown argued convincingly that the case was predictable but important.\textsuperscript{205} This is a fair point if one considers well-established ECtHR jurisprudence, especially in relation to Article 2. Even so, it is hard to avoid the conclusion that the case fostered enormous debates on the 1961 Act, the DPP’s Policy, and human rights law. Most notably, the case changed the judicial approach in assisted suicide cases. The ECtHR ensured that courts in the UK and other states from this point onwards regard the prohibition on assisted suicide as a \textit{prima facie} violation of Article 8(1).

\textsuperscript{202} ibid [65].

\textsuperscript{203} Pretty v the UK (2002) 35 EHRR 1 [74].


2.3.2 Debbie Purdy

In 2008, the case of Daniel James revitalised the debate on assisted suicide in the UK. James, a 23-year-old young man, suffered severe spinal injuries in a rugby accident which left him quadriplegic. He travelled to Switzerland with the assistance of his parents and ended his life. Following this, then DPP Keir Starmer QC publicly announced that although Crown Prosecutors had sufficient evidence to initiate proceedings against his parents, doing so was not in the public’s interest. The case is unique in the sense that no such statement was previously made in the UK. In 2009, the case became relevant again when Ms Debbie Purdy brought her case before the Courts.

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Debbie Purdy was a 45-year-old woman suffering from primary progressive multiple sclerosis since 1995. Ms Purdy wished to be able to end her life when living became unbearable. She and her husband wished to have clear indication as regards the likelihood of his prosecution under Section 2(1) in case of assistance, considering the outcome of the Daniel James case in 2008 and Section 2(4).

The Divisional Court examined whether the DPP acted unlawfully in failing to publish detailed guidance as to the facts and circumstances leading to prosecution. Scott Baker L.J. reminded the Court that the case was not about decriminalisation or advance immunity for a criminal conduct, but about the clarification of the law. Ms Purdy argued that the DPP’s failure to issue an offence-specific guidance breached Article 8 and specifically the requirement that the interference is ‘in accordance with the law’. The DPP had previously published offence-specific guidance on other criminal offences, for example, driving offences or non-fatal offences. Therefore, Mrs Purdy argued that she saw no reason the DPP could not do the same for assisted suicide. The Divisional Court held that Article 8 was not engaged, but even if it was, the DPP’s discretion and the manner of its exercise under Section 2(4) was ‘in accordance with the law’ and therefore complied with Article 8(2).

In the House of Lords, Lord Hope noted that the applicant, unlike Mrs Pretty, was asking for information not immunity from prosecution; information that was necessary to make a decision that affected her private life. The House of Lords departed from

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209 R (on the application of Purdy) v DPP [2008] EWHC 2565 (Admin); R (on the application of Purdy) v DPP [2009] EWCA Civ 92; and R (on the application of Purdy) v DPP [2009] UKHL 45.


211 ibid.

212 ibid [11], [18].

213 ibid [58]-[59].

214 ibid [63]-[64].

215 R (on the application of Purdy) v DPP [2009] UKHL 45 [30]-[31] (Lord Hope) [emphasis added].
Pretty, and for the first time recognised that Section 2(1) engaged Article 8(1). The House of Lords examined whether Section 2(1) satisfied the ‘legality requirement’ under Article 8(2). While Section 2(1) established a clear criminal offence and provided no exceptions, Ms Purdy’s argument referred to Section 2(4) and to the manner the DPP exercised discretion in assisted suicide cases. It was held that Section 2(4) did not allow Ms Purdy to make a decision affecting her private life, in other words, Section 2(4) failed the test of accessibility and foreseeability. The DPP was ordered to promulgate an offence-specific Policy on assisted suicide cases. Lord Brown referred to the Daniel James case to suggest that the Policy should consider the factors of the 2008 case. Chapter One discussed the details of the Policy in the context of the law on assisted suicide in England and Wales. The publication of the Policy was, to some extent, a win for Ms Purdy and a step forward for the development of the law on assisted suicide. However, Section 2(1) remains the subject of legal proceedings. The Nicklinson case, heard in December 2013 by the Supreme Court, casts new light on the judicial thinking on assisted suicide in the UK, highlights problems with the 1961 Act, and exposes the conflict between the prohibition of assisted suicide and human rights law.

2.3.3 Tony Nicklinson, ‘Martin’, Jane Nicklinson, and Paul Lamb

The Nicklinson case raised significant moral, ethical, and constitutional questions on the relationship and role of the domestic Courts and Parliament, questions in relation to the power and future of human rights law, and end of life questions in general. The

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216 ibid [40].
217 ibid [42].
218 ibid [53].
219 ibid [56], [69] (Baroness Hale), [83]-[86] (Lord Brown), [88], [101]-[102] (Lord Neuberger).
220 ibid [86] (Lord Brown).
Supreme Court issued a direct challenge to Parliament to consider a relaxation or amendment of the law on assisted suicide. In an alternative case, the Court warned that it ‘might step in’ and challenge the law by means of a declaration of incompatibility under the HRA.

Mr Tony Nicklinson, a man in his late 50s, was paralysed and unable to speak after a stroke in 2005 (locked-in-syndrome). He communicated by blinking and using limited head movements. He asked the court first, for a declaration that a doctor could legally terminate his life on grounds of necessity, second, for a declaration that the law of murder and/or of assisted suicide is incompatible with Article 8(1) as both active euthanasia and/or assisted suicide are criminal offences, and third, for a declaration that the current law and practice fail adequately to regulate the practice of active euthanasia in breach of Article 2. Mr Nicklinson was prepared to commit suicide by means of a machine invented by an Australian doctor, Philip Nitschke, which can be loaded with a lethal drug and digitally activated by the individual. The High Court noted that Mr Nicklinson had an arguable case only in relation to the first two claims. In his legal battle in the High Court, Mr Nicklinson was joined by a man known as ‘Martin’, a 47-year-old man who suffered a brainstem stroke which left him quadriplegic. Martin was also only able to communicate by means of slight movement of his head and eyes. He made two claims first, that the DPP clarifies his Policy in relation to assisting suicide on compassionate grounds, and if this failed, a declaration that Section 2(1) is incompatible with Article 8(1).

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224 R (on the application of Nicklinson) v Ministry of Justice; R (on the application of AM) v DPP [2012] EWHC 2381 (Admin) [8] (Toulson LJ).

225 ibid [10].
In relation to Mr Nicklinson’s first claim, the High Court held that to allow active euthanasia required the creation of a new defence to murder, a major change in an area with ‘strong held conflicting views’ and with Parliament repeatedly rejecting change.\textsuperscript{226} As to the declaration of incompatibility, the Court referred to assisted suicide and the fact that the ECtHR previously held (in \textit{Pretty}) that even a blanket ban is compatible with the ECHR and within the margin of appreciation of states. The same principle, the Court said, applies to the more radical practice of voluntary euthanasia.\textsuperscript{227} In relation to Martin’s first claim, Mr McGuinness on behalf of the DPP commented that it would be wrong for the Court to further require the DPP to clarify the Policy; it would mean that the DPP is ‘crossing a line which constitutionally he should not be required to cross’.\textsuperscript{228} To respond to Martin’s second claim on Section 2(1) and its compatibility with Article 8, the Court again referred to the wide margin of appreciation on assisted suicide.\textsuperscript{229}

Following Mr Nicklinson’s death in 2013,\textsuperscript{230} Mrs Jane Nicklinson, his wife, joined the proceedings and made two claims to the Court of Appeal. First, a claim for a violation of her own Article 8 rights;\textsuperscript{231} and second, a declaration of incompatibility of Section 2(1) under Article 8(1).\textsuperscript{232} A third claimant, Mr Paul Lamb joined the proceedings. Mr

\textsuperscript{226} ibid [84], [87].

\textsuperscript{227} ibid [121]-[122].

\textsuperscript{228} ibid [137]-[138].

\textsuperscript{229} ibid [148].


\textsuperscript{231} N.B. \textit{Koch v Germany} (2013) 56 EHRR 6. In the case, the ECtHR noted that Article 8 was of a non-transferable nature therefore a close relative or successor could not pursue a complaint under Article 8. The applicant in the case had no standing, and the claim was judged to be inadmissible (\textit{ratione materiae}).

\textsuperscript{232} \textit{R (on the application of Nicklinson) v Ministry of Justice} [2013] EWCA Civ. 466. The necessity ground was not pursued further as Mr Nicklinson died following the High Court’s ruling.
Lamb was a 57-year-old man, who was left paralysed following a car accident. His claim was identical to Mr Nicklinson’s. The Court of Appeal upheld the High Court’s conclusions, but allowed Martin’s appeal.\textsuperscript{233} The Court of Appeal acknowledged that the DPP’s Policy was not sufficiently clear, especially in relation to healthcare professionals providing assistance in suicide on compassionate grounds. The Court held that the requirement of legality\textsuperscript{234} under Article 8(2) was not satisfied.\textsuperscript{235} The case was heard by the Supreme Court that dealt with two main questions: whether Section 2(1) was in breach of Article 8(1), and whether the DPP’s Policy was lawful.\textsuperscript{236} The judgment shows significant development in judicial thinking on assisted suicide.

The Supreme Court, overruling the Court of Appeal’s decision on Martin’s claim, concluded that it would not be proper to dictate to the DPP what the contents of the Policy should be.\textsuperscript{237} Yet, Lord Neuberger went on to say that if the DPP’s Policy does not mean what it is intended to mean then it is the DPP’s duty both as a matter of domestic public law and as ‘a public authority’ to clarify the confusion.\textsuperscript{238} The DPP revised the Policy in October 2014, in a change which seems to indicate that a healthcare professional that provides assistance to a patient is more likely to be prosecuted only if they were in a relationship of care with the victim and have exerted

\begin{itemize}
\item \textsuperscript{233} R (on the application of Jane Nicklinson), Paul Lamb v Ministry of Justice, R (on the application of AM) v DPP [2013] EWCA Civ 961 [54]-[56], [88].
\item \textsuperscript{234} Sunday Times v the UK (1979) 2 EHRR 245, [49]; and Hasan and Chaush v Bulgaria (2002) 34 EHRR 1339 [84].
\item \textsuperscript{235} R (on the application of Jane Nicklinson), Paul Lamb v Ministry of Justice, R (on the application of AM) v DPP [2013] EWCA Civ 961 [140], [148].
\item \textsuperscript{236} R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP [2014] UKSC 38 [1]-[2] (Lord Neuberger).
\item \textsuperscript{237} ibid [141], [144]-[145].
\item \textsuperscript{238} ibid [143].
\end{itemize}
some influence. This has been the subject of criticism as essentially decriminalising assisted suicide ‘by the back door’. In April 2015, the High Court granted permission for a judicial review of the DPP’s amendment as a result of a claim by a woman who suffers from crippling nerve condition. In December 2015, the High Court unanimously ruled that the case lacked merit and dismissed the application for judicial review. The CPS website has been updated with a clarification, which however, does remain open to interpretation. It reads as follows:

For the avoidance of doubt the words "and the victim was in his or her care" qualify all of the preceding parts of this paragraph [43.14]. This factor does not apply merely because someone was acting in a capacity described within it: it applies only where there was, in addition, a relationship of care between the suspect and the victims such that it will be necessary to consider whether the suspect may have exerted some influence on the victim.

Responding to the argument of Mrs Nicklinson and Mr Lamb on the compatibility of Section 2(1), the Supreme Court unanimously held that, according to the ECtHR

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241 R (on the application of Kenward and another) v Director of Public Prosecutions and another (AM intervening) [2015] EWHC 3508 (Admin).

jurisprudence, even a blanket ban is within the margin of appreciation of states. 243 It was however held that it was constitutionally open to domestic Courts to consider whether Section 2(1) violated Article 8(1) 244 and was indeed ‘institutionally appropriate’ despite the morality of the subject. 245 Under the HRA, Courts can hold Section 2(1) incompatible with the ECHR, a power given to domestic Courts by the enactment of the HRA by the Parliament. 246 The Supreme Court concluded, however, that a declaration of incompatibility was not appropriate at the time as Parliament should be given the opportunity to consider Section 2(1) by means of the parliamentary procedure. 247 The most notable aspect of the judgment is found in paragraph 118, where Lord Neuberger warns that Parliament should address questions relating to Section 2(1), otherwise there is a real prospect of a declaration of incompatibility being made. Although the conclusion was against the claimants, a closer look at the judgment points towards changing judicial attitudes on assisted suicide. Several of the Justices suggested schemes for assisted suicide which are reviewed below. This comes into stark contrast with the judgments of the Law Lords in Pretty in 2001, which were, in general terms, supportive of the law and its rationale. 248

Lord Neuberger, the then President of the Supreme Court, suggested a judicial scheme involving a judge or an independent assessor whose duty will be to assess in advance that the individual considering assisted suicide has made a voluntary, clear, settled,

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243 R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP [2014] UKSC 38 [66] (Lord Neuberger), [154] (Lord Mance), [218] (Lord Sumption), [267] (Lord Hughes), [339] (Lord Kerr).
244 ibid [76] (Lord Neuberger), [191] (Lord Mance), [299] (Lady Hale), and [326] (Lord Kerr).
245 ibid [90]-[98] (Lord Neuberger), [259] (Lord Hughes).
246 ibid [100] (Lord Neuberger).
247 ibid [113], [115]-[116].
248 R (on the application of Pretty) v DPP [2001] UKHL 61.
and informed wish to die.\footnote{249} Such system will allow the suicide to be organised ‘in an open and professional way’, and at the same time, ‘provide greater and more satisfactory protection for the weak and vulnerable’.\footnote{250} This comes in contrast with the current system which involves a lawyer in the DPP’s office inquiring after the event whether the ‘victim’ and the ‘assister’ had the appropriate motives. The involvement of the Courts in assisted suicide is examined in Chapter Seven of this thesis.\footnote{251} Lord Wilson agreed with the proposal: English Courts will be able to identify a genuine intention to commit suicide by assessing whether the request is voluntary, clear, settled, and informed.\footnote{252} His Lordship indeed listed 18 factors which Courts may wish to investigate in such case.\footnote{253} Lady Hale similarly suggested four requirements an individual should satisfy before proceeding with a request.\footnote{254} Lady Hale argued that such framework is sufficient to protect the vulnerable, more efficient than the DPP’s Policy, and able to solve problems in advance instead of ‘relying on \textit{ex post facto} executive discretion to solve the problem’.\footnote{255} Lord Mance also suggested a prior

\footnote{249} R (on the application of Nicklinson and another) \textit{v Ministry of Justice; R (on the application of AM)} \textit{(AP) v DPP} [2014] UKSC 38 [107]-[108] (Lord Neuberger).

\footnote{250} ibid.

\footnote{251} In November 2014, the House of Lords voted in favour of the High Court’s involvement in the procedure of assessing an assisted dying request. See further: HL Deb 7 November 2014, vol756 col1851, and Chapter Seven.

\footnote{252} R (on the application of Nicklinson and another) \textit{v Ministry of Justice; R (on the application of AM)} \textit{(AP) v DPP} [2014] UKSC 38 [205]. Lord Kerr at [355] agreed.

\footnote{253} ibid [205]. Examples include the capacity to reach a voluntary, clear, settled, and informed decision to commit suicide, the prognosis of the disease, the life expectancy, and the motive of the ‘assister’.

\footnote{254} R (on the application of Nicklinson and another) \textit{v Ministry of Justice; R (on the application of AM)} \textit{(AP) v DPP} [2014] UKSC 38 [314]-[316]. The individual should have the capacity to make the decision, the decision should be reached without undue influence and with full knowledge of the situation, alternatives, and consequences of the decision, and finally, the individual concerned should be ‘unable, because of physical incapacity or frailty, to put that decision into effect without some help from others’.

\footnote{255} ibid [316].
review framework that will be able to distinguish between ‘a distinct and relatively small group’ of individuals making a free and informed decision.\textsuperscript{256}

Other than suggesting possible legalisation schemes, some of the Justices spoke directly against the law, its rationale, and functionality. Lord Neuberger, for instance, suggested that Section 2(1) ‘adversely impinges’ on the personal autonomy of some individuals, and at the same time ‘indirectly cuts short their lives’ by forcing them to die earlier while still physically able to do so.\textsuperscript{257} Most notable is his direct criticism of the law: the interference with the applicants’ Article 8 right is ‘grave’, the arguments in favour of the current law are ‘by no means overwhelming’, the official attitude to assisted suicide in practice comes ‘close to tolerating it in certain situations’, and the rational connection between the aims and effects of Section 2 are ‘fairly weak’.\textsuperscript{258}

Along similar lines, Lord Mance noted that, despite the current prohibition, individuals are assisted in dying and without prior review and safeguards.\textsuperscript{259} The suggestion of various legalisation schemes and the criticism of the law demonstrate that the judicial approach to assisted dying in the UK is changing and this may be an important step in the pathway to reform.

To summarise, Lord Neuberger, Lord Wilson, and Lord Mance decided that a declaration of incompatibility was not appropriate in the case despite acknowledging that the Court could make such declaration. Lord Clarke and Lord Sumption said that they may intervene if Parliament decides not to. Lord Reed and Lord Hughes said that this is only a matter for Parliament. Lady Hale and Lord Kerr were the two Justices that dissented. They noted that they are firmly of the view that the law is not compatible with the ECHR.\textsuperscript{260} Lady Hale remarked that a declaration of incompatibility will allow

\begin{itemize}
\item \textsuperscript{256} ibid [186] (Lord Mance).
\item \textsuperscript{257} ibid [96] (Lord Neuberger).
\item \textsuperscript{258} ibid [111] (Lord Neuberger).
\item \textsuperscript{259} ibid [186] (Lord Mance).
\item \textsuperscript{260} ibid [299]-[300], [317] (Lady Hale), [356] (Lord Kerr).
\end{itemize}
Parliament to ‘cure the incompatibility’ by a remedial order under Section 10 of the HRA, or by an Act of Parliament, or do nothing. Lord Kerr noted that if a law is incompatible with the ECHR, it is the duty of the Courts to say so under the HRA. The fact that two of the most senior judges in the country were prepared to issue a declaration of incompatibility is crucial. In fact, Elizabeth Wicks notes that the options presented by Lady Hale do not explain the reluctance of the Justices to ‘present Parliament with these options’. The Nicklinson judgment shows a significant shift in judicial thinking on assisted dying in the UK. Judges are now dealing not with whether the law should change, but with how the law could change. The judgment recognises the ‘flawed nature of the current universal prohibition of assisted suicide’, raising difficult human rights questions especially in relation to the role of domestic Courts under the HRA. It will undoubtedly be interesting to see the judicial response in a Nicklinson-like future case. In July 2015, Mrs Jane Nicklinson and Mr Paul Lamb had their case declared inadmissible by the ECtHR.

261 ibid [300] (Lady Hale).
262 ibid [327], [342] (Lord Kerr).
Following the Supreme Court’s judgment, the Assisted Dying Bill 2013 (‘ADB 2013’) run out of time in the 2014-2015 parliamentary session.\textsuperscript{268} Its successor, the Assisted Dying Bill (No.2) 2015 (‘ADB 2015’) was overwhelmingly rejected by the House of Commons on the 11\textsuperscript{th} of September 2015.\textsuperscript{269} The problem however remains for individuals who want to end their lives and are prevented by Section 2(1). This is evident by the cases of Mr Noel Conway and Mr Omid T that are briefly examined below. At the time of writing, none of the two cases had their full hearings.

\subsection*{2.3.4 Noel Conway}

Mr Noel Douglas Conway, a 67-year-old man, was diagnosed in November 2014 with motor neurone disease, a degenerative and terminal illness. His wish is that a healthcare professional brings about his peaceful and dignified death when he decides that he no longer wants to live. The claimant seeks a declaration of incompatibility under Section 4(2) of the HRA that Section 2(1) of the Suicide Act 1961 is incompatible with Articles 8(1) and 14 of the ECHR. On the 30\textsuperscript{th} of March 2017, the Divisional Court denied Mr Conway permission to apply for judicial review (2:1).\textsuperscript{270} It was held that the circumstances which led the Supreme Court in \textit{Nicklinson} to refuse to issue a declaration of incompatibility in June 2014 have not changed as to lead to a different outcome; specifically, Parliament has since re-considered the law both in the House of Lords and in the House of Commons.\textsuperscript{271} The Divisional Court also noted that there is

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\begin{itemize}
\item Elizabeth Wicks, \textit{‘Nicklinson and Lamb v United Kingdom: Strasbourg Fails to Assist on Assisted Dying in the UK’} (2016) 24 Medical Law Review 633.
\item Assisted Dying HL Bill (2013-14) 24.
\item HC Deb 11 September 2015, vol599, cols656-728.
\item ibid [4]-[5] (Burnett LJ), [58] (Jay J).
\end{itemize}
no new evidence to reconsider the question considered by the Supreme Court in 2014 on whether a declaration is ‘institutionally appropriate’. 272

An appeal led to a hearing that took place on the 11th of April 2017, which reversed the Divisional Court’s decision.273 Permission to appeal and permission to apply for judicial review was granted.274 The Court of Appeal based its decision firstly, on the fact that new evidence exists to support the creation of an assisted dying framework to suit the needs of a narrowly defined group of terminally ill individuals, and secondly, that there is no current active consideration of the law. The Court noted the availability of a ‘more wide-ranging selection of primary factual and expert evidence’, including, for instance, evidence from consultant clinicians with experience of caring for terminally ill individuals.275 The Court’s latter argument means that Mr Conway is in a position to argue that ‘it is no longer institutionally inappropriate for the court to consider whether to make a declaration of incompatibility’. 276 The full hearing of the case took place in July 2017, but the judgment is not expected until late autumn 2017.

### 2.3.5 Omid T

Mr Omid T is a 54-year-old man who suffers from Multiple System Atrophy (MSA), a non-terminal but irreversible and deteriorating disease.277 His speech and limb

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272 ibid [12] (Burnett LJ).

273 R (Conway) v the Secretary of State for Justice [2017] EWCA Civ 275.

274 ibid [42] (Beatson LJ).

275 ibid [40].

276 ibid [38].

functions are severely affected, and he needs help with most aspects of his daily life. He has previously attempted but failed to commit suicide, and was subsequently moved to a nursing home where he remains. The claimant seeks a declaration under Section 4(2) of the HRA that Section 2(1) is incompatible with Articles 2 and 8. It is the first time that a claimant seeks a declaration of incompatibility with Article 2.278 On the 21st of March 2017, his legal team appeared before the Administrative Court seeking permission for the case to proceed. The permission hearing took place on the 22nd of May 2017, and the case was granted permission to proceed to judicial review.

The case is to be distinguished from the case of Mr Conway considered earlier. Mr Omid T’s condition is life-limiting but he is not terminally ill. His life-expectancy may extend into years. Rather, the Omid T case, with regards to the condition of the individual, is similar to that of Mr Nicklinson and the other claimants who were not terminally ill. This point is of crucial importance for the argument of the thesis. The next Chapter, in particular, notes the limitations of limiting assisted dying to those terminally ill only, a requirement that would exclude, for instance, Mr Omid T and other individuals in similar conditions.

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278 See Chapter Six for an analysis of the claimant’s argument under Article 2.
2.4 Concluding Remarks

The Chapter was concerned with assisted dying and the ECHR. It discussed the two provisions used in this thesis: Article 2 and Article 8, and the domestic cases that challenged the criminal offence of assisted suicide in England and Wales. The most important points to take from the discussion is that, firstly, Article 8 now encompasses the right to self-determination in determining the timing and manner of one’s death, and that the ECtHR considers the prohibition on assisted suicide as a *prima facie* violation of Article 8(1); secondly, that because of the language and interpretation of Article 2, the provision is used in the context of assisted dying to highlight the need to protect the life of others, and especially those who are vulnerable and may be at risk by the availability of assisted dying; thirdly, that cases such as the case of *Omid T* considered above may give rise to new arguments under Article 2; and fourthly, that the *Nicklinson* case shows that some judges in the UK are now concerned with *how* the law could change, not with *whether* the law should change, something that should be decided by Parliament. The last point is in line with the approach of this thesis. Chapter Two is the last of the two introductory Chapters for this thesis. Chapter Three will now examine the terminal illness eligibility criterion and the unbearable suffering eligibility criterion to assess their suitability for a future assisted dying framework in England and Wales.
Several jurisdictions around the world permit a form of assisted dying. In their laws and other practical guidance regulating assisted dying, all use some type of ‘eligibility’ to limit access to assisted dying. Here, I use the term ‘eligibility’ to describe the physical or mental condition of the individual requesting assistance in dying.¹ The eligibility in the jurisdictions that permit a form of assisted dying broadly falls into two categories. On the one hand, there is a terminal illness eligibility used predominantly in the US states. Montana in the US,² and Colombia in South America,³ for instance, 

¹The CAD, for example, in its proposed framework sets the assisted dying ‘eligibility’ to the terminally ill.

²The Montana Supreme Court in 2009 ruled that there is ‘nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy’ (Baxter v Montana, MT DA 09-0051, 2009 MT 449 [49]). The ruling broadened the existing Rights of the Terminally Ill Act 2013. Death with Dignity Acts failed in 2011 (SB 167), 2013 (SB 220), 2015 (SB 202), and 2017 (HB 536).

³The Colombia Constitutional Court held in 1997 that mercy killing for terminally ill patients suffering unbearably is subject to a lesser punishment (Constitutional Court of the Republic of Colombia. Carlos Gaviria Diaz. Constitutional Claim Decision, C-239/1997. May 20th 1997, Bogota). The Court urged Congress to use the ruling to enact legislation without success. In 2014, the unofficial criteria were further clarified in the Constitutional Court of the Republic of Colombia. Luis Ernesto Vargas. Action to protect fundamental rights, Decision T-970/2014. December 15th 2014, Bogota. In April 2015, the Ministry of Health and Social Protection (executive) proposed Resolution Nº 1216 (not a law) to advise that terminally ill patients have the right to die with dignity to fulfil Decision T-970/2014. Article 2 states that patients must be suffering from illness or serious condition, diagnosed by a doctor to be progressive and irreversible, with a fatal prognosis of near or relatively short time, not susceptible of curative treatment and proven efficacy (own translation from Spanish). The first euthanasia case took place in July 2015.
also use a terminal illness eligibility but not under codified law. On the other hand, at European level, the Benelux countries (the Netherlands, Belgium, and Luxembourg) use a suffering-based eligibility. A suffering-based eligibility is also used in Japan, for instance, but similarly not under codified law.\footnote{Active euthanasia (‘sekkyokuteki anrakushi’) is based on the Tokai University local case: patients must be suffering from unbearable physical pain, and death must be inevitable and imminent (Judgment of March 28, 1995, Hanerijihou, 1530, 28). See further details: Katsunori Kai, ‘Euthanasia and Death with Dignity in Japanese Law’ (2009) 27 Waseda Bulletin of Comparative Law 1; and Miki Hayashi and Toshinori Kitamura, ‘Euthanasia Trials in Japan: Implications for Legal and Medical Practice’ (2002) 25 International Journal of Law and Psychiatry 557.}

For Switzerland\footnote{In Switzerland, while voluntary euthanasia is a criminal offence (Code pénal suisse du 21 décembre 1937 (CP), Article 114), assisting or inciting suicide is prohibited only if done for ‘selfish reasons’ (Article 115). The Penal Code does not specify any eligibility; therefore, the law is not limited to the terminally ill or the suffering. Doctors are not directly involved but prescribe the lethal drugs and assess the mental capacity. Non-profit right-to-die voluntary organisations carry out most assisted suicides and set their own eligibility. EXIT and DIGNITAS are the largest, the former providing end-of-life care to those with hopeless prognoses, or unbearable symptoms and disabilities; the latter assisting the suicide of those with medically diagnosed hopeless or incurable illness, unbearable pain or unendurable disabilities.} and Canada\footnote{Bill C-14 2016 permits medical assistance in dying and is based on the case of Carter v Canada (Attorney General), 2015 SCC 5 [2015] 1 SCR 331. The individual must have ‘a grievous and irremediable medical condition’ (Section 241.2(1)(c)) defined in Section 241.2(2). The Government was advised against limiting the eligibility to the terminally ill. See further: Special Joint Committee on Physician-Assisted Dying, ‘Medical Assistance in Dying: A Patient-Centred Approach Report’ (February 2016, 42\textsuperscript{nd} Parliament, 1\textsuperscript{st} Session) available at: <http://www.parl.gc.ca/content/hoc/Committee/421/PDAM/Reports/RP8120006/pdamrp01/pdamrp01-e.pdf> accessed 28 September 2017, p. 12; and Legislative Background: Medical Assistance in Dying (Bill C-14) (2016) available at <http://www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/ad-am.pdf> accessed 28 September 2017, p. 15. The reasonably foreseeable death requirement in Section 241.2(2) means that the individual does not have to be dying from a fatal or terminal disease.} the eligibility criterion relating to the physical or mental condition of the individual is straddling between the US and Europe, i.e. it is a mixed approach combining elements from both types of eligibility. In England and Wales, reform proposals have used either...
a terminal illness eligibility only, or a combination. The most recent proposals have used a terminal illness eligibility only.\textsuperscript{7} Chapter Three assesses the suitability of both types of eligibility relating to the physical or mental condition of the individual in the context of a future assisted dying framework in England and Wales. Part 3.1 is concerned with a terminal illness eligibility, and Part 3.2 with a suffering-based eligibility. Chapter Three concludes by challenging the suitability of both types of eligibility. This is not least because of problems with their identification and practical application, but most importantly because these two characteristics (terminal illness and/or unbearable suffering) should not be the basis for being allowed to request access to an assisted death. Rather, the right to request an assisted death should be based on the right to self-determination in choosing the manner and timing of one’s death under Article 8, an argument fully explored in Chapter Six of this thesis.

