Ending One's Own Life: Unjustifiable Injustice

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UNJUSTIFIABLE INJUSTICE

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To the woman who has never ceased to provide her guidance, support and love. Thank you for believing in me, Mum.

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1.
INTRODUCTION

Despite significant advancements in modern medicine, death remains our inevitable destiny; be it by accident, disease, illness or old age. Owing to the universal applicability of mortality, death is a particularly delicate and emotionally evocative issue, and thus, there are numerous viewpoints on the value of life and the principles which should govern its cessation. Moreover, significant medical advancements now enable individuals to live longer with a variety of illnesses and diseases, and consequently, the controversy pertaining to end of life has further intensified, being thrust to the forefront of social debate. As a result of the increasing prominence surrounding the end of life debate, the law developed to govern its regulation has become subject to ever-intensifying scrutiny. At the core of this controversy is the s.2 Suicide Act 1961, which served to decriminalise the practice of taking one's own life. However, what makes the Act contentious is that it is extremely unusual for a practice to be lawful, where assisting in that practice is unlawful; yet assisted suicide remains a crime. Any person who intentionally "encourage[s] or assist[s] the suicide or attempted suicide of another person" faces a sentence of up to fourteen years imprisonment.[1] Moreover, the Suicide Act is simply the central piece of legislation in a web of interrelated controversies surrounding end of life decisions. As the nature of death has become more complex, and the situations in which it arises have become more varied, the law has developed to draw a line between what is permissible and what is impermissible. The central purpose of this thesis is to ascertain whether the current legal system is justified in the positioning of this line.

1.1 Aims

The first aim of this thesis is to analyse the current law regarding end of life decisions and to address the distinctions it makes between permissible end of life choices and impermissible end of life choices. Let us consider a hypothetical example in order to frame the key issues:

[1] *Ibid* at s.2(1) and 2(4).

Imagine Alice, your eldest sister, is involved in a horrific car accident where her husband and three children tragically pass away. After the funeral, Alice discovers that her husband had acquired over two hundred thousand pounds worth of debt, all of which passes into her hands. Alice truly believes that her life has lost all sense of purpose and no longer wishes to continue living. One evening, Alice takes a lethal dose of paracetamol and ends her life.

Beatrice was driving the car which collided with that of Alice and her family. Although Beatrice survives, she is left severely paralysed retaining only the movement of her eyelids and in need of artificial ventilation. Prior to the collision, Beatrice was set to compete in the 2012 Olympic Games as a professional gymnast. Her life revolved around actively participating in sporting events and travelling the world as a spectator. Consequently, Beatrice feels that her life had lost all value and wishes to commit suicide. Unlike Alice, she is unable to do so unaided. Nevertheless, Beatrice *is* able to refuse any further medical treatment, and thus, the ventilation is removed and she passes away.

In that same hospital, Candice had spent the past twelve months receiving treatment for bone cancer. However, the cancer persists through continual chemotherapy and radiation sessions, and thus, the doctors eventually classify Candice's situation as terminal. Over the past year her family had watched her condition deteriorate and the pain she was suffering intensify. Candice makes the decision that she no longer wishes to cope with the constant physical agony and that she does not want her family to have to watch her deteriorate any further. Unlike Alice, Candice is too weak to end her own life and, unlike Beatrice, Candice is not receiving any life-sustaining treatment. Instead, after loving goodbyes, Candice requests that the doctor administer a dose of palliative drugs strong enough to ease her pain, a dose which she is aware is likely to result in her peaceful death.

Now imagine that you have been suffering from Motor Neurone disease,[2] a progressive neurodegenerative condition which leads to wasting of muscles, for over ten years. Your condition has deteriorated to the extent that you are wheelchair bound, paralysed from the neck down and struggle to communicate on the most basic level. You know that it is only a matter of months before your diaphragm is damaged and

[2] Note that I have chosen this condition as one which often causes mainly mental anguish as opposed to physical pain, and one in which the sufferer is rendered paralysed. Although I have chosen a physical illness, I could have equally chosen a mental illness which has caused the same desire to end life.

you suffocate to death. However, you would prefer to die peacefully and at your time of choosing, surrounded by your closest family members. After suffering at the hands of such a terrible illness, which effectively takes control of your entire life, you wish to make the final decision, something you believe will provide you with a dignified ending. Unlike Alice, Beatrice and Candice, your ability to choose the time and manner of your own death is severely constrained by the law. You are unable to take your own life without assistance, have no life-sustaining treatment to refuse and do not require palliative drugs. What is more, s.2 of the Suicide Act 1961 makes it a criminal offence for anyone to assist in your suicide. Simply because of your physical and medical situation, your ability to exercise choice over your parting moments is curtailed: Is this fair? This thesis seeks to answer such a question in the negative. The law allows particular categories of people to make decisions regarding the manner and timing of their death, but prohibits others, creating severe inequality.

The second aim of this thesis is to address the question of whether this unfairness can be justified by some broader reasoning: can the distinctions employed by the law be defended with reference to any moral or legal standard? The initial category of justification that will be discussed is that which appeals to the inherent dignity or sanctity of human life. Such positions hold that all innocent human life is sacred, or inherently valuable, and thus, should never intentionally be taken.[3] It will be argued that such claims are not compatible with the current law and that the distinctions employed by this viewpoint cannot withstand any deep analysis.