\textsuperscript{7} See Chapter One of this thesis, Part 1.2.
3.1 A Terminal Illness Eligibility for Assisted Dying

Since 2002, terminal illness is used to determine ‘eligibility’ in assisted dying reform proposals in England and Wales.\(^8\) A series of Bills presented to the Lords between 2003 and 2006 also used a terminal illness eligibility criterion;\(^9\) and in 2012, the CAD’s findings were implemented into a Bill using the same ‘eligibility’.\(^10\) Similarly, the US states permitting physician-assisted dying all use a terminal illness eligibility criterion.\(^11\) Death with Dignity laws in the US largely rely on the Oregon law model,\(^12\) Oregon being the first state in the US to legalise physician-assisted dying in 1997. This was three years following the enactment of the initiated state statute via the initiative process (ballot initiative procedure).\(^13\) Part 3.1. is therefore concerned with a terminal illness eligibility and aims to assess its suitability for a future assisted dying framework in England and Wales.

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\(^8\) Patient (Assisted Dying) HL Bill (2002-03) 37.

\(^9\) Originally introduced as: Assisted Dying for the Terminally Ill HL Bill (2003-04) 17.


3.1.1 The Meaning of Terminal Illness

Terminal illness is a term used across many disciplines, including medicine and law. It is subject to many interpretations, often inconsistently or not at all defined. The Disability Living Allowance scheme in England and Wales, for example, defines terminal illness as a progressive disease that may reasonably lead to death within six months. The Department of Health, End of Life Strategy of 2008 suggests that healthcare professionals use the question: ‘Would I be surprised if this patient was to die in the next six months or year?’ Terminal illness is defined by the Oxford English Dictionary as a disease ‘predicted to lead to death; especially slowly; incurable’, whereas medical dictionaries use various definitions such as, an incurable or irreversible illness at the end stage that will result in death within a short time. This inconsistency in the definition makes terminal illness an inappropriate standard to determine eligibility for assisted dying because problems are likely to arise when assessing who is, and who is not, terminally ill and therefore eligible for assistance.

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and law reform is revealed here through the study of the definition in domestic law reform proposals, by parliamentary debates that examined these proposals, and an argument based on medical advances.

All domestic reform proposals since 2002 used a terminal illness eligibility for assisted dying. The Patient (Assisted Dying) Bill (‘PADB’) defined terminal illness in Section 1(2) as an incurable and physical illness, likely to result in death within six months from the prognosis date.\(^{19}\) Physical illness was defined as a serious incurable and progressive physical illness. These terms used to define terminal illness were heavily criticised during the Second Reading debate of the Bill.\(^{20}\) Lord Clement-Jones, for instance, argued that the term ‘serious and progressive illness’ is problematic, questioning whether rheumatoid arthritis and diabetes would fall in this category.\(^{21}\) Baroness Howells of St. Davids and Lord Chan were similarly concerned as to the scope of the term ‘physical illness’.\(^{22}\) Lord Phillips of Sudbury agreed, commenting that ‘serious’ is a ‘wonderfully rubbery word’ and ‘progressive’ a ‘liquid expression’.\(^{23}\) Indeed, these concerns are justified. What does incurable mean? At which stage is cancer, for example, incurable?\(^{24}\) If cancer treatment is declined by the patient, is cancer incurable for that particular patient? In the context of assisted dying, the pursuit for certainty is crucial, with clarity being key in assessing eligibility. To achieve this, and assuming that a terminal illness eligibility is adopted, a terminal illness definition could list specific terminal conditions and illnesses indicating when an individual is eligible for assisted dying. Assuming that this is medically, scientifically, and practically

\(^{19}\) Patient (Assisted Dying) HL Bill (2002-03) 37.


\(^{21}\) ibid col1678.

\(^{22}\) ibid col1592 and col1670.

\(^{23}\) ibid col1607.

possible, uncertainty would be minimised as vague terms such as ‘serious’ or ‘incurable’ would be avoided. However, the fact that this was not done in the PADB, or indeed in any of the later law reform proposals, raises questions as to whether in fact anyone can specify what a terminal illness is. In fact, none of the US states that permit assisted dying specify, or indeed give preference to, what a terminal illness or condition a patient must have to be eligible. The requirement is ‘simply and intentionally broad’ to include only a ‘terminal illness’ and a ‘6-month prognosis’ with both elements inspired by hospice practice.

In 2003, a revised version of the PADB, the Assisted Dying for the Terminally Ill Bill (‘ADTIB’), defined terminal illness in Section 1(2) as an inevitably progressive illness which cannot be reversed by treatment, likely to result in death within a few months at most. The 2002 and the 2003 definitions are substantially different, especially as regards prognosis. The more simplistic 2003 definition is possibly a response to the criticism during the PADB’s Second Reading debate. The ADTIB received no opposition.

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25 N.B. The serious concerns from the disability community about a blurry line between terminal illness and disability. For instance: Baroness Jane Campbell’s remarks to the HLSC: Select Committee, Assisted Dying for the Terminally Ill Bill, Vol. II: Evidence (HL 2005 Paper 86-II), p. 241, but also Tom Shakespeare’s remarks to the HLSC: ‘terminally ill people could be seen to be disabled, but disabled people are not necessarily terminally ill’ in Select Committee, Assisted Dying for the Terminally Ill Bill, Vol. II: Evidence (HL 2005 Paper 86-II), p. 248 and Lord Ashley of Stoke’s remarks to the House of Lords: ‘the public often misunderstand disability, largely because they are not basically interested in it, but they surely cannot be so stupid as to believe that Britain’s 11 million disabled people are terminally ill’ in HL Deb 12 May 2006, vol681, col1199.

26 See (below) the argument on medical advances which also challenges whether specific conditions or illnesses can be listed under a definition of terminal illness.

27 My personal email exchange on the 30th of August 2016 with Peter Korchnak, Death with Dignity National Center in Portland, Oregon.

28 This is similar to the CAD’s use of ‘advanced, progressive, incurable disease or illness leading to death within 12 months’, a definition also used in a palliative care context.

29 Assisted Dying for the Terminally Ill HL Bill (2003-04) 17 [emphasis added].
by the House of Lords in Second Reading\textsuperscript{30} and was referred to the HLSC. Evidence submitted to the HLSC underlined problems with the terminal illness definition, including evidence from the Association of Hospice and Palliative Care Chaplains,\textsuperscript{31} and Help the Hospices.\textsuperscript{32} A revised version of the 2003 ADTIB was re-introduced to the House of Lords in 2005 with the terminal illness definition again different as regards the prognostic period, which was back to six months.\textsuperscript{33} This is more relevant to the discussion on prognosis below though, for current purposes, it is important to note that this tendency of adjusting the terminal illness definition with each new reform proposal shows that uncertainty as regards the meaning of terminal illness is also present among those drafting the proposals.

Almost a decade later, the CAD similarly used a terminal illness eligibility in its assisted dying legalisation proposal. The CAD’s findings were used to draft the Assisted Dying Bill (‘ADB’), first introduced to the House of Lords in 2013.\textsuperscript{34} Interestingly, the ADB used the 2005 ADTIB’s definition of terminal illness, not the CAD’s definition. The CAD defined terminal illness as an advanced, progressive, incurable condition, likely to lead to death within twelve months.\textsuperscript{35} This definition is unique amongst the other domestic reform proposals. The word ‘advanced’ was never previously used to define terminal illness, and the prognostic period specified is significantly higher compared to previous reform proposals. ‘Incurable’ was used only by the PADB, and ‘progressive’ was used by both the ADTIB and ADB. Yet, the terms ‘advanced, progressive, incurable’ were not previously used together to define terminal illness. The CAD’s definition of terminal illness was based on the General Medical Council’s (‘GMC’) 2010 guidance on

\textsuperscript{30} HL Deb 10 March 2004, vol658, cols1317-1324.
\textsuperscript{32} ibid 702.
\textsuperscript{33} Assisted Dying for the Terminally Ill HL Bill (2005-06) 36, Section 2(1).
\textsuperscript{34} Originally introduced as: Assisted Dying HL Bill (2013-14) 24.
\textsuperscript{35} CAD’s Report, pp. 27, 30, 197, 304.
decision-making relating to the care and treatment of patients at the end of life.\textsuperscript{36} The GMC guidance states that patients ‘approaching the end of life’ are those likely to die ‘within twelve months’. This includes patients whose ‘death is imminent (expected within a few hours or days)’ and those with:

‘a. advanced, progressive, incurable conditions; b. general frailty and co-existing conditions that mean they are expected to die within twelve months; c. existing conditions if they are at risk of dying from a sudden acute crisis in their condition; and d. life-threatening acute conditions caused by sudden catastrophic events’.\textsuperscript{37}

The CAD noted that these four categories are appropriate for the ‘broad context of end of life care planning’ but only the first category is appropriate for assisted dying.\textsuperscript{38} This is because the ‘risk of death’ in categories b, c, and d, is not a sufficient basis for ‘proceeding with a serious decision as ending one’s own life’ and because ‘an advanced, progressive, incurable condition that is likely to lead to the patient’s death within the next twelve months’ would be easier for doctors to assess.\textsuperscript{39}

The CAD does not expand on the meaning of the terms ‘advanced’, ‘progressive’, and ‘incurable’. This is problematic for the same reason discussed above: the absence of a definition means that who is, and who is not, terminally ill for the purposes of ascertaining eligibility for assisted dying is not clear, much less consistent. The GMC guidance that the CAD uses to define terminal illness similarly does not expand on


\textsuperscript{37} ibid p. 8.

\textsuperscript{38} CAD’s Report, p. 304.

\textsuperscript{39} ibid. Under the CAD’s proposed assisted dying framework, the first and second doctor must independently certify and document that the individual concerned has ‘an advanced, progressive, incurable condition that is likely to lead to the patient’s death within the next twelve months’.
these terms. Are these terms used together, i.e. does a condition or illness need to be advanced and progressive and incurable to be terminal? If not, asthma is incurable, but is it a terminal condition? Insulin-dependent diabetes patients would die without insulin (incurable), but otherwise would lead a life with good life-expectancy. Baroness Finlay of Llandaff in the context of the ADB noted that some conditions are progressive and cannot be reversed by treatment, but the underlying cause may be curable. So, would that condition be considered terminal under the CAD’s definition? Similarly, not everyone with a progressive and incurable condition is expected to die within six or twelve months. Would that be a terminal illness under the CAD’s definition? Despite the lack of clarity associated with the CAD’s definition of terminal illness, research shows that the term ‘advanced, progressive, incurable’, as a whole, is widely used, especially in a palliative care context. This may in fact be the reason that the CAD chose to use these terms to define terminal illness. In an assisted dying context, as also earlier suggested, specific terminal conditions and illnesses could be listed under a terminal illness definition in the interests of certainty. One unofficial source, for instance, reports that an advanced, progressive, incurable illness may include: advanced cancer, heart failure, chronic obstructive pulmonary disease, stroke, dementia, or chronic neurological conditions. So perhaps listing specific conditions and illnesses under a terminal illness definition is not impossible; especially if consideration is given to evidence from other jurisdictions. The latest data from Oregon, for instance, specify that those who received assistance in dying in 2016

[40] Other professional bodies, including the Royal College of Anaesthetics, and the Royal College of General Practitioners also do not define these terms.


[42] Ibid.


suffered from malignant neoplasms (78.9%), Amyotrophic Lateral Sclerosis (‘ALS’) (6.8%), chronic lower respiratory disease (1.5%), heart disease (6.8%), and other terminal illnesses (6%). However, none of the terminal illness definitions domestically or in the US refer to specific terminal conditions or illnesses, and indeed, at least in the US, the definition was left ‘simply and intentionally broad’. Therefore, the terminal illness eligibility is not as restricted and refined as its proponents seem to argue. This does not only show the difficulties in defining terminal illness, but is also evidence of the fact that its proponents recognise that perhaps attempting to define it may be too restrictive.

The difficulty in defining terminal illness can also be attributed to the immense advances of western medicine. Since the earliest reform proposal in England and Wales, this argument has been used to highlight that prognosis, an element of a terminal illness definition, is rarely accurate, further perplexing the situation. An assisted dying framework incorporating a terminal illness eligibility may, therefore, be outdated within a few years because of medical advances. In other words, the prognostic period proposed today may be completely irrelevant tomorrow, and what may be incurable today, may be curable tomorrow. The Disability Rights Commission’s submission to the HLSC in 2005, for instance, referred to AIDS to note that some


46 My personal email exchange on the 30th of August 2016 with Peter Korchnak, Death with Dignity National Center in Portland, Oregon.

47 For instance, see: Dignity in Dying’s policy, or the CAD’s Report.


conditions previously considered terminal are now treatable, if not curable.\(^{50}\) A terminal illness definition then becomes less and less plausible over the years as new advances in medicine emerge.

Terminal illness is a non-specific term. This was confirmed by the study of the terminal illness definition in domestic reform proposals. The proposals, although largely encompassing similar elements, defined terminal illness differently with the exception of the 2005 ADTIB and the 2013 ADB. This constant adjustment of the terminal illness definition shows that uncertainty as regards the meaning of terminal illness is not only present in the literature, but also among the drafters of these proposals. Defining terminal illness is also difficult because of the advances in medicine. Prognosis, an important element of a terminal illness definition, is now examined to highlight further problems with a terminal illness eligibility in an assisted dying context.

### 3.1.2 Terminal Illness and Prognosis: A Difficult Relationship

The accuracy with which doctors are able to give a prognosis, a prediction of the progression of a condition or illness, is critical in identifying if and when a patient is terminally ill. An accurate prognosis is also valuable for a number of other reasons. It allows dying patients to put their affairs in order, and assists the healthcare team to make other necessary decisions including whether the patient should go into hospice care, or whether the patient will benefit from any treatment.\(^{51}\) Prognosis is an element used in all domestic reform proposals that contained a terminal illness eligibility. The analysis assesses whether prognosis is clinically or scientifically plausible.

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by using evidence submitted to the HLSC and to the CAD, parliamentary debates, and scientific and other research studies.

A House of Lords speech in 2003 noted that prognosis is ‘at best, an inspired guess’, 52 and another in 2014 described prognosis as an ‘educated guess’. 53 Health professionals themselves describe prognosticating as an art not science as there is great uncertainty as to the accuracy of the prognostic period leading to death. 54 A study found that in Oregon, for instance, doctors are not confident in giving a six-month prognosis in the context of the 1997 Act. 55 In 2005, the Royal College of General Practitioners (‘RCGP’) told the HLSC that a ‘reasonably accurate’ prognosis can only be given within minutes, hours, or a few days of the patient’s death, and that when months are at stake the scope for error can extend into years. 56 Samantha Halliday similarly noted that ‘as the length of life expectancy extends, the reliability of the prognosis declines’. 57 Professor John Saunders told the HLSC that an accurate prognosis may be possible within the last two or three weeks, 58 whereas Dr David Cole suggested one or two months, and no more than three. 59 Baroness Finlay is one expert

59 ibid pp. 541-542.
that suggested one of the shortest prognostic periods for a terminal illness definition.\textsuperscript{60} During the ADB’s Committee debate, the Baroness suggested a reduction of the proposed six-month period to a six-week period, but her amendment was eventually rejected.\textsuperscript{61} One of the HLSC’s recommendations in 2005 was that any terminal illness definition in the context of assisted dying ‘should reflect the realities of clinical practice as regards prognosis’.\textsuperscript{62} Evidently, clinical practice requires a short prognostic period to be close to the ‘right’ prognosis.

A discrepancy is thus noted between clinical practice requiring a short prognostic period to be close to the right prognosis, and patients’ needs. In practice, a short prognostic period will not benefit dying patients though patients’ preferences may vary.\textsuperscript{63} Firstly, a short prognostic period will not allow patients to alleviate their pain and discomfort until very late in their illness with all the indignity and suffering that this entails. Canada’s Bill C-14, for example, intentionally does not impose a requirement on prognosis or proximity to death because some conditions may cause irreversible decline and suffering for a long period of time before death.\textsuperscript{64} Secondly, because a short prognostic period may jeopardise patients’ safety. It will not allow for a safeguarded procedure as all paperwork and procedures, legal or medical or both, will have to be initiated and completed within a few weeks. Finally, some patients may not have a prognosis at all, that is, they may not be terminally ill. The \textit{Debby Purdy}

\textsuperscript{60} HL Deb 16 January 2015, vol758, cols1001-1070.
\textsuperscript{61} ibid.
\textsuperscript{63} For instance, an individual may prefer a short prognostic period to alleviate fear and depression associated with the assisted dying procedure.
\textsuperscript{64} See further: Legislative Background: Medical Assistance in Dying (Bill C-14) (2016) available at \url{http://www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/ad-am.pdf} accessed 25 September 2017, p. 10.
case, for instance, concerned a woman who suffered from Multiple Sclerosis (‘MS’), a progressive and incurable disease that the MS Trust, however, does not consider as terminal. In the Nicklinson case, Tony Nicklinson had Locked-In-Syndrome which is not regarded as terminal condition, and ‘Martin’ and Paul Lamb were quadriplegics. In the case of Omid T, the man has Multiple System Atrophy (‘MSA’), a rare condition that affects the nervous system but is not terminal. As Lord Neuberger noted in the Supreme Court in 2014, there is more justification in assisting the dying of individuals that have ‘the prospect of living for many years a life that they regarded as valueless, miserable and often painful, than if they have only a few months left to live’. In other words, an individual with a relatively good quality life may be imminently dying thus qualify under a life expectancy-based framework; whereas an individual with a very low quality life may not be imminently dying thus not qualify under a life expectancy-based framework. A terminal illness eligibility would not have benefited these individuals unless their overall prognosis accorded to the prognostic period specified

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65 R (on the application of Purdy) v DPP [2009] UKHL 45.
67 R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP [2014] UKSC 38.
70 R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP [2014] UKSC 38 [122] (Lord Neuberger).
in the terminal illness definition. On the contrary, a terminal illness eligibility framework would prolong their suffering.\(^{72}\) Representatives of Dignitas, the right-to-die voluntary organisation, told the CAD that there are indeed categories of individuals who are not terminally ill but are suffering, including, for instance, paraplegics and quadriplegics, patients suffering from Parkinson’s, Multisystem-atrophy and Huntington’s Chorea, or individuals suffering from mental illness.\(^{73}\) This leads to an almost impossible dilemma. What is a clinically or scientifically plausible but also appropriate for the needs of patients and safe prognostic period for a terminal illness definition in the context of assisted dying? Six months,\(^{74}\) ‘a few months’,\(^{75}\) twelve months,\(^{76}\) or no prognostic period requirement?\(^{77}\)

Another reason that makes prognosticating difficult is that various conditions and illnesses affect each patient differently.\(^{78}\) Baroness Finlay in 2015 noted that prognosticating may be reasonably accurate on a population level but not at an


\(^{74}\) Patient (Assisted Dying) HL Bill (2002-03) 37; Assisted Dying for the Terminally Ill HL Bill (2005-06) 36; and Assisted Dying HL Bill (2013-14) 24.

\(^{75}\) Assisted Dying for the Terminally Ill HL Bill (2003-04) 17.

\(^{76}\) CAD’s Report, pp 27, 30, 197, 304.

\(^{77}\) The text of the Canadian Bill C-14 2016 implies a terminal illness eligibility, however, lawmakers intentionally avoided the words ‘fatal’ or ‘terminal’, and did not include a requirement of prognosis. See further: Department of Justice - Canada, ‘Types of medical assistance in dying and eligibility for it’ available at: <http://www.justice.gc.ca/eng/cj-jp/ad-am/faq.html#three> accessed 27 September 2017.

individual level.\textsuperscript{79} For example, there may typically be a six-month prognosis for terminal liver cancer on a population level, however, individual patients may respond differently outliving the prognosis, dying at six months, or much earlier. Talking about MS, Professor Nigel Leigh on behalf of the Association of British Neurologists noted that prognosis also depends on many external factors, for instance, the patient contracting an infection.\textsuperscript{80} As such, degenerative diseases including Motor Neurone Disease, MS, or heart disease are harder to prognosticate because of their unpredictable nature.\textsuperscript{81} For heart failure patients, Professor Mike Richards noted that most patients are \textit{slowly} getting worse, but particular incidents may accelerate the dying procedure making prognosticating almost impossible.\textsuperscript{82} The Association for Palliative Medicine made similar remarks in reference to cardiac or respiratory failure patients.\textsuperscript{83} Dr Adrian Tookman told the CAD that it is becoming increasingly difficult to identify a specific moment during a condition or illness when healthcare professionals can say that death will be uninterrupted.\textsuperscript{84} What further complicates prognosticating is that treatment for some patients is attempted or continued after a prognosis is made.\textsuperscript{85} It is thus very likely that the dying course is slowed if treatment is working,

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\textsuperscript{79} HL Deb 16 January 2015, vol758, col1034.
\textsuperscript{83} ibid p. 140.
\textsuperscript{84} Evidence Adrian Tookman (December 2010)
\end{flushleft}
accelerated if treatment is making the patient worse, or even that the treatment does not have any effect on the patient and the dying procedure.

Scientific evidence and research studies further challenge whether prognosis is clinically and scientifically plausible. A leading study in 2000 by Nicholas Christakis, a US-based doctor and sociologist, and Elizabeth Lamont, a medical oncologist at Massachusetts General, described the accuracy with which doctors give prognosis to terminally ill patients in Chicago. Christakis and Lamont found that only 20% of prognoses were accurate: 63% overoptimistic and 17% over pessimistic. Later studies, for instance by Nicola White et al. in 2016, John W. Finn in 2006, Paul Glare et al. in 2003, and Edward Chow et al. in 2001, confirm that the majority of prognoses in terminally ill patients are often inaccurate with the majority being overoptimistic. The fact that prognoses tend to be overoptimistic is also confirmed by evidence submitted to the CAD. At the same time, however, several terminally ill patients survive much longer than the prognostic period suggested by healthcare

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87 ibid. An overoptimistic prognosis means that a patient dies sooner than the period suggested. An over pessimistic prognosis means that the patient lives longer than the period suggested.


professionals. During the parliamentary debates of the past 15 years, countless such cases were described in both Houses. Other evidence submitted to the CAD describes cases of terminally ill patients that survived much longer than expected. Peter Bailey is one example of an expert who referred to real life examples of patients in his evidence to the CAD, but also to what he describes as ‘the most extraordinary’ example: Professor Stephen Hawking. Hawking, today 75, was diagnosed at the age of 21 with Motor Neurone Disease and was given a two-year prognosis. Overall, scientific evidence and studies challenge whether prognosis is clinically or scientifically plausible. Specifically, evidence shows that prognoses are often inaccurate, either overoptimistic or over pessimistic.

Nicholas Christakis in his influential book ‘Death Foretold: Prophecy and Prognosis in Medical Care’ makes an interesting argument that is relevant to the question of whether prognosis can be clinically or scientifically plausible. Christakis argues that doctors for various conscious and unconscious reasons sometimes refuse to (even)


94 See as early as 2003: HL Deb 6 June 2003, vol648, col1678. Lord Clement-Jones talked about his late wife who had a prognosis of only three months but lived ‘a triumphant five years further’.


97 Nicholas A. Christakis, Death Foretold: Prophecy and Prognosis in Medical Care (University of Chicago Press 1999).
formulate prognoses or fail to engage in ‘good faith prognostication’ by communicating effectively with patients and their loved ones. In a New York Times interview in 2000, Christakis suggested that prognosis needs to regain its rightful place in medical practice. An argument against his argument is that if terminal illness becomes the legal eligibility for assisted dying, doctors and other healthcare professionals involved may be under a legal or professional (or both) duty to formulate and communicate prognoses. However, the counterargument may well be that doctors fail to formulate and communicate prognoses not because there is no legal duty or professional guidance to motivate, or rather put pressure on them, but simply because prognostication is, by its nature, and as argued in Section 3.1.2, a fundamentally difficult exercise. Thus, a legal or professional duty on doctors - and even perhaps relevant training - does not necessarily mean that doctors and other healthcare professionals will get better at prognosticating or communicating prognoses.

The analysis above studied whether prognosis for terminally ill patients is clinically or scientifically plausible. It was revealed that there is great uncertainty among healthcare professionals and other experts as regards the length of the prognostic period leading to the patient’s death. This is further complicated by various factors, including that conditions and illnesses have different effects and different progression for patients, or that treatment is sometimes attempted, or continued, after prognosis. Scientific research and studies confirmed that prognoses are often inaccurate with doctors typically overestimating prognosis. Real-life cases, however, show that many terminally ill patients survive much longer than expected. Lastly, Christakis’ argument that doctors sometimes refuse to formulate or effectively communicate prognosis to

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patients further highlights practical problems with prognosis in the context of terminal illness.

### 3.1.3 Concluding Remarks

Part 3.1 was concerned with terminal illness as a potential eligibility (standard or criterion) for assisted dying. It is concluded that the arguments relating to the lack of a clear legal definition of terminal illness, the advances in medicine, and the problems with prognosis challenge the suitability of such an eligibility for an assisted dying framework in England and Wales. To associate assisted dying with terminal illness would mean finding an accurate and workable legal definition of terminal illness. If not, there would be huge practical problems with identifying who is, and who is not eligible to request assistance. Other than the practical problems with the identification and practical application of a terminal illness eligibility, terminal illness should not be the basis for being allowed to request an assisted death. Rather, the right to request an assisted death should be based on the right to self-determination in choosing the manner and timing of one’s death under Article 8, an argument fully explored in Chapter Six. Terminal illness is thus not an appropriate standard to determine eligibility for assisted dying.
3.2 A Suffering-Based Eligibility for Assisted Dying

The second most prevalent type of eligibility criterion relating to the physical or mental condition of the individual (or short: ‘the eligibility’) is mainly used in the Benelux countries. By the Netherlands with the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (‘TLRAS’) 2002,99 by Belgium with the Euthanasia Act (‘EA’) 2002,100 and by Luxembourg with the Law on Euthanasia and Assisted Suicide (‘LEAS’) 2009.101 In England and Wales, the earlier reform proposals used ‘unbearable suffering’ to ascertain eligibility for assisted dying. The PADB 2002 aimed to enable a competent adult suffering unbearably as a result of a terminal or serious and progressive physical illness to receive medical help to die at his own considered and persistent request.102 Similarly, the ADTIB 2003 aimed to enable a competent adult suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request.103


102 Patient (Assisted Dying) HL Bill (2002-03) 37 [emphasis added].

103 Originally introduced as: Assisted Dying for the Terminally Ill HL Bill (2003-04) 17 [emphasis added]. The HLSC, which examined the ADTIB, recommended that any future reform proposal should use a test of ‘unrelievable’ or ‘intractable’, rather than ‘unbearable’ suffering (Select Committee, Assisted Dying for the Terminally Ill Bill, Vol. I: Report (HL 2005 Paper 86-I), pp. 87, 91). This would enable a more objective medical assessment of the patient’s suffering, and ensure that all available steps have been considered.
domestic reform proposals, however, including the CAD in 2012, have strongly rejected the suitability of this type of eligibility.\(^{104}\) Part 3.2 assesses the suitability of an eligibility based on suffering. Section 3.2.5 concludes by challenging the fact that a suffering-based eligibility is suitable for a future domestic assisted dying framework.

3.2.1 Setting the Scene

Suffering is a subjective, multifaceted experience which cannot be easily defined, quantified, or assessed.\(^{105}\) It is a term that suggests that one is experiencing or showing, or is subjected to something typically bad or unpleasant. This can be physical (illness, condition), mental (distress), psychological (loss), harm (accident), or some change or development (for instance, in personal or professional relations).\(^{106}\) One is ‘suffering’ from a cold or from exhaustion; a party ‘suffers’ a defeat during an election; one is ‘suffering’ from a tendency to exaggerate. Marianne Dees et al. define unbearable suffering as ‘a profoundly personal experience of an actual or perceived impending threat to the integrity or life of the person, which has a significant duration

\(^{104}\) CAD’s Report, pp. 305-307. The CAD recommended an eligibility criterion with ‘no element of suffering’ as terminally ill patients should not be ‘required to be already experiencing unbearable suffering to request an assisted death’. The prospect of anticipated suffering is sufficient.


and a central place in the person's mind'. \(^{107}\) Eric Cassell’s definition, that has also influenced the Dutch law on voluntary euthanasia and assisted suicide, is that unbearable suffering is ‘the state of severe distress associated with events that threaten the intactness of the person’. \(^{108}\) In the context of assisted dying though, if the term is to be used to determine eligibility, legal certainty demands that it is given a workable, specific definition. This is to ascertain when suffering justifies granting a request for assisted dying, and when it merely requires medical attention or care, or a change of habits. Potential problems with a suffering-based eligibility are here revealed through the study of its definition in past domestic reform proposals, and the laws of the Benelux countries.

As hinted earlier, two domestic reform proposals have used the term ‘unbearable suffering’ to determine eligibility for assisted dying. The PADB defined ‘unbearable suffering’ as suffering by reason of pain or otherwise resulting from an irremediable condition, the ending of which would be a humane act for the patient. \(^{109}\) The revised version of the PADB, the ADTIB, defined ‘unbearable suffering’ as suffering by reason of pain or otherwise which the patient finds so severe as to be unacceptable and results from the patient’s terminal illness. \(^{110}\) Both definitions provide for ‘suffering by reason of pain or otherwise’ suggesting that suffering need not necessarily be physical (somatic) in nature. Both definitions require that suffering is the result of something. However, there is a key difference: while the PADB takes an arguably more flexible approach in specifying the cause of the suffering (‘an irremediable condition’): a


\(^{109}\) Section 1(2). Both the attending (Section 2(2)(d)), and consulting physician (Section 2(3)(c)) should conclude/be satisfied that the patient is suffering unbearably as a result of the irremediable condition.

\(^{110}\) Section 1(2). Both the attending (Section 2(2)(d)), and consulting physician (Section 2(3)(d)) should conclude that the patient is suffering unbearably as a result of the terminal illness.
terminal or a serious physical illness), the ADTIB requires a terminal illness. Another key difference is that while the ADTIB expressly incorporates a subjective element (‘which the patient finds so severe as to be unacceptable’), the PADB does not, at least not expressly.

The Dutch Act requires that the patient is suffering hopelessly and unbearably but does not expand further on what suffering, hopeless, or unbearable mean. The Belgian Act requires that the patient is in a medically futile condition of constant and unbearable physical or mental suffering than cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident. Neither the 2002 Act as such, nor any parliamentary proceedings expand on the terms used. The Luxembourg Act requires that the patient is in a hopeless situation of physical or mental suffering that is constant and unbearable, with no prospect of improvement, resulting from an accident or a condition. The 2009 Act similarly does not expand on the terms used. The three jurisdictions all use the term ‘unbearable’. All three definitions refer to ‘hopelessness’: the Dutch Act expressly refers to ‘hopeless suffering’, the Belgian Act refers to ‘a medically futile condition […] that cannot be alleviated’, and the Luxembourg Act refers to ‘a hopeless situation […] with no prospect of improvement’. Moreover, while the Dutch Act does not expressly specify the type of suffering that would make an individual eligible, the Belgian and Luxembourg Acts both provide for physical or mental suffering that must be constant. Similarly, while the Dutch Act does not specify the cause of the suffering, the Belgian Act specifies that suffering must result from a serious and incurable disorder caused by illness or accident, and the Luxembourg Act that suffering must result from an accident or a condition. The overview of the suffering-based eligibility definitions in

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111 TLRAS 2002, Article 2(1)(b) (own translation from Dutch).

112 EA 2002, Section 3.


114 LEAS 2009, Article 2.1 (3) (own translation from French).
domestic reform proposals and in the laws of the Benelux jurisdictions raises three main questions: the type of eligible suffering, the assessment of the suffering, and the cause of the suffering.

3.2.2 The Type of Eligible ‘Suffering’ (Physical or Non-Physical)

Individuals who wish to end their lives may experience physical suffering (somatic pain), or non-physical suffering (non-somatic pain) including psychological/mental, and sometimes existential suffering, or indeed sometimes both physical and non-physical suffering.\(^{115}\) Human beings are complex physical, psychological, social, and existential beings; therefore their suffering can originate from any dimension of human nature.\(^{116}\) This complex nature of human suffering is recognised by all jurisdictions that use (or in the case of England and Wales, in reform proposals that used) a suffering-based eligibility for assisted dying. This is because all the suffering-based eligibility definitions studied earlier cover, expressly or following interpretation, more than physical suffering. Domestically, the PADB and the ADTIB referred to suffering by reason of ‘pain or otherwise’ which indicates that non-physical suffering is also accepted.\(^{117}\) In Belgium and Luxembourg, the law explicitly refers to both physical and mental suffering, but neither is further defined. The situation in the Netherlands is more complicated. This is because, although not explicit in the text of the law, suffering other than physical is also accepted.\(^{118}\) A number of developments in the

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\(^{118}\) The 1993 Report ‘Assistance with Suicide in Psychiatric Practice’ noted that competent psychiatric patients should be allowed access to assisted dying. The 1997 Dutch Association for Psychiatry Report agreed but highlighted the need for additional safeguards. In 1994, this was confirmed by the Supreme
Netherlands, including the *Brongersma* case, the ‘Dijkhuis Committee’, and a 2016 Cabinet letter to the Second Chamber of Parliament mean that, sometimes, even existential suffering is an acceptable reason to die.

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119 In the *Brongersma* case, HR 24 December 2002 (LJN AE8772), an 86-year-old former lawyer and senator was assisted in dying after hopeless suffering was confirmed without a recognisable type of suffering. The physician was prosecuted.


It is right that the suffering-based eligibility definitions recognise that suffering can also be non-physical.\textsuperscript{122} This way, the suffering of individuals who wish to end their lives will not be prolonged because their suffering does not fall under the physical pain scale. However, it remains controversial that the terms used to define what an ‘eligible’ suffering is are not defined. This may be problematic for both patients and doctors as neither will be in a position to know what gives rise to euthanasia and/or assisted suicide. The counterargument, however, may well be that legislators intended that the ‘eligibility’ is broad, similar to the argument in relation to the terminal illness eligibility, so the emphasis is on the circumstances of individual cases. But then again, if the ‘eligibility’ can potentially cover literally every type of suffering that can exist, why have it as a legal requirement? And indeed, why should the law make individuals wait until their suffering becomes ‘unbearable’ or ‘hopeless’? Frankly, any individual may claim to be unbearably suffering as a result of something. A correlated problem is that physicians, in general, are more comfortable in assessing physical rather than non-physical suffering. Physicians are more likely to find suffering to be ‘unbearable’ when it is physical in nature, and less likely when suffering is non-physical.\textsuperscript{123} In other words, the more subjective the suffering the less likely the physician will grant the request.\textsuperscript{124} Donald van Tola et al. found that physicians are more likely to find suffering to be unbearable when suffering is directly related to untreatable and actual pain, or physical symptoms.\textsuperscript{125} At the same time, different studies suggest that patients are more likely to be concerned with psycho-social suffering, while physicians are likely to adopt a narrow perspective on unbearable suffering.\textsuperscript{126} The fact that


\textsuperscript{123} CAD Commissioners’ meeting with Professor Luc Deliens (Professor of Public Health and Palliative Care); and Professor Lieve van der Block (End-of-Life Care Research Group, Vrije University, Brussels).

\textsuperscript{124} ibid.

\textsuperscript{125} Donald van Tola et al., ‘Judgment of Unbearable Suffering and Willingness to Grant a Euthanasia Request by Dutch General Practitioners’ (2010) 97 Health Policy 166.

\textsuperscript{126} Roeline Pasman et al., ‘Concept of Unbearable Suffering in Context of Ungranted Requests for Euthanasia: Qualitative Interviews with Patients and Physicians’ (2009) BMJ 39: b4362; Hilde Buiting et
physicians are more comfortable in assessing physical suffering is likely because non-physical suffering is much harder to identify or understand, much less quantify or measure for the purposes of assisted dying eligibility. Thus, physicians will take a cautious approach when physical suffering is not present and sometimes, even judge that some types of suffering are ‘not sufficiently unbearable’.\textsuperscript{127} This raises questions not only with regards to the earlier argument that suffering should not become ‘unbearable’ to be an acceptable reason to request an assisted death, but also with regards to a third party (the physician) assessing the suffering of another individual, which is examined below.

\textbf{3.2.3 A Subjective or an Objective Assessment of Suffering?}

A further consideration that may challenge the suitability of a suffering-based eligibility for assisted dying is whether ‘unbearable suffering’ should be judged against a subjective (assessment carried out by the patient), or an objective (assessment carried out by third party, typically physicians) standard.

Out of the five suffering-based eligibility definitions studied above, only the ADTIB definition \textit{explicitly} incorporates a subjective assessment of suffering (‘which the patient finds so severe as to be unacceptable’). Lord Joffe in 2005 and 2011 confirmed that the test is ‘clearly subjective’: ‘it is not what a doctor might say is the norm; it is that particular patient’s suffering which is the subject matter of his decision’.\textsuperscript{128} The involvement of the consulting and attending physicians in the assessment of suffering


adds the objective element. Similarly, the Dutch Act is construed in such a way (unbearable and hopeless suffering) as to include both a subjective and an objective element. Whether suffering is unbearable is subjectively assessed by the patient, whereas whether suffering is hopeless is objectively assessed by physicians. Physicians use their professional expertise to assess the chance of improvement, if any, the availability of reasonable treatments, if any, always with reference to the current state of medicine. The laws in Belgium and Luxembourg also include both elements. Whereas ‘the medically futile condition that cannot be alleviated’ and ‘the serious and incurable disorder caused by illness or accident’ can be objectively assessed by the physicians, the patient alone subjectively assesses that suffering is ‘constant’ and ‘unbearable’.

Suffering is a very personal experience; how much suffering one may endure, the impact of the suffering on one’s quality of life, or one’s perception of the value of continued existence with suffering is without doubt a very subjective assessment. The impact of suffering on the individual also depends on various factors, including the patient’s perspective or personality, the patient’s norms and values, any increasing physical deterioration and dependency, loss of dignity, and so on. Suffering is determined by the psychological tensions and inner resources of the individual.

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130 CAD’s meeting with Dr Gert van Dijk of the Royal Dutch Medical Association.


enduring the suffering as comparisons are made between present and past life. In evidence to the CAD in 2012, Peter Morgan, a social worker, noted that if eligibility relates to the individual’s quality of life or suffering it is imperative that the individual concerned, not a third party, makes the judgement. One potential problem with a wholly subjective assessment of suffering, however, is that it will place a heavy burden on individual patients to give an accurate and persuasive description of the level of their suffering. On the other hand, an objective assessment of suffering means that the individual’s personal experiences and feelings are no longer the focus of the procedure, hence invalidating an argument that can be used in favour of a suffering-based eligibility that would place the individual’s feelings and experience of suffering at the heart of the procedure. In

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other words, an objective test of suffering diminishes individual choice by minimising the role of the individual in the procedure. Most importantly, an objective test means that a third party is placed in the impossible and inappropriate position of assessing another’s suffering. This was the major justification of the CAD for rejecting a suffering-based eligibility.\textsuperscript{139} It is an impossible position because a third party, despite their professional experience, cannot persuasively assess another’s perception of suffering, and inappropriate because a third party may suggest that suffering is not ‘bad enough’, or ‘unbearable enough’.\textsuperscript{140}

But how do physicians assess their patients’ suffering in the jurisdictions that a suffering-based eligibility is already used? One study, for instance, found that physicians took into consideration the personhood of the patient (including the personal history of the patient), while others compared the situation of the patient with that of other patients in comparable situations.\textsuperscript{141} A similar study attempted to assess how physicians breach the gap from a 3\textsuperscript{rd} person assessment to a 1\textsuperscript{st} person assessment when assessing ‘unbearable suffering’.\textsuperscript{142} The study observed that physicians used two main ‘cognitive routes’ in their assessment of the patients’ suffering: putting themselves in the position of the patient (‘imagine self’), or adopting the perspective of the patient (‘imagine other’). Hence, there is also a discrepancy between the methods used by different physicians to assess suffering. This means that


\textsuperscript{140} See, an example: Alison Langley, ‘Request to die denied’ Niagara Falls Review (6 October 2016) <www.niagarafallsreview.ca/2016/10/06/request-to-die-denied> accessed 26 September 2017.


\textsuperscript{142} Donald G. van Tola et al., ‘Empathy and the Application of the ‘Unbearable Suffering’ Criterion in Dutch Euthanasia Practice’ (2012) 105 Health Policy 296. Their overall argument is that physicians should be aware of both ‘cognitive routes’ and their own personal norms when assessing suffering.
each physician will subjectively assess the already subjective experience of suffering of the patient. Moreover, the physician’s interpretation of suffering may be influenced by his or her general experience or ideology, the type of relationship or the length of the relationship with the patient, or, as Van Tola et al. found, by the physician’s private norms, values and emotions on assisted suicide and euthanasia.\textsuperscript{143} Therefore, whether a request for an assisted death will be granted may be a matter of chance for the patient.\textsuperscript{144} What is difficult to dispute, however, is that there is no specific skill or knowledge that can teach physicians how to empathise with their patients.\textsuperscript{145} The National Council for Hospices and Specialist Palliative Care Services remarked that agreeing on a common objective professional standard, or benchmark, or parameters for physicians to judge suffering may be unrealistic.\textsuperscript{146} Therefore, an objective assessment of suffering minimises the role of the patient in the assisted dying procedure, leaves the assessment of suffering entirely up to the discretion, ideology, and methods of physicians, and makes the whole procedure uncertain as different physicians are likely to use different methods to assess the suffering of their patients. Even with a combination of a subjective and an objective assessment of suffering, the approach currently favoured in the jurisdictions that use a suffering-based eligibility, the problems discussed above persist.

\textsuperscript{143} ibid.
\textsuperscript{145} Donald van Tola et al., ‘Judgment of Unbearable Suffering and Willingness to Grant a Euthanasia Request by Dutch General Practitioners’ (2010) 97 Health Policy 166.
3.2.4 ‘Unbearable Suffering Must Result From…’

Most of the definitions already studied specify that suffering must be the result, the cause of something. The PADB specified that unbearable suffering must result from ‘an irremediable condition’, i.e. a terminal or serious physical illness.\(^{147}\) Terminal illness was defined earlier, and serious physical illness means a serious incurable and progressive physical illness. The terms used to define ‘an irremediable condition’ are very broad, raising questions similar to the questions raised in the terminal illness eligibility debate. This lack of clarity means that problems are very likely to arise in the assessment of who is, and who is not eligible for assistance under a suffering-based eligibility. Similarly, the ADTIB specified that unbearable suffering must result from the patient’s terminal illness.\(^{148}\) This requirement is even more controversial than the PADB’s ‘irremediable condition’ as it invalidates perhaps the most persuasive argument in favour of a suffering-based eligibility that a suffering-based eligibility is more likely, at least compared to a terminal illness eligibility, to account for the majority of those who wish to end their live.\(^{149}\) This is simply because the requirement that suffering must result from the patient’s terminal illness demands the presence of a terminal illness which, as concluded in Part 3.1, suffers from serious shortcomings.\(^{150}\)

The fact that most of the suffering-based eligibility definitions specify that suffering must result from something is likely an attempt to make the definitions more limited, thus more workable. The problem, however, is that a requirement such as the one that requires suffering to result from a terminal illness is very limiting as it excludes

\(^{147}\) PADB 2003, Section 1(2).

\(^{148}\) ADTIB 2004, Section 1(2).

\(^{149}\) See, for instance, the legal cases that challenged the criminal prohibition on assisted suicide in England and Wales discussed earlier in the Chapter.

\(^{150}\) The same problems are likely to arise in Belgium (Section 3: suffering must result from a serious and incurable disorder caused by illness or accident), and Luxembourg (Article 2.1 (3): suffering must result from an accident or a condition).
those who suffer from non-terminal conditions and illnesses. As argued in Part 3.1, a terminal illness eligibility excludes many individuals who suffer from non-terminal yet incurable, painful, or debilitating conditions and illnesses. At the same time, a requirement that suffering results from something that is more broadly defined (for instance, a serious physical illness, or a serious and incurable disorder, or an accident) is ambiguous, and is likely to cause great uncertainty for both patients and physicians. This creates a catch-22 situation where to strive for certainty is too limiting, and, in contrast, attempting to include those individuals who actually suffer by using broad terms causes uncertainty among those involved.

3.2.5 Concluding Remarks

Part 3.2 was concerned with suffering as a potential eligibility (standard or criterion) for assisted dying. It was noted that suffering as a term does not have a single definition, and as a legal term fails to give definite answers to both patients and physicians involved. To associate assisted dying with suffering within a legalisation framework would mean finding an accurate and workable legal definition of ‘suffering’. If not, there would be huge practical problems with identifying who is, and who is not eligible to request assisted death. The failure to define what physical and non-physical suffering is leads to uncertainty while attempting to make the definition of ‘suffering’ workable by specifying that suffering needs to result from something is similarly problematic, as it leads to either too limiting or too vague results. Moreover, while it is imperative that suffering is subjectively assessed by the patient, an objective assessment of suffering carries a number of problems, principally that it is unlikely that a third party will be in a position to judge another’s already subjective experience. Other than the practical problems with the identification and practical application of a

151 Though this could be in line with the argument in Chapter Six of the thesis, it is unclear why having an unclear criterion is preferable than having no criterion relating to the physical or mental condition of the individual at all.
suffering-based eligibility, suffering should not be the basis for being allowed to request an assisted death. The right to request an assisted death should be based on the right to self-determination in choosing the manner and timing of one’s death under Article 8 of the ECHR. From a human rights perspective, the suffering of an individual, no matter its type or its source, should be accepted as justification for requesting assistance in dying. Suffering is therefore not an appropriate standard to determine eligibility for assisted dying in a future domestic legalisation framework.
3.3 Concluding Remarks: ‘Eligibility’ and Assisted Dying

Chapter Three identified that all jurisdictions that permit a form of assisted dying use some type of eligibility criterion relating to the physical or mental condition of the individual: either a terminal illness eligibility, preferred largely by US states, or a suffering-based eligibility, preferred largely in Europe. In England and Wales, reform proposals have used either a terminal illness eligibility only, or a combination of terminal illness and a suffering-based eligibility. Parts 3.1 and 3.2 of Chapter Three discussed both types of eligibility to assess their suitability for a potential assisted dying framework in England and Wales. It concluded by challenging the suitability of both types of eligibility because of the practical problems identified and discussed in this Chapter. In addition, neither a terminal illness, nor a suffering-based eligibility is likely to be compatible with the human rights argument advanced in Chapter Six of the thesis. It is not argued here that the two types of eligibility cannot be sustained, despite the difficulties identified in this Chapter. This is evident from their use in other jurisdictions. Rather, what is argued is that an eligibility criterion based on the physical or mental condition of the individual ignores the fact that a life or death decision is a protected human right under Article 8, and as discussed in Chapter Six, the European Court of Human Rights (‘ECtHR’) in its jurisprudence does not specify whether the individual should be terminally ill or suffering to request access to assisted dying.
CHAPTER FOUR:
THE MENTAL CAPACITY ELIGIBILITY CRITERION

The decision to request assistance in dying must come from an individual with decision-making capacity. There is no question of assisted dying if the individual lacks the capacity to decide it. Moreover, only an individual with mental capacity can exercise an autonomous decision. Autonomy is the central idea behind the Mental Capacity Act (‘MCA’) 2005. An individual with capacity can make almost any unwise decision, even if that will lead to death.\(^1\) The MCA aims to allow those with mental capacity to make decisions, while protecting those who lack this capacity.

It should be easy for an assisted dying framework to identify cases in which mental capacity is significantly impaired, that is, when individuals completely lack capacity.\(^2\) The difficulty lies with cases that do not fall in this category.\(^3\) Indeed, many factors may temporarily or permanently affect an individual’s decision-making capacity, such

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\(^1\) Re B (Adult: Refusal of Medical Treatment) [2002] 2 All ER 449 (HC); Re T (Adult: Refusal of Treatment) [1993] Fam 95 (Lord Donaldson MR): ‘the patient’s right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent’.


as mental health problems. In fact, the prevalence of mental health problems in our society makes it even more pressing for an assisted dying framework to identify whether these significantly impair the individual’s capacity. It is often suggested that this is a particular concern for ‘vulnerable groups’. It is important to note, however, that this may become an issue for any one that may feel ‘vulnerable’ at some stage in life. Thus, it is crucial for an assisted dying framework to ensure that those who actually lack the capacity to decide are protected, and those who have the capacity (and satisfy the other criteria and safeguards) are allowed to request assisted dying. As also noted in *Haas*, it is necessary to distinguish between the wish to commit suicide as an expression of illness, and the wish to commit suicide as an autonomous, considered, and sustained decision.

A mental capacity requirement is found in the laws and regulations of all jurisdictions that permit a form of assisted dying, and in the reform proposals in England and

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7 Transcript of Evidence Debbie Purdy (December 2010) <https://web.archive.org/web/20160327122526/http://commissiononassisteddying.co.uk/wp-content/uploads/2010/12/Debbie-Purdy-Transcript1.pdf> accessed 26 September 2017, p. 5. There is a need to ensure ‘that protection is offered to anybody who does lack capacity to make those decisions’, but respect the personal choices of mentally capable individuals who wish to die.

8 *Haas v Switzerland* (2011) 53 EHRR 33 [47].
Wales. The CAD’s mental capacity eligibility criterion, which is used as starting point in this Chapter, is phrased as follows: ‘the person has the mental capacity to make a voluntary and informed choice, and the person’s decision-making is not significantly impaired as a result of mental health problems such as depression’. Both the mental capacity criterion and voluntariness criterion discussed in Chapter Five are necessary for an autonomous decision. The individual needs both the internal capacity for self-government (free will), and to be free from external constraints (liberty). The former is reflected in the CAD’s mental capacity criterion, the former in the CAD’s voluntariness criterion.

Chapter Four argues that it is possible for an assisted dying framework to identify and guarantee a competent, autonomous request for assisted dying allowing the individual to exercise his/her right to self-determination, and at the same time protect those whose lives may be in danger by the availability of assisted dying. Chapter Four considers the legal rules in other jurisdictions, and academic and scientific studies to assess whether the CAD’s third eligibility criterion and the safeguards proposed to support it are suitable for a domestic assisted dying framework, or whether anything should be removed, retained, or developed.

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10 See Chapter Six of the thesis.
4.1 The Mental Capacity Assessment

4.1.1 The CAD’s Mental Capacity Assessment

The CAD’s third eligibility criterion states that ‘the person has the mental capacity to make a voluntary and informed choice, and the person’s decision-making is not significantly impaired as a result of mental health problems such as depression’.\(^\text{11}\) The phrasing of the criterion is interesting. The use of the word ‘and’, italicized above, divides the criterion into two parts. This is unclear in the CAD’s Report, but most likely these two parts establish the ‘more formal assessment’ of mental capacity envisaged by the CAD. The CAD in its Report identified two possible models of assessing the decision-making capacity of individuals in the context of assisted dying: a new ‘formal assessment’, summarised below, and the MCA assessment. The latter was rejected by the CAD as ‘clearly insufficiently rigorous’ in the context of assisted dying\(^\text{12}\) because of the presumption of capacity.\(^\text{13}\) Doctors, the CAD noted, should not assume that an individual requesting assistance in dying has mental capacity because of the serious nature of the decision. Hence, the CAD considered that a formal assessment of mental capacity is necessary.\(^\text{14}\)

The CAD proposed that a minimum of at least two doctors should independently assess the individual’s decision-making capacity.\(^\text{15}\) In difficult cases, the two doctors can consult other professionals involved in the individual’s care and treatment ‘to fill in any gaps in knowledge or increase their understanding of how the patient may have a history of being consistent or inconsistent in his/her decisions over time’.\(^\text{16}\)

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\(^{11}\) CAD’s Report, pp. 21, 26, 301, 337 [emphasis added].

\(^{12}\) ibid p. 308.

\(^{13}\) See: Section 1(2) of the MCA.

\(^{14}\) CAD’s Report, pp. 27, 307-310.

\(^{15}\) ibid pp. 28-30.

\(^{16}\) ibid p. 340.
noted that it will be the responsibility of the relevant professional bodies to develop codes of practice to guide the capacity assessment. These should, for instance, include specific guidance on identifying depression or other psychological disorders significantly impairing the decision-making capacity of the individual requesting assisted dying. Another safeguard that forms part of the CAD’s formal assessment of mental capacity is that any individual who has difficulties communicating their wishes during the capacity assessment can make use of the help of an independent advocate. In fact, any individual going through the process can use an independent advocate. The advocate, according to the CAD, may be a professional who knows the individual well, or a family member or friend that will help the individual articulate his/her wishes and motivation. Moreover, before providing the individual with the lethal medication, the doctor or other suitably qualified professional must be satisfied that, at the particular moment the individual continues to have mental capacity to make an assisted dying decision. A written report should be produced, giving the date and time of the final assessment. The two models considered by the CAD, the MCA model and the ‘formal assessment’ model, will now be examined to assess whether the CAD’s conclusion in favour of the later is justifiable.

4.1.2 Who Should Assess the Mental Capacity of the Individual

All jurisdictions allowing a form of assisted dying, similar to the CAD, require that doctors (in most cases two doctors) assess the decision-making capacity of the individual requesting assisted death. Mental capacity assessments are carried out by healthcare professionals in most medical procedures, including all treatment-related

\[17 \text{ ibid pp. 30, 316.}\]

\[18 \text{ ibid p. 340.}\]

\[19 \text{ Ibid.}\]

\[20 \text{ ibid p. 344.}\]
decisions, and any investigatory procedure. All US states permitting assisted dying require that two doctors assess the individual’s mental capacity. Oregon’s law, for instance, requires that the attending physician makes the initial determination of whether the individual, among other things, is ‘capable’. The physician must then refer the individual to a consulting physician who, among other things, must examine the patient and the relevant medical records to confirm, in writing, among other things, that the individual is ‘capable’. All the US states permitting physician-assisted dying reflect the Oregon law and require that two doctors assess the individual’s mental capacity. In Canada, the law also requires two professional assessments; however, these can also be carried out by nurses. A medical or nurse


23 127.815 §3.01(1)(a).

24 127.815 §3.01(1)(d).

25 127.820 §3.02.


27 The Act is available at: <http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=8183660> accessed 27 September 2017. The law is based on Carter v Canada (Attorney General), 2015 SCC 5 [2015] 1 SCR 331. The Supreme Court in the case found that medically-assisted death should be limited to mentally competent or capable adults who clearly consent at the time of the assistance. See further:
practitioner must ensure that the individual meets all the criteria set in the law, including that the individual is capable of making decisions with respect to their health. They must also ensure that another medical or nurse practitioner provides a written opinion confirming that the individual meets all the criteria, and that all parties involved are independent. The US states additionally require a witnessing safeguard. In Oregon, a valid request for medication must be witnessed by at least two individuals who, in the presence of the patient, among other things, must confirm that to the best of their knowledge and belief the individual is ‘capable’. This is the case in all the US states, however, the law in Vermont requires the witnesses to confirm that the individual ‘appeared to understand the nature of the document’, whilst in California the law requires that the witnesses confirm that they know or have identified the individual. This difference in approach in Vermont and California highlights a major problem with the witnessing safeguard. It is difficult to see how witnesses may confirm that the individual has the mental capacity to make an assisted dying decision. This is not only because the witnesses are not healthcare or legal professionals, but also because most witnesses are not acquainted with the individual and his/her personal circumstances, and not trained to perform such expert assessment.

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28 241.2(b).

29 See further: 241.6.

30 127.810 §2.02.

31 §5283.

32 443.3(3)(A) and (C).

33 See further Chapter Five of this thesis.
In stark contrast, none of the European jurisdictions that permit a form of assisted dying require a witnessing safeguard, and in fact, most require that mainly one doctor is involved in the assessment of the individual’s mental capacity. Under Article 2(1)(a) of the Dutch law, for instance, the physician must identify a voluntary and well-considered request. Interestingly, the Act does not expressly refer to decision-making capacity, however, the RRCs’ Code of Practice notes that this falls under the ‘voluntary and well-considered’ requirement. Specifically, the individual must be ‘decisionally competent’, which is labelled as ‘internal voluntariness’. The RRCs advise that in cases where competence is not clear - in the case of minors, patients with psychiatric disorder, patients with dementia, patients with an intellectual disability, patients with aphasia, patients in coma/reduced consciousness- physicians should perform a more explicit and in-depth assessment of mental capacity, and also consult a second physician with relevant expertise. In the Netherlands, therefore, the second physician is only involved in difficult cases. Section 3(1) of the Belgian law requires that the physician performing euthanasia ensures that the patient has

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attained the age of majority or is an emancipated minor, and is legally competent and conscious at the moment of the request. Unlike the Netherlands, the consultation with the second physician only concerns ‘the serious and incurable condition’ of the patient, not mental capacity. In Luxembourg, the law is, this time, slightly different than Belgium. Under Article 2(1)(1) of the 2009 Law the physician must ensure that the patient is capable and conscious at the time of the request. Although the consultation with the second physician also concerns the ‘serious and incurable condition’ of the patient only, the physician may involve an additional adviser or expert in the assessment of mental capacity. Therefore, only Belgium does not provide for a second capacity assessment by physicians. In Switzerland, assisted suicide operates under no official statutory framework, but individuals must have mental capacity to request assisted suicide. This is implied in the Swiss Criminal Code. If the individual lacked capacity, the offence of homicide through negligence under Article 117 is triggered leading to three years imprisonment or a monetary fine. Moreover, and similar to the discussion on voluntariness in the next Chapter, if


39 Section 3(2)(3).


doctors decide to be involved, SAMS suggests that, among other things, they check whether the individual is capable of making the decision.43 A third party, not necessarily a physician, must also confirm capacity. A non-professional confirmation or assessment of mental capacity is here considered no different from the witnessing safeguard, earlier rejected as insufficient to ensure that the individual has mental capacity. Moreover, the right-to-die organisations that perform most assisted suicides, set their own criteria on decision-making capacity. EXIT and DIGNITAS are the biggest organisations, the former requires that its members ‘know what they are doing’ (in their website, this is labelled as ‘faculty of judgement’),44 and the latter states that assistance is provided to individuals with ‘sound judgement’.45

The safeguard proposed by the CAD requiring that the two doctors assess the mental capacity of the individual independently of each other does not appear, at least explicitly, in the jurisdictions studied here with the exception of California46 and Canada.47 It is here considered necessary that, in the interests of safety in creating a robust domestic assisted dying framework, in addition to the involvement of at least two healthcare professionals (and possibly a third in difficult cases) that the

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46 443.1(f) California’s End of Life Option Act 2016.

47 241.2(6) Canada’s Bill C-14 2016.
assessments are separately and independently carried out to ensure, to the extent possible, a vigorous process and to prevent ‘collusions’.\textsuperscript{48}

\textbf{4.1.3 A Standard or Test for Assessing Mental Capacity}

Other than the question of who should assess mental capacity (doctors, or other healthcare professionals) examined above, as well as the number of assessments that should be required (one, or at least two), it is also significant to examine what test or against which standards the assessment should be carried out. As earlier noted, the CAD envisaged that under its formal mental capacity assessment, the relevant professional bodies, including the General Medical Council (‘GMC’) and the Nursing and Midwifery Council, will develop codes of practice to guide the assessment by doctors.\textsuperscript{49} It is here argued, however, that it is vital for an assisted dying framework itself to identify a test for capacity, or at minimum provide some definition of ‘mental capacity’.\textsuperscript{50} In jurisdictions that already permit a form of assisted dying, a test of capacity is only sometimes expressly included in the law (Oregon, Washington),\textsuperscript{51} with codes of practice usually advising doctors on how to carry out the assessment of mental capacity. Most jurisdictions examined below, however, require very similar standards: making, weighing, understanding, and communicating the relevant information.

In Oregon, a capable adult is an individual who is able to make and communicate healthcare decisions to healthcare providers, including communication through third

\textsuperscript{48} CAD’s Report, pp. 20, 26, 301, 312, 338.

\textsuperscript{49} ibid pp. 30, 316.

\textsuperscript{50} Annabel Price et al., ‘Concepts of Mental Capacity for Patients Requesting Assisted Suicide: A Qualitative Analysis of Expert Evidence Presented to the Commission on Assisted Dying’ (2014) 15 BMC Medical Ethics 32.

\textsuperscript{51} ibid p. 9.
parties familiar with the individual’s manner of communicating.\textsuperscript{52} The Task Force to Improve the Care of Terminally-Ill Oregonians suggests that healthcare professionals ensure, in particular, that the individual understands and weighs information, is able to communicate a choice, and that no mental health condition is impairing the individual’s judgement.\textsuperscript{53} The law in Vermont, otherwise identical, defines ‘impaired judgment’ as the judgment of an individual who does not sufficiently understand or appreciate the facts necessary to make an informed decision.\textsuperscript{54} The phrasing of the law in California is also slightly different. ‘Capacity to make medical decisions’ means that the individual is able to understand the nature and consequences of a healthcare decision, and its significant benefits, risks, and alternatives, and to make and communicate an informed decision to healthcare providers.\textsuperscript{55} In Canada, the capacity assessment is not included in the law, similar to the CAD’s formal assessment of mental capacity. However, the Department of Justice states that a mentally competent or capable individual has the capacity to understand the nature and consequences of his/her actions and choices, including decisions related to medical care and treatments.\textsuperscript{56}

The Dutch law also does not include a test of capacity, or a definition of mental capacity, or any other relevant definition (expect in reference to minors). As noted

\textsuperscript{52} 127.800 §1.01(3).


\textsuperscript{54} §5281(5).


earlier, the mental capacity criterion falls under Article 2(1)(a) and the ‘voluntary and well-considered request’. The individual must be ‘decisionally competent’ (internal voluntariness), meaning an ability to understand relevant information about his/her situation, prognosis, alternatives, and to assess the implications of the decision.\textsuperscript{57} Competence must be decision-specific as an individual may be competent to make a euthanasia request, but not other types of decisions.\textsuperscript{58} In Belgium, although competency is defined in the law, there is no reference to a capacity test that physicians should follow. Section 3(1) refers to an individual who has attained the age of majority or is an emancipated minor, and is legally competent and conscious at the moment of the request.\textsuperscript{59} Same in Luxembourg: under Section 2(1)(1), the individual must be capable and conscious at the time of the request,\textsuperscript{60} but no mental capacity test is specified. The Department of Health in Luxembourg notes that the patient must be of legal age, that is, not be deemed by the courts incapable of making decisions.\textsuperscript{61} Therefore, a minor, an adult under ‘guardianship or trusteeship’, or an incapable individual cannot request euthanasia or assisted suicide.\textsuperscript{62} This comes in contrast to


\textsuperscript{58} ibid.


the laws in the Netherlands and Belgium that do allow access to minors. It is argued here that an assisted dying framework must include a test of mental capacity that will be made explicit in the text of the law, or at minimum provide a definition of what mental capacity is in the context of assisted dying. Healthcare professionals and other parties involved will then rely on the test to carry out the assessment. It is also argued that the MCA test is more suitable than the CAD’s ‘formal assessment’ for two main reasons.

The first reason is that the MCA test is an established test in England and Wales, and is already widely-used by healthcare professionals and lawyers who will be more familiar and more confident to use it also in the context of assisted dying. A new ‘formal

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63 Whether assisted dying should be available to minors is an important consideration. Though this thesis does not discuss this option, it is considered crucial that in the future, and based on the argument put forward in Chapter Six, that the option is considered.


65 Section 62 of the MCA must be revisited in case of legalisation in England and Wales in the future: ‘For the avoidance of doubt, it is hereby declared that nothing in this Act is to be taken to affect the law relating to murder or manslaughter or the operation of section 2 of the Suicide Act 1961 (c. 60) (assisting suicide).’

66 It is unclear whether the CAD entirely moves away from the MCA, although Price et al. note that it does not in: Annabel Price et al., ‘Concepts of Mental Capacity for Patients Requesting Assisted Suicide: A Qualitative Analysis of Expert Evidence Presented to the Commission on Assisted Dying’ (2014) 15 BMC Medical Ethics 32, 33.

assessment of capacity’ will cause confusion and uncertainty and will require further unnecessary guidance and training by professional bodies and hospitals. It is unnecessary because professional bodies are unlikely to produce codes of practice and guidance that will be substantially different from the existing ones. A number of questions are likely to arise: for instance, what would be the differences between the new formal assessment and the MCA assessment? Would the former require a higher standard of mental capacity by individuals, and what would the additional expectations by those applying it be? The MCA test is also currently used in the Policy for Prosecutors with respect to cases of encouraging or assisting suicide.\textsuperscript{68} Therefore, prosecutors are also familiar with its use. The Policy was published by the Crown Prosecution Office in 2010 to guide prosecutors on the public interest factors that need to be considered when deciding in relation to prosecutions of cases of encouraging or assisting suicide.\textsuperscript{69} One of the public interest factors in favour of prosecution is that the ‘victim’ did not have capacity (as defined by the MCA) to reach an informed decision to die. The individual’s capacity is assessed in retrospect, that is, following the ‘assistance’ or ‘encouragement’.\textsuperscript{70} In oral evidence to the CAD, Keir


Starmer explained that capacity is investigated by the police. Officers talk to witnesses who knew, and perhaps talked to the deceased about dying, to gather evidence as to the individual’s state of mind, or they may gather evidence from healthcare professionals the deceased may have talked to.

The second reason in favour of the use of the MCA test in a future domestic assisted dying framework is the assumption of capacity. Section 1(2) of the MCA states that an individual ‘must be assumed to have capacity unless it is established that he lacks capacity’. Although it is not entirely clear in the CAD’s Report, the rejection of the MCA test seems to be largely because of the assumption of capacity. In the context of such a serious decision, the CAD argued, doctors should not assume that the individual requesting assistance has mental capacity. As a general remark, the CAD seems to take a very cautious approach to its proposals. An example is not only the rejection of the presumption of capacity in favour of a new ‘formal’, therefore more advanced, assessment, but also, as discussed in Chapter Three, the limiting of assisted dying to the terminally ill only. This is likely a cautious approach to a legalisation proposal that may, in the future, be considered acceptable by the UK Parliament. However, the CAD’s rejection of the MCA test because of the presumption of capacity goes against a most fundamental principle of English medical law. The presumption of capacity respects the right of individuals to make any decision with regards to their health. This should not be different for the decision to request an assisted death. It is a fundamental principle of the MCA that individuals (generally 16 or older) have full


72 CAD’s Report, p. 308.

73 See: Annabel Price et al., ‘Concepts of Mental Capacity for Patients Requesting Assisted Suicide: A Qualitative Analysis of Expert Evidence Presented to the Commission on Assisted Dying’ (2014) 15 BMC Medical Ethics 32. The authors studied evidence submitted to the CAD and found different opinions with regards to the presumption of capacity and its role in an assisted dying framework.
legal capacity, and therefore a right to make decisions for themselves (autonomy) unless evidence can be produced that proves otherwise. Moreover, doctors assessing the capacity of individuals requesting assistance in dying should not assume that the individual lacks capacity because of the nature of the decision.74 Section 1(4) of the MCA specifically notes that an individual should not be treated as ‘unable to make a decision merely because he makes an unwise decision’. The MCA Code of Practice highlights that individuals have their own values, beliefs, preferences, and attitudes, therefore lack of capacity should not be assumed just because others consider a specific decision to be unwise.75 The presumption of capacity under the MCA also supports the absence of a mandatory psychiatric evaluation for individuals requesting assistance in dying.76 Such requirement, which was proposed for instance in the last official review of the law by the HLSC in 2005,77 goes directly against the assumption of capacity as it assumes that an assisted death decision is an unjustifiable choice that may be based, by default, on a psychological disorder or a problem.78 Moreover, a mandatory psychiatric evaluation is not a prerequisite for other permitted end-of-life practices (for instance, refusal of even life-sustaining treatment). Hence, its use in the context of assisted dying would require a serious justification.79


76 See also: HL Deb 7 November 2014, vol756, col1933 per Lord Falconer.


78 Ibid pp. 46-48. Professor Kennard and Dr Bateman arguing that every applicant should be assessed by a clinical psychologist or consultant psychiatrist.

Other MCA provisions that are potentially relevant to assisted dying are now identified. Section 1(3) of the MCA establishes that an individual should not be treated as ‘unable to make a decision unless all practicable steps to help him to do so have been taken without success’. The CAD’s independent advocate safeguard is in accordance with Section 1(3).\textsuperscript{80} An individual who has difficulties communicating his/her wishes during the assessment, and in fact any individual going through the process of requesting assistance, should have access to an independent advocate. In fact, the current MCA Code of Practice suggests practical steps on how individuals may be supported to reach a decision.\textsuperscript{81} The CAD’s independent advocate safeguard is important to facilitate the competent and autonomous decision-making of the individual.\textsuperscript{82} This is already provided by the MCA and existing Codes of Practice.

Section 2(1) of the MCA establishes that an individual ‘lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain’. Section 2(2) specifies that the impairment or disturbance can be permanent or temporary. Paragraph 4.12 of the MCA Code of Practice gives numerous examples of an impairment or disturbance in the functioning of the mind or brain.

\textsuperscript{80} CAD’s Report, p. 341.


including, for instance, some form of mental illness, dementia, or significant learning disabilities. However, Section 2(3)(b) states that lack of capacity cannot be established merely by reference to a condition of the individual, or an aspect of his behaviour which may ‘lead others to make unjustified assumptions about his capacity’. In practice, this means that an individual suffering, for instance, from depression or other mental health problems may still make an autonomous, competent decision to request assisted dying. Andrew McCulloch, Chief Executive of the Mental Health Foundation, for instance, told the CAD that any future assisted dying framework should not discriminate against individuals with mental health problems, and that the assumption that those who suffer from mental health problems are assumed to automatically lack capacity is wrong. The presence of a mental health problem in the case of an individual who considers assisted dying is an

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example of a situation where the judicial involvement safeguard discussed in Chapter Seven will be necessary as an additional safeguard.

The individual who wishes to access an assisted death, however, must satisfy the test in Section 3.\(^{87}\) Section 3(1) of the MCA establishes that an individual is unable to make a decision for himself if unable to: a. understand the information relevant to the decision; b. retain that information; c. use or weigh that information as part of the process of making the decision; or d. communicate his decision (whether by talking, using sign language or any other means). The MCA Code of Practice explains that the first three points are considered together, while the fourth becomes relevant when individuals are unable to communicate their decisions.\(^{88}\) The first point implies that the individual has been first given relevant information.\(^{89}\) Section 3(2) explains that an individual is ‘not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means)’. Every effort must be made to present information in a way that facilitates understanding.\(^{90}\) The second point requires that the individual is able ‘to hold the information in their mind long enough to use it to make an effective decision’.\(^{91}\) Section 3(3) adds that an individual is deemed able to make a decision even if able to

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\(^{87}\) The test was established in common law before 2005: *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290 (HC); and *Re MB (An Adult: Medical Treatment)* [1997] 2 FLR 426 (CA).


\(^{89}\) ibid. Examples of ‘relevant information’: the nature of the decision, the reason why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all.


\(^{91}\) ibid.
retain the information for a short period. The third point requires that the individual is in a position ‘to weigh up information and use it to arrive at a decision’. It is not enough that individuals understand the information. Finally, if the individual fails to satisfy the fourth point, and if all practicable and appropriate efforts have already been made, the individual should be treated as unable to make a decision. Overall, I argue that, in case of legalisation of assisted dying in England and Wales, the MCA test of assessing mental capacity should be used. This is not only because it is an established test and already used by healthcare professionals and lawyers, but also because of the presumption of capacity that protects the self-determination and personal autonomy of individuals who are considering an assisted death.

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92 ibid.

93 Ibid pp. 48-49.
4.2 Screening for Depression and other Mental Health Problems

4.2.1 The CAD’s Screening for Depression Safeguard

Another safeguard proposed by the CAD to support its third eligibility criterion concerns screening individuals for depression. This forms part of its proposed formal assessment of mental capacity. The CAD highlighted the link between depression, terminal illness, and assisted death in its Report. The CAD proposed that each of the two doctors screens the individual for depression by means of ‘a validated screening tool in the context of an interview’. No specific screening tool is suggested in its Report, instead, similar to the assessment of capacity, the CAD considers appropriate that professional bodies should make the choice and set the relevant protocols and codes of practice. Unlike the test of the assessment of capacity, however, entrusting these bodies with this particular choice is here considered reasonable, this being a technical consideration requiring specialist knowledge and experience.

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95 CAD’s Report, p. 340.

96 See some depression screening tools that may be considered in a future assisted dying framework: Patient.info <patient.info/doctor/patient-health-questionnaire-phq-9> accessed 26 September 2017. The Patient Health Questionnaire (PHQ-9) is used to monitor the severity of depression and response to treatment. The Ohio Association of Country Boards <http://www.oacbdd.org/clientuploads/Docs/2010/Spring%20Handouts/Session%20220j.pdf> accessed 26 September 2017. The PRIME-MD Patient Health Questionnaire (PHQ) facilitates the recognition and diagnosis of the most common mental disorders in primary care patients. See also: Linda Ganzini et al.,
suggests that if the screening identifies that the individual is suffering from depression, this should be ‘successfully treated’ before a request proceeds. If the depression does not respond to treatment, the individual should be referred to a specialist (a psychologist or a psychiatrist) for an assessment of whether the depression is significantly impairing the individual’s decision-making capacity. This is a functional approach to capacity as the emphasis is on the individual’s competencies rather than status.

A related safeguard that is also used to support the CAD’s third eligibility criterion is that, if any of the two doctors assessing the individual’s mental capacity suspect ‘abnormal psychotic thinking’, or the individual has a history of psychosis, a specialist assessment by a psychiatrist or other mental health professional should be carried out to determine whether the individual’s capacity to make an assisted dying decision is significantly impaired. The reason that the CAD places particular emphasis on psychosis and not any other mental health problem is not specified in the Report.

4.2.2 The Practice in Other Jurisdictions

The importance of a multidisciplinary assessment of mental capacity in the context of assisted dying was highlighted in a number of evidence submitted to the CAD and in


97 CAD’s Report, p. 340.

98 ibid pp. 28, 309, 340.


100 CAD’s Report, p. 340.

101 Transcript of Evidence, Bridget Robb, The College of Social Work (February 2011)

other international evidence relating to assisted dying. Most jurisdictions permitting a form of assisted dying indeed recognise the need for specialist input if there is suspicion of any mental health problem, including depression. It is crucial to note that not everyone who requests assisted death is experiencing a mental health problem, and that not everyone who experiences a mental health problem will request an assisted death. The Oregon law, for instance, does not require all applicants to have a psychiatric assessment. However, if in the opinion of the attending or consulting physician the individual may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, he/she must be referred to counselling. No lethal medication can be prescribed until a specialist confirms that the individual is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. The law in California, otherwise identical to Oregon, uses the term ‘mental health specialist’ instead of ‘psychiatrist or psychologist’, and is more explicit


104 127.825 s.3.03. Under 127.800 s.1.01(5) ‘counseling’ means: ‘one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment’.
with regards to the specialist’s role. The specialist must examine the patient and the relevant medical records and be satisfied that, among other things, there is no mental disorder impairing the patient’s judgment.

In the Benelux countries, as noted in Chapter Three, both physical and mental suffering is justifiable basis to request assisted suicide or euthanasia. Hence, individuals who suffer from mental health problems are sometimes allowed access to an assisted death. The Chabot case in the Netherlands in 1994 advised that physicians exercise particular caution when dealing with mental suffering. The physicians must be certain that the mental condition or illness does not impair the individual’s ability to form judgments. Other than the second physician, physicians in the Netherlands must consult an independent psychiatrist to assess, among other things, the individual’s decisional competence. In her meeting with the CAD, Inez de Beaufort, RRC member, noted that euthanasia or assisted suicide for individuals who suffer from severe depression is ‘extremely rare’ in the Netherlands, and typically concerns individuals who have suffered for a very long time and have undergone ‘all treatments imaginable, and tried ‘all the therapeutic options and all the pills and electroshocks and [...] still find life too hard’. In Belgium, Section 3(3) provides for the involvement of a psychiatrist or specialist in the individual’s condition if the individual is ‘clearly not

105 443.1(k), 443.1(l), 443.5(a)(1), 443.7(d).
106 443.8.
109 The RRCs advice that it is preferable to consult an independent or SCEN physician who is also a qualified psychiatrist.
110 CAD’s meeting with Inez de Beaufort, in the Netherlands.
expected to die in the near future'. Therefore, the presumption of capacity (or the lack of mental health problems) is rebutted if the individual requesting assistance is not terminally ill. In Switzerland, since 2006 and a Federal Supreme Court’s decision, ‘a serious, incurable, longstanding mental disorder’ may give rise to assisted suicide.\(^{111}\) The SAMS representatives told the CAD that in such cases, individuals must still be lucid and a psychiatrist must ensure that ‘their wish to die is not a symptom of their illness’.\(^{112}\) In evidence to the CAD, Bernard Sutter, EXIT's vice-president, told the CAD that for EXIT these cases are rare.\(^{113}\) Any such case goes through an extended process of assessment, often taking a year or more, and requiring confirmation from more than one psychiatrist who must confirm that the individual is ‘fully competent and that every treatment has been tried and nothing has helped them’.\(^{114}\) Dignitas also sometimes assists individuals suffering from mental illness, although it highlights the very difficult, lengthy, and complex nature of these requests.\(^{115}\) Dignitas requires a number of conditions that have to be met in such cases: a clear diagnosis of the illness, description of its cause and development, evidence of all therapies tried (with or without success), an in-depth psychiatric assessment on the capacity of judgement, judgment of the wish for a self-determined death, and a confirmation that the decision is ‘not a symptom of the psychiatric illness but a well-considered balance decision’.\(^{116}\) Silvan Luley, working member of Dignitas, told the CAD that Dignitas receives a large number of requests from individuals with mental health problems, and that these are dealt with in the same way as all cases: ‘any suffering, mental or


\(^{112}\) CAD’s meeting with SAMS, in Switzerland.

\(^{113}\) CAD’s meeting with Exit DS, in Switzerland.

\(^{114}\) ibid.


\(^{116}\) ibid.
physical, which is proven by the [patient’s] medical records is something which we can look into and if we do find a doctor ready to assess the case and possibly write a prescription for the lethal drug, we can accompany that person." It is however crucial that the individual has mental capacity, notwithstanding the mental suffering, as well as the physical capacity to take the medication himself/herself. Dignitas requires an additional two-month waiting period for individuals requesting assistance on the basis of mental health problems. Overall, it is argued that the capacity assessment of the MCA, and especially Section 3(1), will be able to identify whether a mental health problem, including depression, significantly impairs the decision-making capacity of the individual requesting assistance in dying. The MCA Code of Practice indeed recognises that more complex or major decisions will need more formal assessment by a professional psychiatrist, psychologist, a speech and language therapist, occupational therapist or social worker. The individual’s GP or family doctor may also be contacted if the individual is suffering from a particular condition or disorder. The CAD’s additional depression screening, as earlier argued, is an attempt to present a more cautious, formal assessment of mental capacity in the context of assisted dying that is however unnecessary if the MCA test is used.

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117 CAD’s meeting with Silvan Luley, working member of Dignitas, in Switzerland.

118 Select Committee, Assisted Dying for the Terminally Ill Bill, Vol. III: Evidence – Individual Submissions (HL 2005 Paper 86-III), p. 51. Emily Jackson, Professor of Law, highlights that a patient who is connected to a ventilator may be depressed but still be assessed as having mental capacity. However, this does not prevent these patients from taking life or death decisions, and does not prevent doctors from accepting these. She argues that the response should be ‘a careful assessment of decision-making capacity’.

4.3 The ‘Informed Choice’ Safeguard

4.3.1 The CAD’s ‘Informed Choice’ Safeguard

The CAD highlighted the importance of an ‘informed choice’ by the individual requesting assistance in dying. The ‘informed choice’ is part of the CAD’s third eligibility criterion: the person has the mental capacity to make a voluntary and informed choice, and the person’s decision-making is not significantly impaired as a result of mental health problems such as depression’. The CAD highlighted the importance of an informed decision based on a complete understanding of the nature of the individual’s condition, likely progression, or any alternative options for treatment or care.\(^{120}\)

The CAD proposed that both doctors should ensure (and document): a detailed discussion with the individual about diagnosis and prognosis; any necessary enquiries about locally available services; confirmation that all appropriate and available treatment, care, and support options are offered and discussed in detail; a written record of the treatments offered and relevant discussions; and an explanation of the whole process, including self-administration information, risks, and possible problems that may arise.\(^{121}\) However, the CAD noted that individuals should not feel compelled to accept burdensome or unhelpful treatment, or make use of available end-of-life care, to satisfy the informed decision requirement.\(^{122}\) If the assisted dying procedure is


\(^{121}\) CAD’s Report, pp. 29, 338-339.

\(^{122}\) ibid pp. 313-314.
initiated, the two doctors must also inform the individual about the process, medication and procedure, and possible problems that may arise during the procedure.\textsuperscript{123}

\subsection*{4.3.2 The Practice in Other Jurisdictions}

The need for an informed decision in the context of assisted dying is not disputed in any of the jurisdictions that permit a form of assisted dying. In fact, most jurisdictions require that the individual is given very similar information. In Oregon, the 1997 Act defines an informed decision as the decision that is based on an appreciation of relevant facts.\textsuperscript{124} The attending physician must ensure that the individual is making an informed decision by discussing: his/her medical diagnosis and prognosis; the potential risks associated with taking the medication; the probable result of taking the medication; and the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.\textsuperscript{125} The attending physician must also verify, immediately prior to writing the prescription, that the individual is making an informed decision.\textsuperscript{126} The consulting physician must also examine the individual and the relevant medical records to confirm in writing, among other things, that the individual is making an informed decision.\textsuperscript{127} The individual’s medical record should

\textsuperscript{123} ibid p. 29. On problems likely to arise see, for instance, Oregon Public Health Division, Oregon Death with Dignity Act: 2015 Data Summary (February 4, 2016) available at: <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf> accessed 28 September 2017. Data since 1998 shows that the time between the ingestion of the lethal medication and death varies from a few minutes to around 100 hours.

\textsuperscript{124} 127.800 §1.01(7), reiterated in 127.830 §3.04.

\textsuperscript{125} 127.815 §3.01(1)(c).

\textsuperscript{126} 127.815 §3.01(i).

\textsuperscript{127} 127.820 §3.02.
include evidence that the individual made an informed decision. In Vermont, there is a special provision establishing ‘a right to information’, and a requirement that the attending physician must provide information ‘in person, both verbally and in writing’. Similarly, in Canada, the individual may receive assistance only if, among other criteria, he/she gives informed consent. The Canadian Bill C-14 is not as detailed as the laws in the US, however, informed consent is defined by the Canadian Department of Justice: the individual must be able to understand relevant information, and the consequences of his/her choice.

In the Netherlands, the individual must be informed of his/her situation and prospects. The individual must be ‘decisionally competent’ and this includes an ability to understand relevant information, consider any alternatives, and assess the implications of decisions. The RRCs emphasise that the individual must give careful consideration on the basis of ‘adequate information and a clear understanding of his illness’. The physician must determine, not assume, that the individual is ‘adequately

128 127.855 §3.09(3) and (4).
129 §5282. The individual has the right to be informed of ‘all available options related to terminal care’, and to ‘receive answers to any specific question about the foreseeable risks and benefits of medication without the physician’s withholding any requested information exist regardless of the purpose of the inquiry or the nature of the information’.
130 §5283(6).
131 241.2(1)(e) and 241.2(3)(b)(ii).
133 Article 2(1)(c).
informed and has understood the information provided’. In Belgium, the physician must inform the individual about his/her health condition and life expectancy, and discuss possible therapeutic and palliative courses of action and their consequences. Together with the individual, the physician must be convinced that there is no reasonable alternative. The safeguards in relation to an informed decision are identical in Luxembourg. In Switzerland, SAMS requires that physicians involved must ensure that alternative possibilities have been discussed, and if the individual desires, implemented. Exit requires that once the relevant documents are received and reviewed, an end-of-life attendant visits the individual and discusses over a personal interview. The interview aims to address any issue, question, or concern, and ensure that the individual is aware of alternatives to assisted suicide. Although there is no explicit reference to information, Dignitas in its official guidance states that it ‘always looks for opportunities to help people towards life instead of death’. Presumably, this means that individuals are informed of alternatives to assisted suicide.

Indeed, one of the most fundamental principles of English medical law, also reflecting patient’s autonomy, is that mentally competent patients must be given relevant information to be able to consent before any treatment or care. In the context of assisted dying and as part of the mental capacity assessment of the MCA, it is

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136 Section 3(2)(1).

137 Article 2(2)(1).


necessary that individuals are given relevant information to make an informed decision as to whether they want an assisted death. A most important question is how much information is needed for an informed decision.141 Today, medical practice in this area is guided by the 2015 case of Montgomery.142 The case put patients in the centre of medical decision-making, and emphasised that patients today can receive relevant information by numerous sources and are not dependent on what doctors might share or disclose. Doctors are under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in the recommended treatment, and of reasonable alternative treatments.143 A material risk is a risk which, in the circumstances, a reasonable person in the patient’s position would likely to attach significance, or that the doctor is or should reasonably be aware that the particular patient would be likely to attach significance.144 This means that different information may have more, or no importance, to specific patients.145 In the context of assisted dying an individual may consider, for instance, the risk of the lethal


142 Montgomery v Lanarkshire Health Board [2015] UKSC 11. The claimant in the case had diabetes and while pregnant, she was not informed about a risk of delivering a large baby which could lead to shoulder dystopia (9-10% risk), i.e. the baby’s shoulders being too wide to go through the pelvis. The risk materialised and the baby become seriously disabled. The Supreme Court found that the consultant obstetrician and gynaecologist breached her duty of care by not informing the claimant of the risk.

143 ibid [87].

144 ibid.

medication not working immediately after its prescription a precluding factor in requesting assisted death. As such, safeguards need to be used to support an informed decision in the context of assisted dying. While it is important that an assisted dying framework specifies information that must definitely be provided to the individual, similar to the US, this should be treated as minimum. Doctors must ensure that all the individual’s questions are answered and concerns dealt with. Only then can it be said that the individual can make an informed, competent, and autonomous decision. Again, the capacity assessment under the MCA will ensure both the provision of relevant information, as well as that the individual concerned understands this information.

146 See, for example, Vermont and ‘the right to information’ provision.
4.4 Concluding Remarks: The Mental Capacity Eligibility Criterion

Chapter Four assessed the CAD’s third eligibility criterion on mental capacity. Using the legal rules in other jurisdictions and academic and scientific studies, the analysis concludes that the mental capacity criterion is an essential minimum for a domestic assisted dying framework. In particular, it is proposed that the CAD’s ‘formal assessment of capacity’ is replaced with the capacity assessment of the MCA. The need to provide sufficient and relevant information, the need to ensure that the individual understands and can communicate the decision, and the presence of any condition likely to significantly impair the individual’s decision-making capacity are all covered by the MCA, its Codes of Practice, guidelines, and case law. The MCA most importantly guarantees a presumption of capacity that respects the right of individuals to make any decision they consider right for themselves. Overall, Chapter Four argues that it is possible for an assisted dying framework to identify and guarantee a competent, autonomous wish for assisted dying. It is crucial that any such framework is in such way construed as to ensure that individuals with mental capacity are able to request assistance (personal autonomy), and those who lack the capacity are protected (safeguards). This is also in line with the central argument of the thesis, which is fully explored in Chapter Six.
CHAPTER FIVE:
THE VOLUNTARINESS ELIGIBILITY CRITERION

The decision to request assistance in dying may not always be voluntary, that is, it may not reflect the genuine, true wishes of the individual. This may be because of a number of reasons including undue pressure, influence, or coercion applied on, exercised over, or inflicted upon the individual.¹ The ‘usual suspects’ are the individual’s relatives or friends (i.e. loved ones), healthcare team and, sometimes, individuals themselves who may feel a burden (financial or otherwise) on their loved ones or the healthcare system. Identifying a voluntary decision may be challenging because of many reasons including the inability of the system (legal and/or medical) to identify and prevent undue pressure, influence, or coercion. It is often suggested that the voluntary nature of the decision is a particular concern for ‘vulnerable groups’, including the elderly² or individuals with disabilities³ because of a plethora of possible


reasons including, abuse, exploitation, or manipulation; the availability of appropriate care and support; and physical and emotional reliance. However, it is important to note that it is not just ‘the vulnerable’ that may be the recipients of undue pressure, influence, or coercion but any one that may feel ‘vulnerable’ at some stage in life.¹

Given Euthanasia ‘Rewards’, Say One In 10 Britons’ The Telegraph (6 November 2014)


⁴ Special Joint Committee on Physician-Assisted Dying, ‘Medical Assistance in Dying: A Patient-Centred Approach Report’ (February 2016, 42nd Parliament, 1st Session) available at:
Therefore, any assisted dying framework must safeguard and protect those involved, and ensure that a decision to request assistance in dying is voluntary.

The voluntariness requirement is found in the laws and regulations of all jurisdictions that permit a form of assisted dying, and in the reform proposals in England and Wales, including the CAD. The CAD in 2012 identified a real risk that some individuals may be unduly pressurised to request an assisted death.\textsuperscript{5} Evidence submitted to the CAD revealed that such pressure may take a number of forms: direct pressure from relatives and friends, and/or healthcare professionals;\textsuperscript{6} indirect pressure from social discrimination and lack of appropriate care and support services;\textsuperscript{7} and self-imposed

\textsuperscript{5} CAD’s Report, pp. 27, 307.
pressure from low self-worth or feelings of being a burden. Voluntariness therefore took up a special place in the CAD’s proposed assisted dying framework. Similar to the other eligibility criteria proposed by the CAD, the CAD’s second eligibility criterion on voluntariness is used as starting point in this Chapter. It was phrased as follows: ‘the person is making a voluntary choice that is an expression of his/her own wishes and is not unduly influenced by others’. The criterion’s main component is ‘the voluntary choice’. The use of ‘undue’ (i.e. excessive, unjustifiable) is an important addition to the phrasing of the criterion. It recognises, in my view, that many considerations such as, for instance, that an individual may have the desire to die for the benefits of others does not invalidate the voluntariness of the decision to request an assisted death.

Both the mental capacity criterion, examined in Chapter Four, and the voluntariness criterion are necessary for an autonomous decision in the context of assisted dying. The individual needs both the internal capacity for self-government (free will), and to

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Zigmond expressed similar views. Personal autonomy means that a decision to die based on a desire not to be a burden, or for the benefit of others, should be respected.

9 CAD’s Report, pp. 21, 26-27, 301, 337.

be free from external constraints (liberty). The former is reflected in the CAD’s mental capacity criterion, the former in the CAD’s voluntariness criterion.

In the early 1990s, the House of Lords Select Committee on Medical Ethics\textsuperscript{11} concluded that it is almost impossible to ensure that all euthanasia requests are truly voluntary and that ‘vulnerable groups’ will be protected.\textsuperscript{12} The parliamentary debates that followed the domestic reform attempts since, highlight three different, main views on the matter: that safeguards can never be adequate to ensure voluntariness;\textsuperscript{13} that safeguards proposed (at the time) were sufficient; or that safeguards could be improved to ensure a voluntary request in the context of assisted dying.\textsuperscript{14} Chapter Five argues that it is indeed possible for an assisted dying framework to identify and guarantee a voluntary, autonomous request allowing the individual to exercise his/her right to self-determination, and at the same time protect those whose lives may be in danger by the availability of assisted dying.\textsuperscript{15} Chapter Five considers the legal rules in other jurisdictions, and academic and scientific studies to assess whether the CAD’s second eligibility criterion and the safeguards proposed to support it are suitable for a


\textsuperscript{12} For instance, see: HL Deb 9 May 1994, vol554, col1346 per Lord Walton of Detchant.


\textsuperscript{14} For instance, see: Baroness Mallalieu in HL Deb 7 November 2014, vol756, col1861 talking about judicial involvement.

\textsuperscript{15} See Chapter Six of this thesis.
domestic assisted dying framework, or whether anything should be removed, retained, or developed.
5.1 Initiating the Assisted Dying Procedure

The CAD suggested that only the individual who is considering an assisted death can initiate an assisted dying conversation, and subsequently request the assistance.\(^{16}\) The CAD envisaged no situation appropriate for a third party to offer it as an option. The individual is, however, expected, to spend ‘considerable time’ discussing his/her wishes and thoughts with his/her doctor. It is expected that this may last for many months or even years, but can be shorter.\(^{17}\)

Most jurisdictions allowing a form of assisted dying do not use a legal provision to require that only the individual considering an assisted death initiates the assisted dying conversation and procedure. There are of course exceptions. Paragraph 443.2(c) of the California’s End of Life Option Act 2015, for instance, expressly requires that the request is made ‘solely and directly by the individual’ and not by any other designated party.\(^{18}\) Some other jurisdictions *imply* that the individual considering an assisted death must initiate the conversation and subsequent request. In the Netherlands, for example, many sources underline the importance of the request coming from the individual. Although loved ones and healthcare professionals are in practice involved in the decision, it is not necessary that they agree.\(^{19}\) A request by an individual other than the patient thus ‘cannot be granted’, and a patient cannot authorise a third party

\(^{16}\) CAD’s Report, pp. 29, 310.

\(^{17}\) ibid pp. 316-317.


to make the request on his/her behalf. However, a third party may inform the physician of the individual’s wish so that the physician can then discuss it with the individual.

The CAD was right to highlight the importance of the individual having a conversation(s) with loved ones and healthcare professionals before requesting an assisted death. Although most individuals can find relevant information on their own in making an informed decision, it is only reasonable that they will seek further advice and discussion. A professional will provide specialised information and advice, for example, on other end-of-life options, whereas loved ones will provide moral support and personal advice. No assisted dying framework should treat these type of conversations as something that automatically contests the voluntariness of the individual’s request. In fact, an assisted dying framework should be designed in such way as to filter out advice and discussions that cross the line into undue influence, and assume more than an advisory role. The English medical law approach to undue influence can be a guiding principle. For instance, in Re T (Adult: Refusal of Treatment) Lord Donaldson MR noted that the will of the patient (e.g. strength of character) and circumstances (e.g. the level of his/her pain), and the type of relationship of the ‘persuader’ and patient should be considered when identifying when influence becomes undue. Another way of achieving the right balance between allowing much needed professional and personal discussion and advice, but

20 ibid.
23 Re T (Adult: Refusal of Treatment) [1993] Fam 95 (CA) [662].
not undue pressure, influence, or coercion is, similar to California, a legal provision prohibiting third parties from suggesting assisted dying as an option to any individual.  

This will highlight the significance of the request coming from the individual himself/herself, and may prevent third parties from interfering. The provision, however, should be drafted in such way as to allow much needed discussion and advice from loved ones and professionals and not prevent individuals from accessing or seeking information elsewhere (e.g. leaflets, or TV programmes). Overall, the CAD was right to suggest that only the individual should initiate an assisted dying conversation and make the request as a clear sign of voluntariness and autonomy, but also that the individual should spend time discussing with loved ones and professionals before making the request.

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24 See, for instance, Amendment 12 by Lord McColl of Dulwich during the HL Deb 7 November 2014, vol756, cols1851-1956: ‘No other person apart from the person who is terminally ill may initiate a request for assistance to end a life’, and ‘No registered medical practitioner, registered nurse or other health professional may suggest that a person consider seeking assistance to end his/her own life’.

25 CAD’s Report, pp. 29, 310.
5.2 The Form and the Number of Requests

In addition to the safeguard relating to the initiation of the assisted dying procedure, it is also important to examine the form and number of requests that could be required in a future assisted dying framework in England and Wales. The CAD’s Report only briefly states that the individual requesting an assisted death should make two oral requests.\(^{26}\) A written or signed request is required only at the end of the procedure, immediately before the prescription of the lethal medication by the doctor.\(^ {27}\) If the individual is unable to write or sign, according to the CAD, at least two independent observers (not the first and second doctor) must witness an oral statement or request by the individual.\(^ {28}\)

It is interesting that the only written request required by the CAD is at the end of the procedure. Being the final confirmation required by the individual before the assisted death, the reasoning may be that a written request is more convincing evidence of voluntariness as opposed to an oral request. At the same time, however, a written request at the \textit{beginning} of the procedure could be a more solid ground for a voluntary, autonomous decision. Overall, the study of the legal rules in other jurisdictions shows a mixture of approaches. In the Netherlands, for instance, the request is generally preferred in writing or otherwise documented.\(^ {29}\) This is however

\(^{26}\) ibid p. 342.

\(^{27}\) ibid p. 340.

\(^{28}\) ibid.

not required by law, and is not a condition for the request to be accepted by the physician. The RRCs prefer not only a written or otherwise documented request by the individual, but a request written by the individual himself/herself using his/her own words and expressions. In contrast, Section 3(4) of the Belgian Act explicitly requires a written request that must be drafted, dated, and signed by the individual. The situation in Switzerland is very different. The request is made orally over the phone to a volunteer of one of the non-profit right-to-die voluntary organisations, not to the doctor as in most other jurisdictions. Across the Atlantic, Oregon requires two oral and one written request similar to the CAD. The written request must have a specific form, be signed and dated by the patient in the presence of at least two witnesses who in the presence of the patient ‘attest that to the best of their knowledge and belief’ the patient, among other things, is acting voluntarily, and is not being coerced to sign the request. Most US states mirror the Oregon model. The law in Vermont, however, specifies that both oral requests must be made in the doctor’s

30 ibid.
32 But see: John Griffiths, Heleen Weyers, Maurice Adams, Euthanasia and Law in Europe (Hart Publishing 2008), 316. The authors point to at least one case in which the Federal Control and Evaluation Commission approved a euthanasia case that was not the result of a written request...
physical presence, and in California that the witnesses know (‘identify’) the individual, but also that the individual fills and executes a ‘final attestation form’ within 48 hours prior to the self-administration of the lethal medication. It is a significant difference that in Europe there is no witnessing requirement of the individual’s request. The Canadian approach resembles the European approach in requiring only written requests, but similar to the US, it requires the independent witnessing of the request. The witnessing of the request safeguard is a difficult issue. In my view, it is difficult to see how a witnessed request may confirm the voluntariness of the individual’s decision to request an assisted death. It is one thing to require witnesses to confirm that it is indeed the individual who writes the statement, but quite another to require witnesses to confirm that the individual is acting voluntarily, and not as a result of undue influence, pressure, or coercion when drafting it. This is simply because most witnesses are not acquainted with the individual and his/her personal circumstances, and most certainly not trained to detect undue influence, pressure, or coercion. A witnessed confirmation by a

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37 In Canada, many other important documents are witnessed by independent individuals. See further: Government of Canada, Department of Justice/ Gouvernement du Canada, Ministère de la Justice, Medical Assistance in Dying, Questions and Answers/ Aide Médicale à Mourir, Questions et Réponses <www.justice.gc.ca/eng/cj-jp/ad-am/faq.html> accessed 25 September 2017. The witnessing requirement ensures that the procedure is carried out with the involvement of individuals other than the two healthcare practitioners, and that the procedure is transparent.


healthcare professional would therefore make more sense, but this could instead take the form of a third professional formally assessing the individual and his/her assisted dying eligibility more generally. An alternative approach is to require that the individual drafts the first written request before a state official, thus ensuring that the individual is actually the one drafting the request statement.

It is suggested that the CAD’s proposal in relation to the two oral requests is revisited. A more robust safeguard for voluntariness is a legal provision requiring that the individual first makes a written, signed, and dated request. If physically unable to write or sign, the CAD’s suggestion that an oral statement can be witnessed should be adopted. The Mental Capacity Act 2005 (‘MCA’) Code of Practice has similar provisions that may act as guiding principles. The RRCs’ preference for a request expressed in the individual’s own words should also be adopted in favour of voluntariness. A request in this form could give doctors a clearer understanding of the individual’s thoughts, feelings, and motivations for requesting assistance in dying. In general, a written request is unlikely -or at least less likely than an oral request- to be disputed. It can be challenged for its content, or referred back to for review. It will minimise uncertainty among all the parties involved in the procedure, ensure that the individual understands the serious nature of his/her decision, and the request, as such, can be

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40 See, for instance, Paragraph 9.24 Department for Constitutional Affairs, Mental Capacity Act 2005: Code of Practice 2007 (London: TSO) available at: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf> 25 September 2017. Advance decisions must be made in writing however, if the individual is unable to write, a third party can write it down on behalf of the individual. If the individual is unable to sign, the individual can direct a third party to sign on their behalf in the individual’s presence.

used as evidence to protect those involved from any dispute or disagreement.⁴² Requiring a written request immediately before the prescription of the lethal medication is a requirement that can be retained, but again may take the form of a statement in the individual’s own words, for the same reasons described above.

5.3 Waiting Periods

Given that the CAD’s framework concerns terminally ill individuals, a ‘very lengthy approval process’ was considered ‘inappropriate’. At the same time, it was considered vital that some time is built into the procedure to prevent hasty, and promote serious and settled decisions. This safeguard, that is often called ‘waiting periods’, also aims to ensure that the individual is making a voluntary choice. This is because time build into the procedure will allow the individual time to think, but also give time to doctors to identify any undue pressure, coercion, or influence that would prevent a voluntary, autonomous decision. The CAD proposed a minimum of two weeks between the first request of the individual and the assisted death. If death is judged to be imminent (within one month), the waiting period can be reduced to six days. Specifically, the CAD proposed three 48-hour waiting periods: between the first and second oral requests (the second initiating the voluntariness and mental capacity assessments); between the first doctor’s assessment and the second doctor’s assessment; and between the final written confirmation and the prescription of the lethal medication.

The study of the legal rules in jurisdictions that permit a form of assisted dying is useful for assessing the safeguard of waiting periods. As noted earlier, the Benelux countries require only one written request by the individual requesting assisted death. However, various Belgian and Dutch sources highlight that ‘time’ is important in safeguarding the voluntariness of the request. The ‘kamerstukken’, the bundle of preparatory works for the Dutch Act, for example, highlights the importance of a ‘deliberate’, ‘sustainable’ or ‘repeated’, ‘timely’ request, as opposed to one resulting

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43 CAD’s Report, pp. 30, 317.
44 ibid pp. 30, 317, 342.
45 ibid pp. 30, 342.
from a ‘whim’, ‘sudden’, or ‘violent’ state of mind. Section 3(3)(2) of the Belgian Act requires a delay of at least one month between the written request and euthanasia for patients who are ‘clearly not expected to die in the near future’. Oregon’s Act requires that the oral requests be made at least fifteen days apart, and that 48 hours elapse between the written request and the prescription. There is a different approach in California in that there is no waiting between the written request and the prescription of the lethal medication, but the majority of the US states follow the Oregon model. In Canada, the law requires ‘ten clear days’ between the request and the assistance. The waiting periods built in the assisted dying procedure primarily in the US and Canada and by the CAD, aim to ensure that the individual’s request is sustained, considered, persistent, and to act as an additional safeguard for the voluntariness of the individual’s decision. Though it is expected that the procedure will take time considering the involvement of different parties and procedures, setting minimum waiting periods could build a more robust framework. It is crucial, however, and as rightly pointed out by the CAD, that these waiting periods are not unreasonably and inappropriately long as this will obstruct the procedure and will prolong the procedure of assisted death with adverse impact for the individual and


47 The law also requires a second consultation with a psychiatrist or a specialist.

48 127.840 §3.06.

49 127.850 § 3.08.

50 Paragraph 443.3(a).

51 Paragraph 241.2(3)(g).


his/her loved ones. The exact timing, or waiting periods and their duration, can be determined by further, empirical research, specifically on the procedural aspects including, for instance, a prediction of the time needed for the assessment of voluntariness and capacity both by doctors and by the High Court as suggested in Chapter Seven of this thesis.
5.4 The Assessment of Voluntariness

5.4.1 The CAD’s Medical Assessment of Voluntariness

The CAD proposed a number of safeguards to ensure that the second eligibility criterion on voluntariness would be satisfied. Most of the safeguards rely on the establishment of a medical decision-making framework. The reason given by the CAD is that health and social care professionals (and particularly doctors) already have, and on a daily basis use, the skills, knowledge, and training structures required to support such framework. The CAD envisaged the involvement of ‘a minimum of at least two doctors’ responsible for the assessment, advice, support, and judgement of the whole assisted dying procedure. It was considered ‘critical’ that the two doctors are ‘wholly independent’ of one another to ensure a vigorous decision-making procedure, and to prevent ‘collusions’. The two doctors will be responsible to certify independently (provide evidence) and document that the second eligibility criterion and the relevant safeguards used to support it are satisfied. If necessary and appropriate the two doctors can consult other healthcare professionals involved in the care of the individual and request an independent assessment. This should be carried out by a professional, for example, a family doctor, a community nurse, a social worker, or a care worker familiar with the individual patient and his/her circumstances. The professional who is going to carry out the independent assessment should interview the patient alone and, if possible, also his/her relatives to identify any undue influence, or external factors that may be influencing the individual’s decision to

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54 ibid pp. 27, 30.
55 ibid pp. 21, 28-29, 33, 301-303, 310, 324, 342.
56 ibid pp. 29, 312.
57 ibid pp. 20, 26, 301, 312, 338.
58 ibid pp. 30, 315, 339.
59 ibid pp. 315, 340.
request assisted dying. The CAD highlighted the need for appropriate space and time for the doctors to explore and discuss the individual’s motivations, and suggested that more than one conversation ‘over a period of time’, and a conversation with the individual alone, should be required in a future assisted dying framework.

The CAD envisaged that the first doctor will have ‘primary responsibility’ to oversee the assisted dying procedure, taking time to explore whether the individual’s request is serious or ‘cry for help’, and ensuring that the request remains ‘wholly voluntary’ throughout the procedure. A request for assistance may be a ‘cry for help’ for many reasons including, for example, poor pain management, or lack of access to alternative care and support. In the CAD’s proposed framework, the first doctor will ideally be the doctor with ‘usual responsibility’ for the care of the individual, that is, the individual’s General Practitioner (‘GP’), or a specialist in the individual’s condition that knows the individual well. It is important that the first doctor has an established relationship with the patient, and be familiar with his/her personal history and family context. This will allow the doctor to better assess the request for assistance as well as the motivations of the individual. The CAD envisaged that the second doctor would be an ‘experienced professional’, that is, at least five years of experience after higher professional or specialist training, and specialised in end-of-life care and able to provide relevant expertise and support. The second doctor must be able to provide

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60 ibid p. 307.
61 ibid pp. 315-316.
62 ibid p. 338.
64 CAD’s Report, pp. 29, 312, 338.
65 ibid pp. 302, 312, 315.
66 ibid pp. 29, 312.
an independent and objective opinion, and be prepared to challenge the first doctor’s views, if necessary. He/she must not have a pre-existing relationship with the first doctor or the patient, and not be involved with the patient’s care. The second doctor’s role should not be ‘highly specialised or niche’; instead, the CAD expects that many doctors will be eligible for the role of the second doctor in the context of the assisted dying assessment. The CAD allows for conscientious objection from both doctors, but suggests that there should be a duty to refer to another doctor who does not have a conscientious objection. The new doctor should have several conversations with the patient, and also consult other professionals who know the patient well to be in a better position to identify any factors that may influence the individual’s decision.

5.4.2 The Practice in Other Jurisdictions

The legal rules in other jurisdictions that permit a form of assisted death, the CAD’s proposal, as well as other medical practices and procedures including, for instance, the Mental Health Act 1983, the Cremation (England and Wales) Regulations 2008, and the Abortion Act 1967 suggest the involvement of a minimum of two healthcare professionals in the assessment of the individual. The involvement of two healthcare professionals will establish a ‘checks and balances’ system, minimise abuse of the procedure, and according to the Canadian Department of Justice, will reassure doctors

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67 ibid pp. 312, 318.
68 ibid pp. 29, 312.
69 ibid pp. 34, 130-131, 270-273, 311-312, 323-324.
70 ibid pp. 29, 312.
that their actions fall within the scope of the law, and are ‘consistent with reasonable medical knowledge and skill’.  

In the Netherlands, the physician must assess whether the individual is making a voluntary and well-considered request. At least one other independent physician must examine the individual and give a written opinion. The second consultation can also be carried out by SCEN physicians. SCEN is a support and consultation euthanasia program supported by the Ministry of Health and the Royal Dutch Medical Association (‘KNMG’). It is made up by physicians who are trained to advice and support physicians involved with euthanasia. In Belgium, the physician must ensure that the individual’s request is voluntary, well-considered and repeated, and not the result of any external pressure. There is a consultation with a second, independent physician but unusually, he/she is not required to assess the voluntariness of the individual’s request.

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73 Article 2(1)(e).


Interestingly, the first physician can however discuss the individual’s request with a nursing team, if there is regular contact with the patient, and if the patient consents, with relatives appointed by the patient. The first physician must also ensure that the patient discusses the request with any individual he/she wishes. Belgium has a network similar to SCEN in the Netherlands. In Switzerland, assisted suicide is largely carried out by non-profit right-to-die voluntary organisations, EXIT and DIGNITAS being the largest. With regards to the voluntariness of the individual’s request, EXIT requires that its members are not under the influence of a third party (in their website, this is labelled as ‘autonomy’). DIGNITAS states that assistance is provided to those who want ‘voluntarily to put an end to their life’. Assisted suicide in Switzerland does not formally fall under medical practice, unlike the situation in all other jurisdictions. In practice, however, doctors’ involvement is necessary to prescribe the sodium pentobarbital, the lethal medication used for assisted suicide,

76 Section 3(2)(3).
77 Sections 3(2)(4), 3(2)(5).
78 Section 3(2)(6).
80 See their history in Guenter Lewy, Assisted Death in Europe and America: Four Regimes and Their Lessons (Oxford University Press 2014), 89-111.
that can only be prescribed by doctors under the Swiss narcotics laws.\textsuperscript{83} Doctors, in principle, can carry out the assistance themselves, however the majority of doctors direct individuals to the right-to-die organisations.\textsuperscript{84} If a doctor decides to participate though, the Swiss Academy of Medical Sciences (‘SAMS’) suggests that, among other things, the patients’ wishes must be ‘well thought out’, be persistent, not be the result of external pressure, and also that a third individual, not necessarily a physician, should check that these requirements are fulfilled.\textsuperscript{85} In Oregon, the attending physician makes the initial determination of whether, among other things, the patient’s request is voluntary, and refers the patient to a consulting physician.\textsuperscript{86} The consulting physician examines the patient and his/her medical records to confirm, in writing, among other things, that the patient’s request is voluntary.\textsuperscript{87} Otherwise identical, the law in California additionally requires that the assessment of voluntariness by the attending physician should be the result of discussion with the individual alone with no other individuals present, expect an interpreter, if necessary.\textsuperscript{88} There is no similar provision, at least explicit, in the laws of the other US states. In Canada, a medical practitioner or nurse practitioner must be of the opinion


\textsuperscript{84} John Griffiths, Heleen Weyers, Maurice Adams, \textit{Euthanasia and Law in Europe} (Hart Publishing 2008), 475.


\textsuperscript{86} 127.815 §3.01.

\textsuperscript{87} 127.820 §3.02.

\textsuperscript{88} Paragraphs 443.5(a), 443.6(c), and 443.5(a)(4).
that, among other things, the individual has made a voluntary request that, in particular, was not made as a result of external pressure.\textsuperscript{89} Another independent medical or nurse practitioner must confirm, in writing, the Paragraph 241.2(1) requirements.\textsuperscript{90} The law in Canada is unique in involving nurses as assessors.

Several medical practices and procedures in England and Wales also require the involvement of two healthcare professionals. For example, Section 3(3) of the Mental Health Act 1983 provides that a patient may be admitted and detained in hospital ('treatment order') on the written recommendations of two registered medical practitioners. The first must be a trained and experienced psychiatrist, and the second, ideally, the patient’s GP that knows the patient and his/her history. An application for admission for assessment under Section 2(3) is subject to the same conditions. The Cremation (England and Wales) Regulations 2008 similarly requires two medical certificates, one by the doctor who treated the deceased, and the other by a doctor who is completely independent from the first doctor. The second doctor must examine the deceased and discuss with the first doctor and another individual. Section 1(1) of the Abortion Act 1967 also requires the good faith opinions of two registered medical practitioners (one in an emergency) for the medical termination of a pregnancy.\textsuperscript{91} The two doctors must agree to the termination on the same grounds. In June 1990, the House of Commons rejected an amendment to the 1967 Act suggesting that the opinion of a single medical practitioner is sufficient if the practitioner is of the opinion that the pregnancy has not exceeded its twelfth week.\textsuperscript{92} It is not clear in the literature, but it seems that the Abortion Act has set the norm for the involvement of two professionals.

\textsuperscript{89} Paragraphs 241.2(1) and (3).

\textsuperscript{90} Paragraph 241.2(3)(e).

\textsuperscript{91} \textit{R v Bourne} [1938] 3 All ER 615 (KB).

The CAD, as well as the legal rules in some of the jurisdictions that allow a form of assisted dying even suggest the involvement of a third assessor. The Dutch law, for instance, provides for the involvement of ‘at least’ one other independent physician.93 Similarly, in Switzerland, SAMS specifies that if doctors are actively involved, a third individual, not necessarily a physician, should check that the request is voluntary, persistent, and not the result of external influence.94 The US states provide for a third professional assessment only if there are concerns with the individual’s decision-making capacity. Even so, what may be said to assume a similar role in the US is the witnessing requirement. The European approach of requiring more than one professional assessment, instead of the witnessing requirement, seems more plausible for England and Wales.95 A conversation with a professional and the issues that may arise from this conversation are more likely to bring up issues that may affect the voluntary, autonomous nature of the individual’s request, as opposed to a witness signing to confirm the lack of undue pressure, influence, or coercion. A witness is unlikely to know the patient, unless it is made a requirement under the law, and is unlikely to have the professional skills to ensure the voluntariness of the request. It is again crucial, however, to ensure that multiple assessments do not unreasonably and inappropriately obstruct the procedure. A workable, yet robust assisted dying framework should strike the right balance between safety (safeguards) and allowing

93 Article 2(1)(e).


the individual to request assistance and exercise his/her right to self-determination.\footnote{See Chapter Six of this thesis.} Therefore, it is proposed that the CAD’s suggestion as regards the involvement of at least two healthcare professionals in the assessment of the individual’s voluntariness is adopted. Several medical practices and procedures in England and Wales, as discussed earlier, require the involvement of two healthcare professionals. This is important for the reasons discussed earlier. Most importantly, the two assessments will act as a system of checks and balance for the eligibility assessment of the individual requesting an assisted death.

So far, it has been suggested that \textit{at least two} professionals should assess the individual for eligibility. Now it is crucial to also examine the options of \textit{who} should carry out these assessments. Most jurisdictions currently permitting a form of assisted dying require that \textit{doctors} act as the assessors and provide the necessary assistance. There are of course exceptions. Belgium, for instance, allows for discussion of the patient’s request with the nursing team, as well as, subject to the patient’s consent, with relatives appointed by the patient.\footnote{Sections 3(2)(4) and 3(2)(5).} Similarly, in Luxembourg, the doctor can discuss the request with the patient’s healthcare team as a second consultation, if the patient consents.\footnote{Article 2.2(4).} This approach has advantages and disadvantages. On the one hand, the patient’s nursing or healthcare team may be in a better position to assess whether the patient is acting voluntarily because of the direct and close contact with the patient. On the other hand, this approach fails in the element of independence. A second (or indeed third) \textit{independent} professional with no links to the first professional and the patient will be in a better position to make an objective, novel assessment of the individual’s request and voluntariness. A very different approach can be seen in Switzerland where the third assessment can be made by an individual who is not a healthcare professional. The Swiss approach is here considered no different from a witnessing requirement earlier rejected. Canada’s framework allows
for the involvement of nurses in the same level as doctors.\footnote{See, for instance, Sheryl Ubelacker, ‘Nurse Practitioners could Provide Assisted Death under Bill C-14’ \textit{CTV News} (14 April 2016) <www.ctvnews.ca/health/nurse-practitioners-could-provide-assisted-death-under-bill-c-14-1.2859955> accessed 27 September 2017.} A domestic assisted dying framework may combine some of these approaches in relation to the identity of the assessors. For instance, the framework may use \textit{at least two independent, professional} assessments by doctors, nurses, or other social care \textit{professionals}, and the option of an advisory consultation with the patient’s family or friends if there is regular contact and involvement and always subject to the patient’s consent. The third professional assessment can be based on a model similar to the SCEN program in the Netherlands, or on a system similar to the Human Tissue Act (‘HTA’) 2004. Under the HTA, any potential donor and recipient of a solid organ or part organ must be assessed via an interview by an \textit{Independent Assessor}. The Human Tissue Authority trains and accredits the assessors which represent both the Authority and the donors, and ensures compliance with the HRA requirements and other regulations.\footnote{HTA website, About Independent Assessors <https://www.hta.gov.uk/policies/about-independent-assessors> accessed 27 September 2017.} A domestic assisted dying framework may use this as guiding principle for the third professional assessment of the individual’s eligibility in general.
5.5 Doctor-Patient Relationship

The relationship between the doctor and the patient is an important consideration for an assisted dying framework that relies on healthcare professionals. From the very beginning, the individual considering an assisted death must feel comfortable and confident approaching his/her GP to get information and advice, and have an open and honest discussion on the assisted dying procedure but also on alternative options. This will allow the individual to make an informed decision on whether to make a formal request for assisted dying. From the doctor’s perspective, an established, long-standing, pre-existing relationship with the patient would make the assessment of voluntariness and mental capacity easier. The doctor is more likely to be familiar with the patient’s medical history, background and family situation, as well as character. On the other hand, a close relationship between the doctor and the patient does not necessarily guarantee this knowledge, and does not mean that the doctor would be more comfortable but may indeed have the opposite effect. Put simply, a doctor that knows a patient for many years may be more reluctant to be involved with his/her assisted death.

The Netherlands and Oregon are the best examples to use in the present discussion to examine the doctor-patient relationship in the context of assisted dying. In the Netherlands, the importance of a close doctor-patient relationship is highlighted in

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102 However, see also: Guenter Lewy, Assisted Death in Europe and America: Four Regimes and Their Lessons (Oxford University Press 2014), 100-101 (for Switzerland), and 313 (for Belgium).
case law and other relevant sources. A Dutch doctor may only participate in voluntary euthanasia and/or assisted suicide if the individual concerned is in his/her care; in other words, the doctor must have treated the patient in the past, and must know the patient well enough to assess, among other things, whether the request is voluntary and well-considered. The doctor is usually the individual’s GP. In evidence to the HLSC in 2005, and the CAD in 2011, Penney Lewis, a Law Professor researching in the area of assisted dying, highlighted that Dutch doctors have, in general, very lengthy relationships with their patients. The CAD interviewed several experts in the Netherlands that also confirmed the close doctor-patient relationship. Agnes van der Heide of the Erasmus Medical Centre, for instance, in 2011 said that Dutch patients ‘rarely change their GPs’. Gert van Dijk of the Royal Dutch Medical Association (‘KNMG’) told the CAD in 2011 that this close relationship is also important for doctors

103 See, for example, Netherlands Ministry of Foreign Affairs, Ministry of Health, Welfare and Sport, the Ministry of Justice, ‘Euthanasia - A Guide to the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act’ <http://www.bioeticanet.info/eutanasia/LleiEuHol.pdf> accessed 28 September 2017, pp. 4, 10; CAD’s meeting with Agnes van der Heide in the Netherlands highlighting that the RRCs promote, as good practice, the full and open communication between the patient and the doctor conducted over a good length of time where possible; and CAD’s meeting with Gert van Dijk in the Netherlands highlighting that typically, individuals will have spoken at length to their doctors about their wishes, sometimes even two years before making the official request. See also: Ubaldus dr Vries, ‘A Dutch Perspective: The Limits of Lawful Euthanasia’ (2004) 13(2) Annals of Health Law 365.


106 CAD’s Commissioners’ interview with Agnes van der Heide, Senior Researcher, Department of Public Health, Erasmus Medical Centre, 15 March 2011 in the Netherlands.
because before performing euthanasia and/or assisted suicide ‘they want to make sure it’s the right thing’. The KNMG confirms that doctors must have ‘several conversations’ with the patient ‘over time’ to be able to form an opinion on the individual’s eligibility to participate in the 2002 Act.

In stark contrast to the Netherlands, the operation of the Oregon’s law on physician-assisted dying is not so reliant on the close doctor-patient relationship, despite the 1997 Act implying a ‘treating relationship’. The 1997 Act defines the ‘attending physician’ as the physician who has primary responsibility for the care of the patient and treatment of the patient’s terminal disease. In practice, statistical reports and data show that the duration of the average doctor-patient relationship is relatively short, and that patients tend to approach several doctors before finding one that will agree to carry out the assessment required. For example, in the first year of the 1997 Act’s operation, the Department of Human Resources reported that six out of the fifteen patients, that is almost 50%, who used the Act ‘had to approach more than one physician before finding one that would start the prescription process’. It was also reported that ‘two-thirds of otherwise eligible control patients, had they asked, would not have received such prescriptions from the physicians interviewed’, showing the unwillingness, perhaps understandably in the first year of the law’s operation, of

107 CAD’s Commissioners’ interview with Gert van Dijk, Royal Dutch Medical Association (‘KNMG’), Erasmus Medical Centre, Rotterdam, 14 March 2011 in the Netherlands.


109 127.800 s.1.01(2) [emphasis added].

physicians to participate. The same report three years later found that only 41% of patients received the medication from the first physician they visited, and that the duration of the doctor-patient relationship was between eight to twenty two weeks only. The latest data from Oregon show that the median duration of the doctor-patient relationship was eighteen weeks, which is higher compared to 1998-2015 (twelve weeks). Studies also confirm that, in most cases, the doctor-patient relationship is not established, long-lasting, and pre-existing. For example, in 2000, Ganzini et al. reported that 27% of the doctors involved in the study, that is 38 out of 143, had known the patient for less than one month at the time of the request. The same year Sullivan et al. found that only 31% of patients received prescriptions from the first doctor they visited, and others had to ask two (56%), or three doctors (44%). In Oregon, the organisation Compassion and Choices helps individual patients find doctors willing to carry out the assessment required under the law. To some extent this explains why, despite the fact that most doctors, as evident from

111 ibid.


studies and data above, are unwilling to be involved, the law has been in operation for 20 years.

The significant difference in the doctor-patient relationship in the Netherlands and Oregon illustrated above, raises interesting questions for a potential, future assisted dying framework in England and Wales. Both frameworks permit a form of assisted dying. Both frameworks rely on a medical decision-making model. Yet, the relationship between doctor and patient is significantly different in the two jurisdictions. The doctor-patient relationship in England and Wales is similar to Oregon.117 Patients in the UK are registered in a GP practice close to their place of residence. Care and treatment is provided by a team within that practice, with the patient able to choose any GP practicing in the practice. Although patients can, in theory, request for an appointment with the same GP, this cannot be guaranteed. Taking into consideration the time constrains for both doctors and patients, as well as the fact that some GPs work in a practice part-time, the reality is that patients in the UK typically see a different GP with each new appointment. In the context of assisted dying, therefore, this raises the question of whether a GP in the UK that knows the patient very little can be involved with assisted dying and the eligibility assessment of the individual.

Another problem, as evident by data in Oregon, is patients ‘shopping around’ for doctors willing to be involved. On the one hand, a system that allows for ‘doctor shopping’ is a system that respects the right of doctors to refuse participation.118 On the other hand, this may cause significant delays for patients and prolong their suffering, and result in patients registering in different practices to find a doctor willing to participate. Overall, a fundamental change in the relationship between


118 CAD’s Interview with Peter Lyon and Peter Rasmussen, Medical Directors for Compassion and Choices, Oregon in Oregon.
doctors and patients in the UK and the provision of healthcare in general demands a major change to the way the healthcare system works, and a major change of the healthcare culture. At the same time, however, the close doctor-patient relationship is important for both patients and doctors in effectively assessing the assisted dying eligibility. Even if the eligibility criterion relating to the physical or mental condition of the individual requesting assistance (terminal illness/unbearable suffering) does not form part of a future domestic framework,¹¹⁹ and even if the individual may not be considered ‘a patient’, the involvement of healthcare professionals will still remain relevant and will be crucial in assessing the individual’s voluntariness and mental capacity. Also considering the reluctance of most healthcare professional organisations in the UK to support assisted dying,¹²⁰ the involvement of the judiciary in the assisted dying procedure as an additional, last safeguard could potentially deal with any problems likely to arise from the absence of a close doctor-patient relationship in England and Wales in the context of assisted dying.¹²¹

¹¹⁹ See further: Chapter Three and Chapter Six of this thesis.


¹²¹ See further: Chapter Seven of this thesis.
5.6 Concluding Remarks: The Voluntariness Eligibility Criterion

Chapter Five assessed the CAD’s second eligibility criterion on voluntariness and the safeguards proposed by the CAD to support it. It is important to highlight that the safeguards discussed in this Chapter are not exhaustive. The CAD also proposed, for example, the recording or documenting safeguard, as well as the external reporting safeguard. These are safeguards that are also used in other jurisdictions that currently permit a form of assisted dying. Chapter Five, using the legal rules in other jurisdictions, and academic and scientific studies concludes that the voluntariness eligibility criterion, alongside the mental capacity criterion examined in Chapter Four, are essential minimums for an assisted dying framework for England and Wales.

To strengthen the CAD’s second eligibility criterion, and as proposed by the CAD, the individual should be the only one allowed to initiate an assisted dying conversation and subsequently request assistance as a clear indication of autonomy and voluntariness. At the same time, however, an assisted dying framework should not prevent the individual from seeking professional and other advice and discussion, and

\[122\] For the recording/documenting safeguard see: CAD’s Report, pp. 313, 315, 324, 339-341. For the external reporting to a National Monitoring Commission see: pp. 20, 26, 32, 34, 301, 309, 324-325, 345.

\[123\] In the Netherlands, for instance, the physician notifies (by means of a report) the municipal pathologist for all non-natural deaths that occur. The Regional Review Committees (‘RRCs’) (‘Regionale toetsingscommissies’) review compliance with the Article 2 due care criteria (Chapter III, Article 8). The RRCs then report to the Board of General Prosecutors and the regional healthcare inspector (Chapter III, Article 9), and produce annual activity reports (Chapter III, Article 17). In Belgium, physicians fill and send a form drawn by the Federal Control and Evaluation Commission (‘De Federale Controle- en Evaluatiecommissie/ La Commission fédérale de contrôle et d’évaluation’) (Article 6) within four working days (Section 5). The Commission produces various reports as a result (Section 9). The form includes reasons that the request was judged to be voluntary, and not the result of external pressure (Section 7). In Oregon, information must be recorded in the patient’s record (127.855 §3.09), and the Department of Human Services reviews the cases reported by physicians (127.865 §3.11).
be designed in such a way as to filter out advice and discussions that cross the line into *undue*, excessive influence. As regards the form and the number of requests by the individual, the CAD’s proposal on the two oral requests should be revisited. A more robust safeguard is a legal provision requiring a *written*, signed, and dated request at the beginning of the procedure. A request expressed in the individual’s own words, as opposed to a standard form, similar to the Netherlands, should be preferred. A number of reasons were given earlier, including, most importantly, that the doctor would have a clearer understanding of the individual’s thoughts and motivations. If a witnessing requirement is adopted, this should take the form of a state official confirming that the individual is indeed who drafted the request, as opposed to a witness confirming the absence of undue influence, pressure, or coercion. A written statement by the individual before the prescription of the lethal medication can be maintained as safeguard, but again can take the form of a statement in the individual’s own words and expressions. The waiting periods built in various points in the procedure are important safeguards not only for preventing hasty decisions, but also to ensure that the individual has time to think about the decision to request assisted dying, and to give time to doctors to identify any undue pressure, coercion, or influence. It is crucial, however, that any waiting periods are not unreasonably and inappropriately long as to prolong the suffering of individuals. Moreover, it was suggested in this Chapter that *at least two independent* healthcare professionals are involved in the assessment of the individual’s eligibility, with the option of a third one, and an advisory role for loved ones involved in the care of the patient, always subject to the individual’s consent. The assessment can be carried out first with the individual alone, by default, *and again* with the individual, and his/her loved ones.\(^{124}\) This must be a legal requirement. It will allow doctors to compare the discussion with the individual alone, and the discussion with the individual and third parties. As for the identity of the assessors (who will also provide the assistance), at least two

\(^{124}\) See, for instance, CAD’s meeting with Bregje Onwuteaka-Philipsen, Associate Professor at The VU University Medical Center, Amsterdam in the Netherlands.
independent professionals (doctors or nurses) should be involved in the procedure, with the option of an advisory consultation with the patient’s loved ones if there is regular contact and involvement, and always subject to the individual’s consent. It was finally noted that the close doctor-patient relationship is important for a medical model for assisted dying. However, the way healthcare is provided in the UK and the fact that patients do not usually see only one GP means that a change is unlikely (and perhaps undesirable) in the near future. Thus, the judicial oversight safeguard discussed in Chapter Seven of this thesis may deal with any problems likely to arise as a result of the absence of a close doctor-patient relationship.

Overall, Chapter Five argues that it is possible for an assisted dying framework to identify and guarantee a voluntary, autonomous wish and decision for assisted dying. It is crucial that any such framework is in such way construed as to ensure that individuals who make a voluntary decision are able to request assistance (personal autonomy), and those who are unduly influenced in making this decision are protected (safeguards). As Sheila McLean argues, if the argument for legalisation relies partly or solely on autonomy (or in this thesis, self-determination), any individual who seeks an assisted death should be entitled to request access to one.\textsuperscript{125} The law should then focus on the competence and voluntariness of the individual’s request.\textsuperscript{126} This is also in line with the argument of the thesis that is fully explored in the next Chapter.

\begin{footnotesize}
\begin{enumerate}
\item[\textsuperscript{125}] Sheila A.M. McLean, Assisted Dying: Reflections on the Need for Law Reform (Routledge-Cavendish 2007) 180, 199.
\item[\textsuperscript{126}] ibid 184.
\end{enumerate}
\end{footnotesize}
CHAPTER SIX:
THE LAST HUMAN RIGHT

‘We live in a society that promotes individual autonomy and values allowing its members to choose how they spend their lives. We value freedom of speech, of association and of movement. We value tolerance and allowing people to make their own choices, even if we wish to make different choices. The same freedom of choice that applies to how we live should also apply to how we die. If we respect human rights, we should not deny those who know that they are dying the right to bring their lives to a more rapid end to alleviate their misery’.  

On an individual level, how each of us chooses to lead life and experience dying is shaped by our personal beliefs, values, and circumstances, and by external factors, such as social norms and culture, politics, and religious and other beliefs. On a state level, however, and in deciding to legalise a form of assisted dying in the future, Parliament could opt for a framework that will respect both the right to life (Article 2), and the right to self-determination (Article 8), and the state obligations arising from these and attempt to strike a balance. This way, Parliament will respect the rights of those who choose death over life, but also safeguard the lives of those who do not want to die, but may be unduly influenced in seeking an assisted death. Chapter Six argues that the way to achieve this balance is the removal/absence of a criterion relating to the physical or mental condition of the individual requesting assistance (the terminal illness criterion, or the unbearable suffering criterion), and a robust approach to the second and third eligibility criteria and the safeguards proposed to

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2 See Chapter Three of this thesis.
support them, procedural or otherwise. If we are to respect the self-determining, autonomous right of individuals to control the manner and timing of their deaths (Article 8), imposing a time limit (terminal illness criterion) infringes the right of those who are not terminally ill. Similarly, requiring individuals to experience ‘unbearable suffering’ before being eligible for an assisted death, or in fact, to prove ‘unbearable suffering’ to be eligible, is inappropriate, and likewise infringes Article 8. In other words, an individual who is terminally ill or suffers unbearably should not be allowed to request an assisted death because of these two characteristics, but because it is the individual’s right to do so under Article 8. At the same time, any approach to the safeguards in a future assisted dying framework in England and Wales that is not robust is a threat to Article 2 and a potential breach of the state’s duty to protect those who do not want an assisted death.

The medico-legal assisted dying framework proposed in this thesis (and summarised here in Chapter Six) can strike the right balance between safety (Article 2 and Article 8(2)) of those who choose life over death and on the other hand, the respect for personal autonomy and choice (Article 8) and the value of life (Article 2) of those who choose death over life. The proposed framework is summarised in Part 6.3 of this Chapter, and is preceded by a discussion on Article 2 (Part 6.1), and Article 8 (Part 6.2). The right to control the manner and timing of one’s death is ‘the last human right’.

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3 See further: Chapter Four, Chapter Five, and Chapter Seven of this thesis.

4 This right was first recognised in Pretty v the UK (2002) 35 EHRR 1 [65], [67]; and confirmed later in: Haas v Switzerland (2011) 53 EHRR 33 [51]; and Gross v Switzerland (2013) ECHR 429 [60].

5 The argument was first presented here: Nataly Papadopoulou, 'Losing our grip on death: What now for assisted dying in the UK?' (2017) 5 Journal of Medical Law and Ethics 1, 57.

that individuals should be allowed access to if they have decision-making capacity, and act voluntarily.\textsuperscript{7}

\textsuperscript{7} See further: Chapter Four and Chapter Five of this thesis.
6.1 Article 2: The Right to Life

Article 2 has been extensively discussed in Chapter Two of this thesis. The analysis in this Chapter discusses, in particular, the three different ways Article 2 has been, or is currently being used, in domestic legal cases challenging the prohibition on assisted suicide and euthanasia, and in the relevant cases that came before the European Court of Human Rights ('ECtHR'). This is done to ascertain the most likely use and role of Article 2 in a future assisted dying framework in England and Wales.

6.1.1 Article 2 and a Right to Self-Determination in Matters of Life and Death?

In legal cases challenging the prohibition on assisted suicide and euthanasia in England and Wales, Article 2 has been used to argue in favour of a right to self-determination in matters of life and death. In the case of Pretty, however, both the Law Lords and Strasbourg ('ECtHR) judges refused to make such interpretation of Article 2. In a domestic level, the judges referred to the language and spirit of the provision to justify that a right to self-determination cannot be read into Article 2. Lord Hope, in particular, was categorical in rejecting such interpretation of Article 2. Lord Bingham said that a provision that is framed to protect the sanctity of life cannot be used in favour of 'voluntary euthanasia, suicide, physician-assisted suicide and suicide assisted without the intervention of a physician'. Lord Steyn agreed that a right to self-

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9 The case is extensively discussed in Chapter Two of this thesis.

10 See further: Chapter Two of this thesis.

11 R (on the application of Pretty) v DPP [2001] UKHL 61 [87].

12 ibid [4] and [6].
determination under Article 2 is unsustainable because of the need to protect the principle of the sanctity of human life,\textsuperscript{13} while Lord Hobhouse said that assisted suicide directly offends the principle, which is one of the most fundamental of human social values.\textsuperscript{14} The Strasbourg judges agreed. Article 2 could not be interpreted negatively and establish ‘a right to die’ for Mrs Pretty.\textsuperscript{15} Such interpretation, the ECtHR said, would be a ‘distortion of language’.\textsuperscript{16} Writing on the Pretty case, Dan Morris rightly argues that this narrow interpretation of Article 2 is predominately an attempt by the Strasbourg judges to preserve its supreme and fundamental status within the European Convention on Human Rights (‘ECHR’).\textsuperscript{17} In my view, the ECtHR’s strong conclusion that no right to self-determination in matters of life and death can be derived from Article 2, as well as the ECtHR’s emphasis on its fundamental role of protecting the sanctity of human life, explain why no subsequent case, domestically or at a European level, used Article 2 to claim such right.

6.1.2 Article 2 and the States’ Negative Obligations

Article 2 prohibits the deliberate or intentional taking of life subject to the exceptions found in Article 2(2). None of these provides an exception if the individual requests or consents to an assisted death. Therefore, the literal interpretation of Article 2 does not allow states to authorise any party, being a healthcare professional, a relative, or a friend, to end life, even following the individual’s request or consent. Lord Steyn confirmed in the case of Pretty that the claimant’s argument in the case went directly against Article 2 and the principle that no individual should be deprived of life by

\textsuperscript{13} ibid [59].

\textsuperscript{14} ibid [109] and [111].

\textsuperscript{15} Pretty v the UK (2002) 35 EHRR 1 [39].

\textsuperscript{16} ibid.

intentional human intervention. Similarly, Lord Hope, in the same case, noted that the DPP’s refusal to grant immunity to the claimant’s husband enabling him to assist her death was compatible with the language of Article 2 that provides that, ‘no one shall be deprived of his life intentionally’.

Nonetheless, four state parties to the ECHR permit a form of assisted dying. The most likely answer to the question of whether these states are in breach of their negative obligations under Article 2 is that they are not. This is notwithstanding the fact that there has not yet been a case under Article 2 from a national of these four states, for example, who his/her loved one received an assisted death, challenging the compatibility of the law against the ECHR and Article 2. In practice, however, even under Article 2 that is not a qualified right in the same way as Articles 8–11 are, the ECtHR seems to afford a wide discretion to states. In Lambert v France, for instance,

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18 R (on the application of Pretty) v DPP [2001] UKHL 61 [59].

19 ibid [88].


21 But see: Widmer v Switzerland (Dec.) App No. 20527/92 (Commission 1993, unreported). The Commission found that there was no need for a separate law on passive euthanasia other than the criminal offence of death by negligence, and therefore found no violation of Article 2 by the state. In Lambert & Ors v France [2015] ECHR 545, the ECtHR also found no violation of Article 2 as a result of the withdrawal of artificial nutrition and hydration from a man in a vegetative state.

22 See, for instance, Netherlands Ministry of Foreign Affairs, Ministry of Health, Welfare and Sport, the Ministry of Justice, ‘Euthanasia - A Guide to the Dutch Termination of Life on Request and Assisted
a case that concerned the withdrawal of artificial nutrition and hydration (‘ANH’) from a man in a vegetative state (‘VS’), a practice distinct from assisted dying as defined in this thesis, the ECtHR noted that states should be able to decide whether personal autonomy should prevail over the right to life, or *vice versa* (balancing exercise), and indeed placed a lot of emphasis on the importance of autonomy in the dying context. In the context of assisted dying, therefore, a practice also not universally accepted similar to the withdrawal of ANH from VS patients, it is similarly up to each state to strike a balance, if that is considered necessary, between Article 2 and Article 8. Hence, although a literal interpretation of the negative state obligations under Article 2 is against the intentional deprivation of life irrespective of the individual’s request or consent, and as such, against the legalisation of any form of assisted dying, in practice, whether assisted dying is legalised or not remains within the discretion of each state, even under Article 2. The four states that currently permit a form of assisted dying are, most likely, not in breach of their negative obligations under Article 2.

**6.1.3  Article 2 and the States’ Positive Obligations**

Suicide (Review Procedures) Act’ [http://www.bioeticanet.info/eutanasia/LleiEuHol.pdf] accessed 27 September 2017, p. 11: ‘It is generally believed that signatories to the conventions have considerable freedom to interpret their broadly worded provisions within their own national legal systems’.

In general, Article 2 is likely to be invoked against the legalisation of assisted dying because of the states’ positive obligations to preserve and protect life under the provision. As Lord Bingham noted in the case of Pretty in 2001, the ECtHR’s jurisprudence was incompatible with Mrs Pretty’s claim in the case. In 1984, for instance, the Commission in X v Germany observed that under Article 2 states need to secure to everyone the right to life and that, in some cases, this requires positive action. In the case, there was a conflict between the applicant’s right to physical integrity under Article 8, and the state’s positive obligations under Article 2 to protect and preserve her life. The Commission gave priority to the latter, highlighting the need to prevent permanent injury and save the life of the prisoner who was on hunger strike by force-feeding her. More recently, in Osman v the UK, the ECtHR confirmed that Article 2 not only requires states to refrain from the intentional and unlawful taking of life (negative obligation), but also to take appropriate steps to safeguard the life of those within its jurisdiction (positive obligation). Specifically, states not only need to put in place effective criminal law provisions to deter offences against


25 R (on the application of Pretty) v DPP [2001] UKHL 61 [7].

26 X v Germany (Dec.) App No. 10565/83 (Commission, 9 May 1984, unreported) [my emphasis].


individuals, but also, in some cases, to take preventive operational measures to protect individuals whose life is at risk by other individuals. In context, Section 2(1) of the Suicide Act 1961 assumes the role of the criminal law provision that aims to deter crime and safeguard life by restricting individuals from assisting or encouraging suicide or attempted suicide in England and Wales. Section 2(1) also satisfies the preventative operational obligation, for instance, by safeguarding the life of individuals against pressure potentially inflicted on them by other individuals.

The positive obligations of states under Article 2 to preserve and protect life apply in numerous situations, for instance, in prison suicides cases. In Keenan v the UK, for example, the applicant alleged that prison authorities failed to protect her son’s life while in prison, despite knowing of the real and immediate risk of suicide. The ECtHR found no violation of Article 2 by the state as it was judged that the prison authorities did all that was reasonably expected of them in the circumstances to prevent the suicide of the prisoner. Similar cases are the cases of Trubnikov v Russia and Renolde v France. In the first case, the ECtHR found no violation of Article 2 because the prison authorities had no ground to ‘reasonably foresee’ an imminent threat to the prisoner’s life. In the latter case, however, the ECtHR found a violation of the state’s positive obligations under Article 2 where a prisoner, who had impaired mental

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30 See also: Savage v South Essex Partnership NHS Foundation Trust [2008] UKHL 74. The Trust had an operational duty under Article 2 to prevent a mental health patient from suicide. The same conclusion was reached in Rabone and another v Pennine Care NHS Foundation Trust [2012] UKSC 2.

31 Keenan v the UK [2001] ECHR 242 [2], [83], and [85]-[86].

32 ibid.


35 Trubnikov v Russia [2005] ECHR 462 [74]-[79].
capacity, hanged himself in his cell.\textsuperscript{36} It was found that prison authorities knew of his psychotic disorder and the risk of self-harm, and did not discuss the option of a psychiatric institution and actually placed the prisoner in solitary confinement for a prolonged period after having just attempted another suicide.\textsuperscript{37} The ECtHR remarked, in numerous occasions, that there are measures and precautions (surveillance, expert consultation, cell searches, and so on) that could diminish the risk of self-harm or suicide, without infringing the personal integrity rights of individuals guaranteed under Article 8.\textsuperscript{38} A link can be made here with the judicial oversight or judicial involvement safeguard proposed as the last safeguard in Chapter Seven of this thesis. Though such involvement may be regarded by some as interfering with the right to self-determination of individuals who choose death over life, this additional safeguard can instead be considered as balancing safety (Article 2 and Article 8(2)), against the self-determination (Article 8(1)) and the value of life of individuals who choose death over life (Article 2(1)). In the case of \textit{Horoz v Turkey}, the ECtHR found in favour of the state (no violation of Article 2) for prioritising the wishes of a competent prisoner to go on a hunger strike, even though this led to his death.\textsuperscript{39} It was found that prison authorities satisfied their obligation to protect the prisoner’s physical integrity (Article 8) by administering appropriate medical treatment, and indeed could not be criticised for respecting his clear refusal to intervention.\textsuperscript{40} The same approach can be seen in the UK. In the earliest recorded force-feeding prisoner case in 1909, the domestic Court agreed with the prison authorities in prioritising health and life, over the self-determination and physical integrity of the prisoner.\textsuperscript{41} However, later cases show a

\begin{thebibliography}{99}
\bibitem{36} Renolde v France (2008) 48 EHRR 969.
\bibitem{37} ibid [86], [97], [89]-[99], and [106]-[109].
\bibitem{39} App No. 1639/03 (ECHR 2009) (available only in French).
\bibitem{40} ibid.
\bibitem{41} Leigh v Gladstone (1909) 26 T.L.R. 139.
\end{thebibliography}
shift in favour of the self-determination and physical integrity of prisoners of sound mind who understand the consequences of their actions. This is, however, not the case when a mental health problem may be present. This is in line with a crucial suggestion made in Chapter Four of this thesis to be applied in a domestic assisted dying framework. It is crucial for the assisted dying framework to distinguish between mental health problems that significantly impair the decision-making capacity of the individual, and mental health problems that do not. In the latter case, the right to self-determination should take priority, whereas in the former case, it is crucial that the state preserves and protects the health and life of the individual in question. An example of this is the 2012 Supreme Court case of Rabone where a voluntary patient committed suicide while on temporary release from the psychiatric hospital. There was no formal assessment of mental capacity as it is not required for detention under the Mental Health Act 1983; the Supreme Court only remarked that ‘her mental disorder meant that she might well lack the capacity to make an autonomous decision to take her own life’. Arguably, therefore, the deceased may have had the relevant mental capacity despite her background of depression and self-harm. This does not only highlight the importance of a mental capacity assessment, but also the need to

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45 Rabone and another v Pennine Care NHS Foundation Trust [2012] UKSC 2.

46 Ibid [105].

47 N.B. The presumption of capacity under Section 1(2) of the Mental Capacity Act 2005 that seems to be reversed if there is suspicion of a mental health problem. See also, a study that found that a significant number of voluntary psychiatric in-patients have decision-making capacity: Gareth Owen et al, 'Mental Capacity and Psychiatric In-Patients: Implications for the New Mental Health Law in England and Wales' (2009) 195 British Journal of Psychiatry 257.
respect the right to self-determination of individuals in the presence of mental capacity.

Overall, the reasoning in the abovementioned cases highlights the importance of protecting both the right to life under Article 2, and the physical integrity and self-determination rights of individuals under Article 8, prioritising the latter when the individual in question has mental capacity (*Horoz*), and the former when the individual is assessed, or in *Rabone* assumed, to have significantly impaired mental capacity.

### 6.1.4 Article 2 and the States’ Positive Obligations for States that Already Permit a Form of Assisted Dying

As already noted, the conventional interpretation of Article 2 is likely to be invoked against the legalisation of assisted dying as it goes against the positive obligations of states to preserve and protect the life of individuals. Yet, for states that already permit a form of assisted dying, Article 2 and its positive obligations have been used in favour of safety, i.e. safeguards. Such was the case in *Haas v Switzerland* in 2011.48

Mr Ernst Haas, a Swiss national, suffered from a serious bipolar affective disorder for 20 years. He repeatedly failed to obtain a lethal substance (sodium pentobarbital) prescription to end his life in a dignified manner, and used Article 8 to claim that his right to decide how and when to die was breached as a result.49 The ECtHR agreed with the domestic courts that there was no positive obligation under Article 8 on the state to create the conditions for committing suicide without the risk of failure and without pain.50 In other words, it was not possible to allow Mr Haas access to sodium pentobarbital without prescription. In fact, the ECtHR emphasised that Article 2 created a positive obligation on the Swiss Government to put in place a procedure to


49 ibid [7].

50 ibid [10]-[11], and [38].
ensure that the decision to request assisted suicide corresponded to the individual’s free will.\textsuperscript{51} There was, in other words, an obligation to prevent assisted suicide if the decision did not correspond to the individual’s free will. Under domestic regulations and professional guidelines, the prescription requirement was necessary to protect the lives of the vulnerable, to safeguard public health and safety, and to prevent crime and abuse.\textsuperscript{52} The Swiss Federal Court (as quoted by the ECtHR) indeed noted the conflict between Article 2 and Article 8 in the sense that the interference with the right to self-determination could be justified for the protection of life and the prevention of crime.\textsuperscript{53}

Overall, the case highlights the distinction between the right to self-determination and the right to request and receive assistance by the state or a third party; the latter not protected by the ECHR. The case also highlights the important role Article 2 has in the protection of life, even in jurisdictions that already permit a form of assisted death. The decisions of the domestic courts in Switzerland and of the ECtHR were justified and rightly did not set a dangerous precedent.\textsuperscript{54} It was right to acknowledge the importance of safeguards, especially within the Swiss liberal model that is not supported by an official, statutory framework: an individual has the right to decide how and when life should end, on condition that ‘he or she is capable of freely reaching a decision on this question and acting in consequence’.\textsuperscript{55} The right to self-determination under Article 8 is therefore not unrestrained, but qualified based on the criteria set by each state that chooses legalisation to facilitate the self-determination rights of its citizens. Indeed, the applicant’s refusal to undertake a complete psychiatric assessment as required by domestic regulations and guidelines

\begin{itemize}
\item \textsuperscript{51} ibid [16], [46], [54] and [58].
\item \textsuperscript{52} ibid [16], [48], [56], and [58].
\item \textsuperscript{53} ibid.
\item \textsuperscript{55} Haas v Switzerland (2011) 53 EHRR 33 [51].
\end{itemize}
further strengthens the decision by the courts in the case. Following the Swiss Federal Court’s judgment, Mr Haas sent a letter to 170 psychiatrists in the region asking for a physical examination, but rejected any therapy in advance, as well as any alternative options.\textsuperscript{56} Supposedly, if his letter requested an assessment allowing all options to be considered (safeguards), a psychiatrist could eventually have prescribed him with sodium pentobarbital, granting him access to an assisted death. Article 2 therefore requires that any assisted dying framework contains safeguards to ensure that some conditions, such as, in the case of Switzerland, the free will of the individual, are present. Overall, the individual’s right to self-determination in the case was not breached as the Swiss law struck a fair balance between his right to self-determination, and the state’s obligation to protect his life.\textsuperscript{57} As earlier discussed, this balance can indeed be struck in either direction. The case of \textit{Lambert v France}, for instance, can be compared to \textit{Haas} in terms of the balancing exercise carried out by the ECtHR in end-of-life questions.\textsuperscript{58} In the latter case, the ECtHR highlighted the need to protect the right to life under Article 2 when the state already permits a form of assisted dying; in the former case, it highlighted the need to respect the right to self-determination, autonomy, and physical integrity under Article 8, even when the individual lacked decision-making capacity. Both cases highlight the importance of both Article 2 and Article 8, as well as the wide discretion states have when balancing these in an end-of-life context.

\subsection*{6.1.5 Article 2 and the States’ Positive Obligations in Protecting the Article 2 Rights of Individuals Who Choose Death over Life}

\textsuperscript{56} ibid [17] and [44].


\textsuperscript{58} \textit{Lambert & Ors v France} [2015] ECHR 545.
A relatively recent use of Article 2 and its positive obligations in the context of assisted
dying was first seen in the case of *Nicklinson* in 2012. In the Divisional Court, the
claimant, who lived with locked-in-syndrome and wished to have an assisted death,
argued that covert, unregulated euthanasia is already practiced in England and Wales,
and that the DPP’s Policy, by excluding professional healthcare involvement, similarly
encourages covert, amateur assisted suicides risking the lives of vulnerable
individuals. Consequently, the claimant argued, the prohibition of euthanasia and
assisted suicide interferes with the right to life of individuals who receive unregulated
and uncontrolled assistance because of all the risks and possible abuse involved. For
instance, a recent media report in the UK described the use of ‘a euthanasia kit’ which
was ordered online and used without professional assistance by an 81-year-old
woman. The woman eventually succeeded in ending her life in her own cottage.
There are significant risks involved, as Mr Nicklinson argued in his case, in these types
of suicides that are carried out without any professional oversight and without any
legal safeguards. The Divisional Court, however, did not accept Mr Nicklinson’s
argument under Article 2, therefore the claim was not continued in the higher
courts. The Court said that this was a ‘general challenge’ of the law that is a matter
for Parliament and hence did not directly concern the claimant in the case.

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59 See Chapter Two of this thesis for a full analysis of the case.

60 *Tony Nicklinson v Ministry of Justice* [2012] EWHC 304 (QB) [47].

61 ibid.


63 ibid.

64 *Tony Nicklinson v Ministry of Justice* [2012] EWHC 304 (QB) [5].

65 ibid [49].
A similar argument is used in the case of *Omid T*. The argument is that, because of the prohibition of assisted suicide in England and Wales, the claimant could decide to travel abroad early to request assistance in dying, therefore, his life would be shortened. If on the contrary the UK legalised a form of assisted death, the claimant could decide to extend his life by seeking assistance later, at home, irrespective of the state of his health. This predicament, the claimant argues, is inconsistent with the UK’s positive obligations under Article 2. Similar to other qualified rights, his lawyers argue, the UK needs to show that this is necessary and proportionate, and serves a legitimate right. Mr Omid’s argument relies on Lord Neuberger’s speech in the Supreme Court in *Nicklinson* who noted that the value of life is not an argument that can only be used against the legalisation of assisted dying. Put simply, Section 2(1) of the Suicide Act 1961 means that some individuals who suffer from progressive degenerative diseases are forced to end their lives early therefore, the law not only ‘adversely impinges’ on their personal autonomy, but indirectly, may also shorten their lives. Mr Omid T’s lawyers hence argue that the UK must strike a balance between protecting their client’s life, and protecting the lives of other vulnerable individuals whose lives may be at risk by the availability of assisted dying. If adequate

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66 See Chapter Two of this thesis for an analysis of the case.


68 Ibid [2].

69 Ibid [22] and [24].

70 *R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP* [2014] UKSC 38 [96].

71 Ibid.

72 *R (on the application of) Omid T v The Ministry of Justice* [2017] (High Court of Justice, Administrative Court - Claimant's Detailed Statement of Facts and Grounds) [24] available at:
safeguards can be introduced, his lawyers continue, an absolute ban on assisted dying breaches both Articles 2 and 8. A balance is thus needed not only between Articles 2 and 8, but also between the UK’s positive obligations not to shorten the life of the claimant, and the UK’s positive obligations to protect the lives of other vulnerable individuals. The answer may be the introduction of an assisted dying framework in line with the thesis’ argument. In this way, the claimant -and other individuals in similar situation- would not be forced to die sooner than planned, vulnerable individuals would not be forced into assisted dying against their will, and the right to self-determination under Article 8 would be respected for all individuals who choose death over life.

Mr Omid’s claim under Article 2, if successful, will have interesting and long-standing implications for Article 2 and its role in these cases. Yet, although Mr Omid’s argument can be perceived as being more specific, in the sense that it refers to the possibility of him travelling abroad to be assisted in dying, not to vulnerable individuals in general as in Nicklinson, it is likely that the Courts will again see it as a general challenge to the law, or consider it as a necessary and proportionate interference serving a legitimate right, and reject it. Overall, it can be argued that the conventional, strict interpretation of Article 2 and its positive obligations by the Courts highlights the judicial perceptions on what the proper role of the provision should be in this type of cases, and more generally that Courts consider that such interpretations may be for Parliament to make.

6.1.6 Concluding Remarks


73 ibid.
So, what does the case law on Article 2 tells us on its most likely use and role in a future assisted dying framework in England and Wales? With regards to the states’ negative obligations, although a literal interpretation of the provision is inconsistent with the intentional deprivation of life, in practice, whether assisted dying is legalised remains within the discretion of each state. This is evident by the fact that four state parties to the ECHR permit some form of assisted dying without being in breach of their ECHR obligations, but also because recent ECtHR jurisprudence shows that a wide discretion is afforded in end-of-life matters, even under Article 2.\textsuperscript{74} States are free to choose how to strike the balance, if any, between Article 2 and Article 8. With regards to the states’ positive obligations under Article 2, these are likely to be invoked against the legalisation of assisted dying because of the obligation to preserve and protect life. The obligation under Article 2 is particularly strong when the decision-making capacity of the individual is impaired,\textsuperscript{75} whereas states need to respect the self-determination of individuals (Article 8) when the relevant decision-making capacity is present.\textsuperscript{76} For states that already permit some form of assisted dying, Article 2 and its positive obligations have been used in favour of safety by highlighting the importance of safeguards already in place in the jurisdiction.\textsuperscript{77} In other words, the right to self-determination is not unrestrained, but qualified based on the eligibility criteria, requirements, and safeguards set by each state that chooses legalisation.

\textsuperscript{74} Lambert & Ors v France [2015] ECHR 545 [148].

\textsuperscript{75} Renolde v France (2008) 48 EHRR 969.

\textsuperscript{76} Horoz v Turkey App No. 1639/03 (ECHR 2009) (available only in French).

\textsuperscript{77} Haas v Switzerland (2011) 53 EHRR 33.
6.2 Article 8: The Right to Self-Determination in Matters of Life and Death

It is now established in the jurisprudence of the ECtHR that the right to self-determination in choosing the manner and timing of one’s death falls within the scope of Article 8 and private life. Any interference with this right is a de facto violation of Article 8(1). Article 8 being a qualified right, however, affords a margin of appreciation to states to justify any interference, a margin that is especially wide in the absence of a consensus on matters of life and death.\(^{78}\) Moreover, in the case of Haas, as earlier discussed, the ECtHR noted that there is no positive obligation under Article 8(1) ‘to create the conditions for committing suicide’ without the risk of failure and without pain.\(^{79}\) Accordingly, and as argued throughout this thesis, it will be up to the Parliament to decide whether to legalise a form of assisted dying in the future, otherwise, sufficient justification must be provided every time there is an interference with the right under Article 8(1).

6.2.1 Article 8 and the Right to Self-Determination in Choosing the Manner and Timing of One’s Death

In the case of R v the UK, the applicant complained that the UK breached its obligations under Article 8 (and 10) as a result of Section 2(1) of the Suicide Act 1961.\(^{80}\) The applicant was a member of the Voluntary Euthanasia Society, convicted

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\(^{78}\) See further: Steven Greer, ‘The Margin of Appreciation: Interpretation and Discretion under the European Convention on Human Rights’ Human Rights Files No. 17 (Council of Europe Publishing, Strasbourg 2000). The term ‘margin of appreciation’ refers to the ‘space for manoeuvre’ the ECtHR allows contracting states in fulfilling their obligations under the ECHR.

\(^{79}\) Haas v Switzerland (2011) 53 EHRR 33 [10]-[11], and [38].

\(^{80}\) (1983) 33 DR 270.
of, and sentenced to imprisonment for, aiding and abetting suicide, and conspiracy to aid and abet suicide. The Commission not only found that the UK did not breach its obligations under Article 8, but also that acts of aiding, abetting, counselling, or procuring suicide ‘trespass on the public interest of protecting life, as reflected in the criminal provisions of the 1961 Act’. Thus, in 1983, the Commission’s view weighed heavily in favour of the preservation and protection of life. There was, of course, no discussion of a right to self-determination in choosing the manner and timing of one’s death under Article 8. Several years later, the ECtHR, for the first time, recognised that Article 8(1) protects the right to self-determination, i.e. the right to choose when and how to die, in the case of *Pretty*.82

The case of *Pretty* has been extensively discussed in Chapter Two of the thesis. For current purposes, it suffices to reiterate the ECtHR’s recognition of the right to self-determination in choosing the manner and timing of one’s death, and the confirmation of this right in subsequent cases. In *Pretty*, the ECtHR remarked that the concept of ‘private life’ is broad, and not susceptible to exhaustive definition. Its extensive interpretation covers many types of cases, including sexual orientation, sado-masochistic preferences, and personal identity (use of a specific surname). In *Pretty*, the ECtHR observed that the very essence of the ECHR is respect for human dignity and freedom; thus, while respecting the principle of the sanctity of life under Article 2, the ECtHR recognised that ‘notions of the quality of life’ ‘take significance’

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81 ibid [13].
83 *Pretty v the UK* (2002) 35 EHRR 1 [61].
84 *Dudgeon v the UK* [1981] ECHR 5 [41].
85 *Laskey, Jaggard and Brown v the UK* [1997] ECHR 4 [36].
86 *Burghartz v Switzerland* [1994] ECHR 2 [24].
under Article 8.\(^{87}\) Section 2(1) of the Suicide Act 1961, the Court said, prevents the applicant from ‘exercising her choice to avoid what she considers will be an undignified and distressing end to her life’, and as such, interferes with her right to private life under Article 8(1).\(^{88}\) Later ECtHR cases confirm the Court’s conclusion in Pretty, including Haas in 2011,\(^{89}\) and Koch in 2012.\(^{90}\) In Haas, in particular, the ECtHR further developed its jurisprudence by qualifying the right to self-determination under Article 8 to individuals who are capable of freely reaching a decision and acting in consequence.\(^{91}\) The medico-legal assisted dying framework proposed in this thesis also qualifies the right to self-determination in choosing the manner and timing of one’s death to those who make a competent and voluntary decision to request assisted dying.\(^{92}\) The framework is summarised in Part 6.3 below.

### 6.2.2 Article 8 and the States’ Choice on Legalising Assisted Dying

The ECHR does not compel any of its contracting states to legalise any form of assisted death.\(^ {93}\) This is manifest in the very different approach amongst different states, which are free to choose how to strike the balance, if any, between Articles 2 and 8 when it comes to assisted dying.\(^ {94}\) If the balance is struck in favour of Article 2 – the approach favoured by the majority of states – any interference with the right to self-determination must be justified under Article 8(2). In Pretty, for instance, the ECtHR

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\(^{87}\) Pretty v the UK (2002) 35 EHRR 1 [65].

\(^{88}\) ibid [67].

\(^{89}\) Haas v Switzerland (2011) 53 ECHR 33 [51].

\(^{90}\) Koch v Germany (2013) 56 ECHR 6 [51] and [54].

\(^{91}\) Haas v Switzerland (2011) 53 ECHR 33 [51].

\(^{92}\) See Chapter Four and Chapter Five of this thesis.

\(^{93}\) See Chapter Two of this thesis and the analysis of the margin of appreciation.

\(^{94}\) Gross v Switzerland (2013) ECHR 429 [66]; and Koch v Germany (2013) 56 ECHR 6 [69].
found that the restriction of the applicant’s right to self-determination was necessary to protect the rights of the weak and the vulnerable, and especially of those who could not take an informed decision. The ECtHR agreed that the more serious the harm involved (in this case, death), the balance is more likely to be struck in favour of public health and safety. If the balance is struck in favour of Article 8, the ECtHR in *Haas* made the right to self-determination conditional on the existence of safeguards. In the case, Switzerland, the state with arguably the heaviest balance in favour of the right to self-determination, the ECtHR agreed with the limitation of the right to self-determination to those who have taken a free and informed decision. This was because of the positive obligations on states to protect vulnerable individuals, public health and safety, and prevent crime under Article 2. Overall, the ECtHR, by means of the recent development of its jurisprudence in the area, seems to imply that domestic safeguards (or safety) are a necessary condition for a right to self-determination in choosing the manner and timing of one’s death. Overall, it is up to each state to strike any balance between Article 2 and Article 8. The ECHR does not compel the legalisation of any form of assisted death.

### 6.2.3 Concluding Remarks

Part 6.2 highlighted that the right to self-determination, i.e. the right to choose when and how to die, is protected under Article 8(1) and the notion of private life. In fact, any state interference with this right is a *de facto* violation of Article 8(1). Nevertheless, the ECtHR allows for a wide margin of appreciation under Article 8(2) in

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95 *Pretty v the UK* (2002) 35 EHRR 1 [69], [74], [76].

96 ibid [74]. See also: *Laskey, Jaggard and Brown v the UK* [1997] ECHR 4 [43]. The duty also exists when the individual’s own actions is a threat to his or her life: see *Keenan v the UK* [2001] ECHR 242 [91].


98 ibid [54], [56], and [58].

justifying any interference with this right.\textsuperscript{100} This means that contracting states are free to choose how to strike the balance, if any, between Articles 2 and 8 when it comes to assisted dying, its legalisation, or regulation.\textsuperscript{101} In fact, in \textit{Haas}, the ECtHR remarked that there is no positive obligation on states to facilitate an assisted death.\textsuperscript{102} The ECtHR in the case, most importantly, chose to emphasise the current safeguards in Switzerland highlighting that the right to self-determination assumes that the individual concerned is capable of freely reaching a decision and acting in consequence.\textsuperscript{103} There was no reference to any criterion relating to the physical or mental condition of the individual. The right to self-determination is not conditional on the individual suffering unbearably or being terminally ill. In other words, the ECtHR did not specify that the right to choose when and how to die is qualified on these two conditions or characteristics. Adopting such criteria is a safeguard that can be chosen by states that decide to permit assisted death. For example, jurisdictions that choose a terminal illness criterion, limit eligibility to the terminally ill only, thus ‘safeguarding’ all those who are not terminally ill, or those terminally ill who may be pressurised into assisted dying. Presumably, the ECtHR will highlight the existing safeguards in each state that chooses to permit a form of assisted dying.

\textsuperscript{100} On the margin of appreciation see Chapter Two of this thesis.

\textsuperscript{101} \textit{Gross v Switzerland} (2013) ECHR 429 [66]; and \textit{Koch v Germany} (2013) 56 EHRR 6 [69].

\textsuperscript{102} \textit{Haas v Switzerland} (2011) 53 EHRR 33 [10].

\textsuperscript{103} ibid [51].

‘[…] inherent in the whole of the ECHR is a search for a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual’s fundamental rights’. 104

At a European level, most Member States of the Council of Europe choose to prioritise Article 2 (the right to life) over Article 8 (the right to self-determination) in the context of assisted dying. In other words, most states do not permit any form of assisted dying. Indeed, the ECHR does not create any obligation on states to legalise any form of assisted death. Put simply, states are free to choose how to strike the balance, if any, between Article 2 and Article 8 in the context of assisted dying, despite the fact that interference with the right to self-determination in choosing the manner and timing of one’s death is a de facto violation of Article 8(1) after the case of Pretty in 2002. 105

The final part of Chapter Six (Part 6.3) summarises the medico-legal assisted dying framework proposed in this thesis that should be adopted in England and Wales in case Parliament decides to legalise assisted dying in the future. If legalisation is deemed necessary, Parliament must opt for a framework that will respect both the right to life (Article 2), and the right to self-determination (Article 8) and the state obligations arising from these, and attempt a balance. This way, Parliament will respect the rights of those who choose death over life (Article 8(1)), but also safeguard and preserve the life of those who do not want to die, but may be unduly influenced in

104 Soering v the UK (1989) 11 EHRR 439 [89].
seeking an assisted death (Article 2 and Article 8(2)). To achieve this balance, this thesis argues in favour of the removal/absence of a criterion relating to the physical or mental condition of the individual requesting assistance (the terminal illness criterion, or the unbearable suffering criterion), and a robust approach to the second and third eligibility criteria and the safeguards proposed to support them, procedural or otherwise.

6.3.1 The Criterion on the Physical or Mental Condition of the Individual Requesting Assistance in Dying

Looking back at Chapter Three of this thesis, the Chapter identified that all jurisdictions that permit a form of assisted dying use an eligibility criterion based on the physical or mental condition of the individual requesting assistance in dying (in the Chapter labelled as ‘eligibility’). This criterion is divided in two main categories: a terminal illness criterion, and a suffering-based criterion. The former is preferred largely in the US, whereas the former in the European jurisdictions that permit a form of assisted dying. In England and Wales, the earliest reform proposals used a combination of the two types of criteria, but most recent ones have followed the US model and used a terminal illness eligibility criterion. Chapter Three challenged the suitability of both types of ‘eligibility’ for an assisted dying framework in England and Wales. This is not least because of problems with their identification and practical application, but most importantly because neither a terminal illness eligibility, nor a suffering-based eligibility is compatible with the human rights argument put forward in this Chapter. Put simply, none of these two characteristics should be the basis for requesting access to an assisted death.

106 See Chapter Three of this thesis.

107 See further: Chapter Four, Chapter Five, and Chapter Seven of this thesis.
On the Article 8 side of the scale, the way to achieve a balance between Articles 2 and 8 in case of legalisation of assisted dying in England and Wales is the removal/absence of a criterion on the physical or mental condition of the individual (terminal illness, or unbearable suffering). A terminal illness eligibility criterion will breach the right to self-determination in choosing the manner and timing of one’s death under Article 8 of individuals who are not terminally ill, or indeed who are terminally ill but their prognostic period does not accord to the prognostic period identified in the terminal illness definition. Put simply, imposing a time limit in order for individuals to be eligible to request an assisted death is incompatible with Article 8. Moreover, an eligibility criterion based on suffering or ‘unbearable suffering’ will also breach the right to self-determination in choosing the manner and timing of one’s death of those individuals who do not yet experience ‘unbearable’ suffering, or are not able to prove ‘unbearable’ suffering. From a human rights perspective, the suffering of an individual, no matter its type or its source or its duration, should be accepted as justification for requesting assistance in dying. Any individual, being healthy or not, terminally ill or not terminally ill, suffering unbearably or not, should be allowed to request an assisted death. This is because the right to self-determination in controlling the manner and timing of death is not subject to restraints, and is not qualified in the relevant jurisprudence of the ECtHR. There is however an important exception. The ECtHR qualifies this right based on the criteria or requirements or standards and other safeguards each state chooses when legalising assisted dying. In the case of Haas, for instance, the ECtHR emphasised that the decision to request assisted suicide must correspond to the individual’s free will, a requirement set by regulations in Switzerland. Therefore, in case of legalisation of assisted dying in England and Wales, Parliament is free to impose any limitations and any requirements considered appropriate in the context, including a criterion on the physical or mental condition of the individual. Nevertheless, this Chapter and this thesis argue that in case Parliament decides that the time is ripe for legalisation, the criterion on the physical or mental

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108 Haas v Switzerland (2011) 53 EHRR 33 [16], [46], [54], and [58].
condition should be abandoned as this will go against the self-determination right of individuals in choosing the manner and timing of their deaths under Article 8. This rather radical argument on how a domestic assisted dying framework may look like in the future is qualified by a robust approach to safety, i.e. the safeguards in the assisted dying framework, that are summarised in the next Section.

6.3.2 The Mental Capacity and Voluntariness Criteria

Chapter Four and Chapter Five of this thesis dealt with the second and third eligibility criteria in the CAD’s proposed assisted dying framework. The second criterion states that: ‘the person is making a voluntary choice that is an expression of his or her own wishes and is not unduly influenced by others’. The third criterion states that: ‘the person has the mental capacity to make a voluntary and informed choice, and the person’s decision-making is not significantly impaired as a result of mental health problems such as depression’. These two criteria are found in the laws and regulations of all jurisdictions that permit some form of assisted dying, as well as in the past domestic reform proposals, highlighting their vital role in any assisted dying framework. These criteria, fundamentally, aim to ensure that the individual considering an assisted death is making an autonomous decision. The individual needs both the internal capacity for self-government (free will), and to be free from external constraints (liberty). The former is reflected in the CAD’s third criterion, the latter in the CAD’s second criterion. It was concluded that both criteria are essential minimums for an assisted dying framework, but that the improvements discussed in Chapters Four and Five are necessary in building a robust, safe assisted dying framework.

Chapter Seven, that follows, examines an additional safeguard, that of judicial oversight or judicial involvement, that should be considered by Parliament in case it decides that legalisation is necessary in a domestic level.

On the Article 2 side of the scale, it is the argument of this Chapter and this thesis that any approach to the safeguards, procedural or otherwise, in a future assisted dying framework that is not robust in line with what was suggested in Chapters Four, Five, and Seven is a threat to Article 2. It is a potential breach of the state’s positive duty to protect the life of those who do not want an assisted death but may be unduly influenced into it, or those who do not have the relevant mental capacity and may make a decision to request assisted dying that is not autonomous. An approach to Article 2 that is not robust in line with the improvements to the criteria of mental capacity and voluntariness and the additional safeguard discussed in Chapter Seven will distort the balance between Articles 2 and 8. Because of the heavy balance in favour of Article 8 in light of the absence of the criterion on the physical or mental condition of the individual, the Article 2 approach in case of legalisation must be robust in favour of safety. Hence, in case Parliament decides that the time is ripe for legalisation, it should follow the recommendations in Chapters Four, Five, and Seven of this thesis in building a robust framework that will respect not only the right to self-determination under Article 8, but also Article 2 and the positive obligations of the state.

6.3.3 Concluding Remarks

The medico-legal assisted dying framework proposed in this thesis, and summarised in Sections 6.3.1 and 6.3.2, can strike the right balance between safety (Article 2 and Article 8(2)) of those who choose life over death and on the other hand, the respect for personal autonomy and choice (Article 8) and the value of life (Article 2) of those who choose death over life. This balance is needed to respect both the personal rights of individuals under the ECHR (Article 8(1) and the right to self-determination in
choosing the manner and timing of one’s death, and Article 2 and the need to protect life, for instance, by not forcing individuals to die sooner than planned), against public/state interests under the ECHR (Article 2 and the need to preserve and protect life, and under Article 8(2) the protection of health and life, and the rights of others). The right to control the manner and timing of one’s death is ‘the last human right’ that individuals should be allowed access to if they have decision-making capacity, and act voluntary.  

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110 See Chapter Four of this thesis.

111 See Chapter Five of this thesis.
Chapter Seven: The Last Safeguard

Chapter Three of this thesis challenged the suitability of both types of eligibility criteria relating to the physical or mental condition of the individual requesting assistance in dying. More specifically, the Chapter identified that both a terminal illness eligibility criterion, and a suffering-based eligibility criterion suffer from significant limitations, mostly in relation to their practical application and identification. Moreover, Chapter Three and Chapter Six argued that neither a terminal illness eligibility criterion, nor a suffering-based eligibility criterion, is compatible with the human rights argument of this thesis. Chapter Six, in particular, noted that an eligibility criterion on the physical or mental condition of the individual will interfere with the right to self-determination of individuals to choose the manner and timing of their deaths as guaranteed by Article 8 of the European Convention on Human Rights (‘ECHR’). A terminal illness eligibility criterion will interfere with the exercise of the right to self-determination of individuals who are not terminally ill, or who are terminally ill but do not fall within the specified terminal illness definition. A suffering-based eligibility criterion will also interfere with the right to self-determination as the suffering of individuals, no matter its type, duration, or source, should be accepted as the basis for requesting access to an assisted death. To strike the right balance between Article 2 and Article 8, this thesis proposes the absence/removal of the criterion on the physical or mental condition of the individual requesting assistance in a future domestic legalisation framework. To balance the equilibrium for this liberal approach, attention should turn to Chapter Four, Chapter Five, and the analysis in the present Chapter Seven of this thesis.

It is necessary to create robust safeguards for the proposed assisted dying framework to ensure that the UK is not in breach of its Article 2 obligations to protect the life of individuals who may be in danger from the availability of assisted dying, for example,
those who may be unduly influenced in seeking an assisted death, or those who may lack the mental capacity to make such a decision. This will be achieved if the proposals in Chapters Four, Five, and Seven are considered. So far, Chapter Four and Chapter Five have argued that the mental capacity eligibility criterion, and the voluntariness eligibility criterion are essential minimums for a competent, voluntary, autonomous decision to request assisted death. Chapter Seven proposes a last safeguard for the assisted dying framework proposed in this thesis: the judicial involvement, or judicial oversight, of the procedure. This safeguard will contribute in strengthening the framework proposed in the thesis. It is however crucial that any existing or additional safeguards do not unreasonably and inappropriately obstruct the procedure, preventing the individual from requesting assistance and placing an onerous burden on the parties involved.\(^1\) The additional safeguard proposed in the present Chapter will give a ‘psychological advantage’ to healthcare professionals as responsibility will be shared with judges,\(^2\) may encourage healthcare professional associations to adopt a more positive attitude towards assisted dying,\(^3\) and, as argued earlier, will restore the equilibrium of the radical argument put forward in this thesis.


Evidence submitted to the CAD suggested four different models for an assisted dying framework in England and Wales: a strictly legal model, a medico-legal model, a strictly medical model, and a combination of a medical and non-governmental organisations model.\(^4\) The latter of the four refers to the Swiss model,\(^5\) as well as to the operation of the organisation Compassion and Choices in Oregon.\(^6\) As evident in Chapters Four and Five of this thesis, the CAD preferred a medical model. The CAD received much evidence suggesting different legal decision-making models, however, all were rejected as unnecessary and undesirable.\(^7\) Moreover, none of the jurisdictions that currently permit a form of assisted dying around the world uses a legal decision-making model. There is therefore limited evidence to draw upon in discussing and developing this additional safeguard in the present Chapter. However, the most recent domestic reform proposal, the Assisted Dying Bill 2013 (‘ADB’), before its rejection, was amended to include High Court Family Division judges in the assessment procedure.\(^8\) Moreover, some of the Justices of the Supreme Court in the case of *Nicklinson* in 2014 discussed different legal models for assisted dying.\(^9\)

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\(^4\) CAD’s Report, p. 243.

\(^5\) See further details in Chapter Three of this thesis.


\(^7\) CAD’s Report, pp. 28-29.


\(^9\) *R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP* [2014] UKSC 38.
7.1 Legal Models for Assisted Dying and the CAD

In evidence to the CAD, Nick Wikeley, a judge of the Upper Tribunal, described three possible judicial models for an assisted dying framework in England and Wales: the High Court Family Division, the Court of Protection, and an assisted dying tribunal. A tribunal for assisted dying has been suggested in a number of other evidence submissions to the CAD, including evidence by legal practitioners, academics, and campaign groups. In this thesis, a tribunal legal model for assisted dying is not


recommended because of the need to involve judges only to emphasise the seriousness of the decision to request an assisted death. The option of an assisted dying tribunal should not, however, be dismissed so hastily, but evidence and academic and legal commentary is very limited at this stage. Further research should be carried out on its suitability in an assisted dying context in England and Wales.

Evidence submitted to the CAD\textsuperscript{14} and other sources\textsuperscript{15} have proposed the Court of Protection as another judicial model for assisted dying. However, the Court of Protection is also considered in this thesis inappropriate in the context of assisted dying. The Court of Protection was created by the Mental Capacity Act 2005 (‘MCA’). It has jurisdiction in England and Wales in relation to financial or welfare matters of individuals who may lack the capacity to make these decisions.\textsuperscript{16} The reason that the Court of Protection should not be involved with assisted dying is because it deals with individuals who may lack mental capacity. This will send the wrong message to individuals who are considering an assisted death. As argued in Chapter Four of this


\textsuperscript{16} Government website, Court of Protection - What we do \url{https://www.gov.uk/courts-tribunals/court-of-protection} accessed 27 September 2017. On the Court of Protection’s jurisdiction see, for example: \textit{Re F} [2009] EWHC B30 (Fam) [11]-[13], [27]-[29], [33], [35], [46]; \textit{YA(F) and A Local Authority & Ors} [2010] EWCOP 2770 [17]-[21], [23]-[47]; and \textit{Re DT} [2015] EWCOP 10.
thesis, the presumption of capacity under the MCA is vital in highlighting the autonomy of the individual in the context of assisted dying, as well as to highlight that the decision to request assisted dying does not necessarily imply an impaired mental capacity. In other words, not everyone who requests an assisted death is experiencing a mental health problem, and not everyone who experiences a mental health problem will request an assisted death.  

The analysis below (Part 7.2) discusses the third option, presented by Judge Wikely to the CAD: namely, the involvement of judges of the High Court Family Division in assisted dying. It is argued here that this model is presently the most appropriate judicial model for a future assisted dying framework in England and Wales. The analysis is informed by evidence submitted to the CAD, the *Nicklinson* case, and parliamentary debates relevant to the ADB 2013. The involvement of judges of the High Court Family Division in the assisted dying procedure will enhance the credibility of, and public confidence in the decision to allow the assisted death, and highlight the severity of the individual’s request for an assisted death.


18 *R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP* [2014] UKSC 38.

7.2 The High Court Family Division’s Involvement in a Future Assisted Dying Framework in England and Wales

7.2.1 The High Court’s Involvement and the *Nicklinson* case

The High Court’s involvement in assisted dying received some judicial attention in the Supreme Court in the case of *Nicklinson* in 2014. The case, in essence, examined whether the criminal prohibition on assisted suicide (Section 2(1) of the Suicide Act 1981) in England and Wales infringes Article 8 of the ECHR, and whether the Prosecutorial Policy by the Director of Public Prosecutions (‘DPP’) is lawful. Lord Neuberger, President of the Supreme Court, argued in favour of the involvement of the judiciary in assisted dying. Specifically, he argued that it is possible to devise a judicial framework that could ‘eliminate or reduce’ the risks to the vulnerable to ‘an acceptable level’ by identifying a ‘voluntary, clear, settled and informed’ decision to die. He argued that High Court judges have the necessary expertise to be involved with assisted dying as they already decide life and death cases including, cases of ‘sterilisation, denial of treatment, withdrawal of artificial nutrition and hydration, switching off a life support machine, and surgery causing death to preserve the life of another’. Judge Wikeley told the CAD in 2011 that the fact that expertise is already

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20 *R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP* [2014] UKSC 38.

21 See Chapter Two for a full analysis of the case.

22 *R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP* [2014] UKSC 38 [123].

23 Ibid.

24 Ibid [124]. See further: [21]-[26].
present in the High Court will ensure public confidence in the procedure. In his speech in the case of Nicklinson, Lord Wilson, a Family Division judge of twelve years, also agreed. The High Court, he argued, would hear evidence from the claimant and third parties, including the individual’s loved ones and healthcare professionals, as to the individual’s ‘voluntary, clear, settled and informed’ decision. Lord Wilson actually listed 18 factors the High Court may consider in the future during the assessment of the individual: examples include the claimant’s capacity to reach a voluntary, clear, settled and informed decision, and the history and progression of the condition. Lady Hale, an expert in family and social welfare law and its reform, similar to Lord Wilson, also listed factors that the High Court may consider in its assessment, and similarly emphasised that equally difficult and sensitive life and death cases are already considered by the Family Division of the High Court.

7.2.2 The High Court’s Involvement and the ADB

Six months following the release of the Nicklinson judgment (June 2013 to November 2013), the Assisted Dying Bill (‘ADB’) 2013 had its first day of Committee before the House of Lords. On the day the Lords, perhaps influenced by the Supreme Court’s

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26 R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v DPP [2014] UKSC 38 [197] [205].

27 Ibid [205].


judgment in *Nicklinson*, voted in favour of an amendment moved by Lord Pannick requiring the High Court’s consent before the individual’s request for assisted dying is approved.\(^3\) In particular, the amendment requires that the individual satisfies a High Court Family Division judge that he/she has made a voluntary, clear, settled and informed decision. The judge must examine the evidence arising from the discussions between the individual and the doctors, and be satisfied that the criteria have been met.\(^3\) This highlights the need for a medico-legal assisted dying framework, in which healthcare professionals and judges must work together. There were a number of arguments in favour and against Lord Pannick’s amendment.

Lord Pannick, similar to the Justices of the Supreme Court, highlighted that judges of the Family Division of the High Court already decide ‘the most profound questions relating to ‘life and death’ with ‘great compassion’ and where necessary, ‘speedily’.\(^3\) Lord Carlile of Berriew agreed that the Family Division of the High Court is comprised of ‘real experts on issues that cover not only the nuts and bolts, complex as they are, of family life, but also the moral, ethical and even philosophical issues that may move decisions as to whether, for example, deaths should be allowed to take place in a particular way by the switching off of a life support machine’.\(^3\) Other Lords spoke more generally about the benefits of judicial oversight over the procedure. Baroness Mallalieu, for instance, spoke about selfishness -third parties benefiting from the individual’s death- and selflessness -individuals feeling guilty about expenses, trouble, time, and distress caused- that, although cannot be entirely eliminated, can be

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\(^3\) ibid col1853. See also: col1854 *per* Lord Carlile supporting a different type of judicial amendment that was eventually outvoted.

\(^3\) ibid col1956 *per* Lord Falconer of Thoroton.

\(^3\) Lord Pannick referred to: *Airedale NHS Trust v Bland* [1993] AC 789 (HL) (withdrawal of life-prolonging treatment from a Persistent Vegetative State (‘PVS’) patient); and *Re A (Children) (Conjoined Twins: Separation)* [2000] 4 All ER 961 (CA) (separation of conjoined twins).

\(^3\) HL Deb 7 November 2014, vol756, col1854.
significantly reduced by involving the judiciary in the procedure.\textsuperscript{35} She most vividly praised the credibility of the judiciary in the UK by arguing that, ‘although there are crooked lawyers and experts of every kind, our judiciary is still, thankfully, totally respected—who by training and expertise is qualified to judge pressure, coercion and genuine or false wishes, and to examine or evaluate evidence as to whether somebody has capacity, is acting voluntarily and has a clear understanding and a settled wish to end his/her own life’.\textsuperscript{36} Lord Condon spoke in similar terms arguing that judicial involvement may perhaps be the only way to control abuse and coercion.\textsuperscript{37}

Overall, the main argument in favour of the judiciary’s involvement in assisted dying was its already established expertise in life and death cases.

On the other side of the debate, a number of Lords expressed concerns in relation to the speed of cases in the High Court,\textsuperscript{38} the cost of proceedings, and the availability of legal aid.\textsuperscript{39} A number of other Lords were, however, confident that the Family Division of the High Court will be in a position to prioritise urgent assisted dying cases. For instance, Lord Carlile of Berriew said that these can be dealt within days, not months.\textsuperscript{40} Achieving the right balance between efficiency and quality in decision-making, Lord Carlile continued, will make the UK ‘an exemplar to the world of how we have a judicial system that is flexible enough to take in cases at the extremes but sustains the principles in which it has long believed’.\textsuperscript{41} Baroness Butler-Sloss, President of the Family Division of the High Court for six years, said that cases of similar type

\begin{footnotesize}
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\item \textsuperscript{35} ibid col1860.
\item \textsuperscript{36} ibid.
\item \textsuperscript{37} ibid col1862.
\item \textsuperscript{38} For instance, see: col1856 per Lord Framlingham; col1878 per Lord Hunt of Kings Health; and col1891 per Lord Deben.
\item \textsuperscript{39} For instance, see: col1857 per Baroness Tonge; and col1878 per Lord Hunt of Kings Health.
\item \textsuperscript{40} HL Deb 7 November 2014, vol756, col1857.
\item \textsuperscript{41} ibid.
\end{itemize}
\end{footnotesize}
have been heard by the Court within a day, including the appeal if ‘sufficiently urgent’. In fact, in *Ms B*, a case of a paralysed woman who wished for her ventilator to be switched off, Baroness Butler-Sloss actually visited the woman in hospital to gather evidence before delivering her judgment. Baroness Murphy, a doctor and a psychiatrist with expertise in mental health and ageing issues, said that courts can ‘readily convene at 24 hours’ notice’. With regards to legal aid and concerns in relation to the cost of proceedings, Lord Carlile told the House that legal aid would be available under ‘the exceptionality provisions’, while Baroness Butler-Sloss maintained that it would be ‘a matter for the Government of the day’, but that it would be ‘shocking’ if legal aid were not granted in assisted dying cases. Along similar lines, Baroness Finlay of Llandaff commented that dying patients ‘are already reliant on charitable funds of different sorts’, but that assisted dying cases are exceptional, and therefore fees should be covered. Baroness Mallalieu stressed the importance of ensuring that individuals who wish to request assistance are not prevented for financial reasons. She referred to the current ‘absurd anomaly’ whereby, if one has the money, they can travel abroad to be assisted in dying, but if not, there are no options. The cost of travelling to Dignitas, for example, is around

42 ibid col1859.
43 *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam).
45 ibid col1857.
46 ibid col1859. However, in the second day of Committee (HL Deb 16 January 2015, vol758, cols1001-1070) Lord Phillips of Sudbury’s Amendment 12A proposing legal aid regulation was rejected.
47 HL Deb 7 November 2014, vol756, col1866.
48 ibid col1861.
10,000GBP. 49 Lord Phillips of Sudbury, 50 and Lord Davies of Stamford 51 made identical arguments.

The revised version of the ADB 2013, the ADB (No.2) 2015, 52 indeed included the High Court in the assisted dying procedure. The ADB (No.2) 2015 required the consent of the Family Division of the High Court before terminally ill individuals request assistance. The Court would be required to confirm that the individual: has a voluntary, clear, settled, and informed wish to end his/her own life, made the relevant declaration, is aged 18 or over, has the capacity to make the decision, and has been resident in England and Wales for not less than one year. The Court must dispose the application within 14 days, or as soon as reasonably practicable. 53 Rob Morris MP, sponsor of the Bill, clarified that following the assessment by the two doctors, the declaration will be sent to the High Court for the necessary and appropriate inquiries. 54 The ADB 2016-17 is identical to the ADB (No.2) that was rejected by the House of Commons. 55 The ADB 2016-17 was proposed to the House of Lords by Lord Hayward on the 9th of June 2016. This may be evidence of the fact that all future statutory reform proposals in England and Wales will, from this point onwards, include a judicial oversight safeguard. Therefore, the possibility of a medico-legal assisted


50 HL Deb 7 November 2014, vol756, col1863.

51 ibid col1895.

52 Assisted Dying (No.2) HC Bill (2015-16) 7 56/1.

53 This was challenged in: HC Deb 11 September 2015, vol599, col698 per Helen Jones (Warrington North); col688 per Sir Edward Leigh (Gainsborough); col683 per Steve Brine; and col700 per Ben Howlett (Bath).


55 Assisted Dying HL Bill (2016-17) 42 56/2.
dying framework is now real and should be considered in depth. Hopefully, future
debates in Parliament, as well as academic debate will shed further light on the issue.

7.2.3 The Involvement of the High Court in Assisted Dying

Chapter Seven suggests that the judicial involvement or judicial oversight safeguard
considered by the House of Lords and the Supreme Court should be adopted as an
additional safeguard in a future assisted dying framework in England and Wales.
Specifically, the option of an assisted dying tribunal should not be hastily dismissed.
However, at the moment, there is no evidence on its suitability in an assisted dying
context. Sections 7.2.1 and 7.2.2 reviewed the discussion that took place in the UK on
the High Court’s involvement in assisted dying. There are indeed many reasons to
support the involvement of judges of the Family Division of the High Court in assisted
dying. It will enhance the credibility of, and public confidence in the decision, highlight
the severity of the individual’s decision, make existing safeguards more robust, give a
psychological advantage to healthcare professionals as responsibility will be shared
with judges, encourage healthcare professional associations to adopt a more positive
attitude towards assisted dying, and also serve to restore the equilibrium of the
radical argument put forward in Chapter Six.

On a more practical note, the involvement of the High Court Family Division judges in
assisted dying will be valuable in cases where healthcare professionals may disagree,
when the individual is suffering from a mental health problem (for instance, in the
eyear stage of dementia)\textsuperscript{56} but it is unclear whether his/her mental capacity is
unimpaired, or in more particular situations; for instance, when the individual

\textsuperscript{56} Freda Humble, Letter to the Commission (January 2011)
<web.archive.org/web/20160327125355/http://commissiononassisteddying.co.uk/wp-
suffered from early dementia and asked the CAD to consider the status of individuals in her situation.
becomes unconscious during the assessment procedure,\textsuperscript{57} or when the individual is experiencing feelings of being a burden but still satisfies the voluntariness and mental capacity criteria.\textsuperscript{58} The argument put forward in Chapter Six, that an individual does not necessarily need to be terminally ill or suffering to request assistance in dying, makes it even more pressing that High Court judges act alongside healthcare professionals to ensure that only individuals with mental capacity, and who make a voluntary decision, access an assisted death. One may argue that the High Court’s involvement in the assisted dying procedure may be an additional hurdle to the right of individuals to choose the manner and timing of their deaths, and therefore go against the self-determination right advocated in Chapter Six of this thesis.\textsuperscript{59} It is a compromise, however, that needs to be made (legalistic obstacle) in attempting to strike a balance between the right of any individual to choose an assisted death, and the safety of others that may be affected by the availability of assisted dying.\textsuperscript{60} It is

\textsuperscript{57} In Luxembourg, if the individual becomes unconscious during the procedure, the request remains valid until euthanasia is performed. Although controversial, the provision recognises that some conditions are unpredictable and changeable and deteriorate rapidly. It also recognises that individuals may request assistance at a late stage to prolong their living, if they wish to do so. See further: Sante.lu website \url{http://www.sante.public.lu/fr/publications/e/euthanasie-assistance-suicide-questions-reponses-fr-de-pt-en/euthanasie-assistance-suicide-questions-en.pdf} accessed 28 September 2017, p. 14.

\textsuperscript{58} HL Deb 18 July 2014, vol755, col839 speech \textit{per} Baroness Richardson of Calow (‘Why should it be considered shameful for me to wish to protect my family and friends from the burden of watching me slowly die?’); HL Deb 18 July 2014, vol755, col895 speech \textit{per} Lord Layard (‘Why should we prevent people taking altruistic decisions if they want to?’); HL Deb 7 November 2014, vol756, col1908 speech \textit{per} Baroness Warnock (‘why is it thought wrong for someone to ask to die out of a sense of duty or a wish not to continue in a condition that is intolerable—the condition of being disruptive, indeed often destructive, to the well-being of their own family?’); and Select Committee, Assisted Dying for the Terminally Ill Bill, \textit{Vol. II: Evidence} (HL 2005 Paper 86-II), p. 551.

\textsuperscript{59} See, for instance, HL Deb 18 July 2014, vol755, col870 speech \textit{per} Baroness Young of Old Scone; or HL Deb 7 November 2014, vol756, col1859 speech \textit{per} Baroness Wheatcroft.

\textsuperscript{60} See further the analysis in Chapter Six of this thesis.
vital, however, that safeguards, including the judicial involvement or judicial oversight safeguard, do not unreasonably and inappropriately obstruct the procedure, thus preventing the individual from requesting assisted death, and putting an onerous burden on the parties involved.
CONCLUSION

The issue whether assisted suicide should be legalised is a highly controversial and widely-debated question. In this thesis, I attempted to answer the following question: if Parliament in the future considers that the time is ripe for legalisation, how should an assisted suicide framework look in England and Wales? To answer this question, I have used as starting point the three eligibility criteria proposed by the Commission on Assisted Dying (‘CAD’) in 2012. The CAD’s Report is the most recent review of the law on assisted suicide in England and Wales. I have explored each of the CAD’s eligibility criteria in separate Chapters, and I have used the first two Chapters of the thesis to introduce the relevant law and the human rights issues that relate to assisted suicide. In this final Chapter, the key findings of the thesis are presented, and future work discussed in conclusion of this thesis.

Key Findings

Chapter One explored the crime of suicide in England and Wales and its abolition in 1961, and analysed the main provisions of the Suicide Act 1961, the governing law in the area. Chapter One also gave an overview of the assisted suicide law reform proposals with a focus on the CAD. Its aim was not only to set the scene as to the law and the law reform attempts in the area, but also to highlight the value of the CAD’s Report that was used as starting point for this thesis. Even though many of the CAD’s Commissioners had a previous interest or involvement with the legalisation of assisted dying before joining the CAD, Chapter One argued that the CAD’s Report is a credible source of research, and its findings and collected evidence reveal unexplored themes that are valuable to the debate. The value of the CAD’s Report is attributed first to the fact that its Commissioners come from diverse cultural, racial, and other backgrounds, and from a variety of specialisms that include, healthcare professionals, lawyers,
police officers, politicians, and members of the clergy and are thus able to give a holistic analysis of the evidence and the law. Moreover, the CAD has gathered a considerable amount of evidence, have undertaken primary research, and made visits to four jurisdictions that permit a form of assisted death. The CAD’s Report is not only the most recent review of the law in England and Wales, but has also been the subject of limited commentary.

Chapter Two has dealt with the human rights law dimension of assisted dying. It discussed the right to life under Article 2 and the principle of the sanctity of life that underpins the provision. It also discussed the right to private and family life under Article 8 and the principle of autonomy. Though other European Convention of Human Rights (‘ECHR’) provisions are relevant to assisted dying, I consider these two Articles as the most relevant for this thesis. This is not only because this thesis needed a narrow scope, but also because these two provisions have been mostly used, and are currently used, in the legal challenges to the criminal prohibition on assisted suicide in England and Wales. Most importantly, it is under Article 8 that the right to self-determination in issues of life and death has been recognised by the European Court of Human Rights (‘ECtHR’), and it is Article 2 that is mostly used to argue against legalisation of assisted dying because of the need to protect health and life. Chapter Two also analysed the domestic legal cases on assisted suicide from the early case of Dianne Pretty, in 2002, to the most recent, at the time of writing, case of Omid T in 2017. The aim of this Chapter was not only to set the scene on assisted dying and human rights, but to argue that assisted dying is, most importantly, a human rights issue. Chapter Two highlighted first, that Article 8 now encompasses the right to self-determination in determining the timing and manner of one’s death, and that the ECtHR considers the prohibition on assisted suicide as a prima facie violation of Article 8(1); secondly, that because of the language and interpretation of Article 2, the provision is used in the context of assisted dying to highlight the need to protect the lives of others, and especially those who are vulnerable and may be at risk by the availability of assisted dying; thirdly, that cases such as the case of Omid T may give rise to new arguments under Article 2; and fourthly, that the Nicklinson case shows
that some judges in the UK are now concerned with how the law could change, not with whether the law should change something that should be decided by Parliament.

Chapter Three challenged the suitability of the two mainstream eligibility criteria relating to the physical or mental condition of the individual who requests assistance in dying. The majority of jurisdictions that permit a form of assisted dying around the world use either a terminal illness eligibility criterion, predominately used in the US, or an unbearable suffering eligibility criterion, predominantly used by the Benelux countries in Europe. In England and Wales, reform proposals have used either a terminal illness eligibility only, or a combination. The most recent proposals have used a terminal illness eligibility only. The suitability of both types of eligibility criteria was challenged not least because of practical problems, such as their identification and practical application, but most importantly because the two characteristics (terminal illness and unbearable suffering) should not be the basis for being allowed to request access to an assisted death. Neither a terminal illness, nor a suffering-based eligibility, is likely to be compatible with the human rights argument advanced in Chapter Six of the thesis. Rather, the right to request an assisted death should be based on the right to self-determination in choosing the manner and timing of one’s death under Article 8 of the ECHR.

Chapters Four and Five dealt with the mental capacity and voluntariness eligibility criteria. These are criteria or standards or requirements found in all jurisdictions allowing a form of assisted dying. These are also the second and third eligibility criteria proposed by the CAD. The criteria as formed by the CAD were used as starting point, and drawing on the legal rules of other jurisdictions, past reform proposals in England and Wales, and on academic and scientific research studies a number of changes were proposed to make the two eligibility criteria and the safeguards used to support them more robust. An example is that the CAD proposed that individuals who are considering an assisted death should make two oral requests to their doctors to initiate the assisted dying procedure and the assessment of the mental capacity and voluntariness. I suggest instead, based on the legal rules in the Benelux countries, that
the individual should make a written request in a non-specified form using his/her own words and expressions. A written request is preferred over the two oral requests proposed by the CAD for many reasons already analysed, including the fact that this will highlight the severity of the individual’s decision, and that a written request can act as a referencing point for all parties involved. Overall, Chapter Four and Chapter Five argued that the eligibility criteria of mental capacity and voluntariness are essential minimums for a domestic assisted dying framework and proposed some changes that should be considered carefully in creating a robust assisted dying framework. The two Chapters argued that it is possible for an assisted dying framework to identify and guarantee a competent and voluntary, thus autonomous request for assisted dying allowing the individual to exercise his/her right to self-determination, and at the same time protect those whose lives may be in danger by the availability of assisted dying.

Chapter Six argued that in deciding to legalise assisted dying in the future, Parliament could opt for a framework that will respect both the right to life (Article 2), and the right to self-determination (Article 8), and the obligations arising from these and attempt to strike a balance. This option will respect both the rights of those who choose death over life, but will also safeguard the lives of those who do not want to die, but may be unduly influenced in seeking an assisted death. To achieve this balance, Chapter Six suggested the removal/absence of the eligibility criterion relating to the physical or mental condition of the individual, and a robust approach to the second and third eligibility criteria and the safeguards proposed to support them, procedural or otherwise. A terminal illness eligibility criterion will not respect the right to self-determination of those individuals who are not terminally ill or whose terminal illness does not fall within the specified terminal illness definition, whereas requiring individuals to experience ‘unbearable suffering’ to be eligible or to prove ‘unbearable suffering’ to be eligible is inappropriate and also does not respect the right to self-determination of these individuals. At the same time, any approach to the safeguards of a domestic assisted dying framework that is not in line with the proposals of Chapter Four, Chapter Five, and Chapter Seven, is a threat to Article 2 and a potential
breach of the state’s duty to protect the life of those who do not want an assisted death. Safety in the form of robust safeguards is crucial, especially considering the liberal argument put forward in Chapter Six. This argument means that, essentially, any individual with mental capacity that makes a voluntary and informed decision to die should be allowed to request an assisted death. The medico-legal assisted dying framework proposed in this thesis can strike the right balance between safety (Article 2 and Article 8(2)) of those who choose life over death and on the other hand, the respect for personal autonomy and choice (Article 8) and the value of life (Article 2) of those who choose death over life.

Because of the liberal argument put forward in Chapter Six, Chapter Seven suggested a last safeguard for ‘the last human right’ of individuals who choose death over life. Chapter Seven proposed that a medico-legal assisted dying framework that will include the Family Division of the High Court should be adopted in England and Wales in case of legalisation. Though no jurisdiction that currently permits a form of assisted dying adopts a wholly or partially judicial model, this option has already been considered by the Supreme Court and the House of Lords in the UK in recent years. Further research is needed on the matter, however, especially with regards to the cost of the judicial procedure, the duration of the legal proceedings, as well as its impact on healthcare professionals and the individuals involved. Chapter Seven argued that on the assumption that individuals who choose death over life have the mental capacity to make the decision, that individuals make a voluntary and informed decision, and that the Family Division of the High Court approves the assisted death, these individuals should be allowed to exercise their right to self-determination under Article 8 and request access to an assisted death. At the same time, however, under Article 2, Parliament, by means of the medico-legal assisted dying framework suggested in this thesis, must safeguard the lives of those individuals who do not want to die, but may be unduly influenced in seeking an assisted death. The additional safeguard proposed will also give a ‘psychological advantage’ to healthcare professionals as responsibility will be shared with judges, and may encourage
healthcare professional associations to adopt a more positive attitude towards assisted dying.

Scope for future work

A number of themes arise from the work done for this thesis that remained unexplored, or only briefly touched upon in this project. This is because these themes either fell outside the scope of the thesis, or because there were not enough resources to explore them. It is my intention that these themes and related questions are fully explored in future work using the findings of the thesis as a basis.

Other than the work that should be done on assisted dying and the judicial involvement or judicial oversight of the procedure already discussed, I consider that it is important to assess whether, and if so, under which conditions, individuals below the age of 18 may access an assisted death. The CAD suggested that only individuals over the age of 18 should have the option.¹ This was justified first, on the basis of the Director of Public Prosecutions’ (‘DPP’) Policy for Prosecutors in respect of cases of encouraging or assisting suicide. The Policy specifies that if the victim was under the age of 18, public prosecutors should consider this as a factor in favour of prosecution.² Moreover, the CAD relied on several pieces of evidence submitted by individuals³ and

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¹ CAD’s Report, pp. 21, 26, 301, 337.
organisations⁴ that support that assisted dying should be made available to adults only. However, this thesis argued that if an individual has mental capacity and makes a voluntary and informed decision, then the individual should be allowed to exercise his/her right to self-determination in choosing the manner and timing of his/her death. In some cases, these two conditions may also be satisfied by individuals below the age of 18. Indeed, other pieces of evidence submitted to the CAD noted that individuals below the age of 18, under certain conditions, should be able to request an assisted death. For instance, Zoe Clements, a palliative care nurse, argued that young individuals should be able to make such decision when they reach the age of 16 because they already decide to refuse some types of treatments.⁵ Furthermore, Demos’ research on behalf of the CAD that involved young individuals found that most participants were reluctant to set limitations on a minimum age of eligibility for assisted dying.⁶ It is thus evident that there is scope for research on this aspect of the debate which seems to be as polarised as the legalisation debate itself. It may involve, among other things, a need to research how mental capacity and voluntariness will be assessed in case of minors, and whether any additional safeguards will be needed. The experience and legal rules in other jurisdictions that permit assisted suicide or


⁵ Summary of Interview with Zoe Clements, NHS Nurse <http://www.commissiononassisteddying.co.uk/wp-content/uploads/2011/11/Evidence-from-Zoe-Clements.pdf> accessed 23 September 2017, p. 4. However, note that not all refusals of treatment by minors are respected. See, for example, Re E (A Minor) (Wardship: Medical Treatment) [1993] 1 FLR 386 (Fam).

euthanasia for minors, especially the Netherlands\(^7\) and Belgium\(^8\) can be useful in any future attempt to design an assisted dying framework that will accommodate the competent and voluntary decisions of minors.\(^9\)

Another theme that can be explored in future work is the blurry distinction between assisted suicide and voluntary euthanasia. As clarified in the Introduction of this thesis, assisted suicide describes the situation where an individual is provided with the means to end his/her own life, whereas voluntary euthanasia is euthanasia that is the result of the individual’s request, but involves the third party taking an active role in bringing about the death of the individual. A strict application or reading of the assisted suicide

\(^7\) The Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002. A minor aged 12-16 requires parental or guardianship consent. In the case of a minor aged 16-17, the parents or guardians must be included in the decision-making procedure, but their consent is not necessary. In general, the physician may accept the request of patients over the age of 12 provided they are ‘considered capable of a reasonable understanding of their interests’. See further: the Government of the Netherlands, ‘Euthanasia, Assisted Suicide and Non-Resuscitation on Request’ <https://www.government.nl/topics/euthanasia/contents/euthanasia-assisted-suicide-and-non-resuscitation-on-request> accessed 23 September 2017.

\(^8\) Section 3(1) of the Belgian Law on Euthanasia 2002. The individual must be an emancipated minor. ‘Emancipated minors’ are those over the age of 15 who have been legally emancipated by judicial decision. However, note that on the 13th of February 2014, the lower Belgian House of Parliament approved an amendment to the 2002 Act that allows a child in a medically hopeless situation of constant and unbearable suffering, that cannot be eased and which will cause death in short term, access to the 2002 law. The child must have a capacity of discernment and be conscious at the moment of request. The parents must agree with the decision and psychiatric and medical advice is required. See further: Charlotte McDonald-Gibson, ‘Belgium Extends Euthanasia Law to Kids’ Time (13 February 2014) <http://time.com/7565/belgium-euthanasia-law-children-assisted-suicide/> accessed 23 September 2017.

\(^9\) For instance, the Canadian Bill C-14 provides that the Minister of Justice and the Minister of Health, no later than 180 days after the Act receives royal assent, initiates an independent review on whether mature minors may request medically-assisted dying, advance requests, or requests where mental illness is the sole underlying medical condition. The Canadian Bill C-14 is available at <http://laws-lois.justice.gc.ca/PDF/2016_3.pdf> accessed 27 September 2017.
definition would mean that individuals who are physically unable to end their own lives would be excluded from assisted dying. However, in practice, healthcare professionals may take the necessary steps to assist the individual, if unable to bring about his/her own death, but without being actively involved. This is, however, a blurry line and one which does not make much of a difference for the individual. The distinction between voluntary euthanasia and assisted suicide is further complicated by the use of machines, such as the one that Mr Nicklinson was prepared to use to bring about his death, which would allow individuals with physical impairments to die without the involvement of a third party.

A further theme that can be explored in future work is the rationale behind the two types of eligibility criteria relating to the physical or mental condition of the individual requesting assisted dying. Though this thesis has rejected the suitability of both types of eligibility criteria on the basis of the right to self-determination under Article 8, there are interesting questions that need to be explored on the reasons of the different approach adopted in the US and in Europe. These reasons may be political or cultural, or they may be related to the attitudes and culture of healthcare professionals involved with assisted dying. It is interesting to go back in time before the enactment of the assisted suicide or euthanasia laws in the US and in the Benelux countries to explore why the law limits this option to those terminally ill, or to those who are unbearably suffering.

**Final remarks**

This thesis hopes to contribute to the vast work that is, and will be, needed for the legalisation of assisted dying in England and Wales. Its conclusion and findings may also influence other jurisdictions that may decide to legalise a form of assisted dying in

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the future outside England and Wales. This thesis hopes to be of interest and of relevance to all those who will be involved in the assisted dying procedure in the future, the individuals themselves, the healthcare professionals, the judges, but also to those who have a direct and indirect interest in the legalisation debate per se, the politicians, members of the clergy, campaign groups and activists, and anyone else who has an interest in assisted dying. This thesis argues that the right to control the manner and timing of one’s death is ‘the last human right’¹¹ that individuals should be allowed access to if they have decision-making capacity, and act voluntarily. Legalisation is a matter of when, not whether in England and Wales, and this thesis has taken a step forward by attempting to give an answer to the how.

¹¹ The phrase is used by Ludwig Minelli, Dignitas’ founder. See, for example, Imogen Foulkes, ‘Dignitas Boss: Healthy should have Right to Die’ BBC News (2 July 2010) <www.bbc.co.uk/news/10481309> accessed 28 September 2017.
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