The second category of justification which can be invoked in defence of the current legal position is that which appeals to the rights of others. In 2002 the European Court of Human Rights (hereafter ECtHR) accepted that Art.8 of the European Convention on Human Rights (hereafter ECHR), the right to private and family life, includes the right to choose the manner and timing of one's death.[4] However, the Court ruled that the Suicide Act's imposition of a blanket prohibition on assisted suicide was justifiable under Art.8(2), for the protection of the rights and freedoms of others. The Court explained that the justification for the Suicide Act 1961 is that it "was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to take informed decisions against acts

[3] For example, see Keown (2002a) at 39-51.
[4] *Pretty v UK* (No. 2346/02) (2002) 35 E.H.R.R. 1.

intended to end life or to assist in ending life".[5] The fear is that a system which permits assisted death would be open to abuse and would pressurise the vulnerable, elderly or sick to request an early death. This thesis will critique such claims on two grounds. Most simply, the suggestion that the legalisation of assisted suicide would lead to such outcomes has not been proven. There is a lack of evidence, both empirically and logically, that must be established if this justification is to hold any weight. Secondly, it must also be demonstrated that the predicted negative outcome of legalisation would be worse than the current injustice created by the law. Finally, the law governing other end of life situations, such as the removal of life-sustaining medical treatment or the administration of a fatal dose of palliative care, is inconsistent with this defence.

1.2 Structure

The thesis is structured in two parts to reflect the two aims. Part One comprises of Chapters Two to Four and will address the distinctions made by the law at end of life, assessing whether their effects can rightly be classified as 'fair'. Chapter Two focuses on the distinction made between those receiving life-sustaining medical treatment and those who are not. Chapter Three addresses the distinction made between those people who require palliative care and those who do not. Chapter Four makes an analysis of the distinction the law makes between those who are able-bodied and those who are disabled. Through exploiting the justificatory weaknesses of such dichotomies, and illustrating how seemingly irrelevant criteria can affect one's ability to choose to die, I seek to reveal the unfairness of the current law.

Part Two comprises Chapters Five to Six and seeks to demonstrate that the unfairness unveiled in Part One cannot be justified by reference to some wider theory or doctrine. Chapter Five will address claims to 'the rights of the self'; the idea that particular choices should be constrained to protect the self. This chapter deals mainly with the broader argument regarding human dignity, and the more specific doctrine, the sanctity of life. Chapter Six is an analysis of appeals to 'the rights of others'; the suggestion that particular actions should be prohibited to protect others in society. This section focuses mainly on slippery slope arguments and how they shape the end of life debate.

[5] *Pretty v UK* (No. 2346/02) (2002) 35 E.H.R.R. 1 at [74].

Finally, I seek to conclude that the law *is* unjustifiably unfair, and thus, is in urgent need of reform. While the thesis does not, at any great length, attempt to suggest a comprehensive way forward, possibilities are touched upon throughout, and Chapter Seven draws conclusions from these findings. It is suggested that while legislative change is unlikely given the continual rejection of such Bills in Parliament,[6] there is a possibility which has yet to be fully explored. The thesis reveals that the debate is currently centred on 'others in society' who are seen as vulnerable to harm if assisted suicide were legalised. This is often at the expense of those vulnerable individuals who are actually suffering severe harm as they are prohibited from exercising choice over their final moments. Article 3 of the ECHR and its potential to help reconfigure the end of life debate are discussed. Those denied access to assistance in ending life are forced to suffer and inhumane and degrading life, and the possibility of this article providing an alternative angle from which to seek legalisation of assisted suicide, concludes this thesis.

[6] For example, the Assisted Dying for the Terminally Ill Bill 2005 which was rejected 191 votes to 141. More recently Lord Falconer attempted to persuade Parliament to amend the Coroners and Justice Bill 2009 to effectively legalise accompanying a loved one to travel abroad to die. The Falconer Amendment was also rejected by 194 voted to 141; see HL Deb 7 July 2009 vol 712 cols 595-634.

PART ONE

THE CURRENT LEGAL POSITION

2.
ARBITRARY DISTINCTION ONE: LIFE-SUSTAINING TREATMENT vs. NO LIFE-SUSTAINING TREATMENT

2.1 Introduction

Let us recall the hypothetical story mapped out in the introduction to this thesis, and in particular, Beatrice. Beatrice was the Olympic gymnast involved in a horrific car accident, rendering her severely paralysed and in need of artificial ventilation. After making the decision to end her life, Beatrice was able to refuse the life-sustaining medical treatment she was receiving – the artificial ventilation – which was duly removed, resulting in her death. You, however, a sufferer of Motor Neurone disease, paralysed from the neck down with only months to live, cannot make that same choice. You have no life-sustaining treatment to refuse and no on can legally assist you. How is it fair that Beatrice can legally choose to end her suffering, but you, simply because of circumstance, must suffer until the very end against your will? This chapter seeks to explore the justifications given as to why those in Beatrice's situation *can* make the choice to end their life, but others cannot. Can such reasoning withstand critical analysis? If not, we face an extremely unfair legal position which permits certain categories of people to make the choice to end life, but arbitrarily prohibits others.

The legal position stipulates that any competent person may lawfully refuse medical treatment, even where such treatment is necessary to sustain life.[7] The result is that individuals receiving such vital medical care may essentially obtain assistance in ending their own life. In the case of Ms B, she felt her life was no longer worth living and consequently requested the artificial ventilation keeping her alive be removed.[8] The Court held that the doctors were legally obliged to comply with her wish.[9] However, assisting in the suicide of another is a criminal offence under s.2

[7] *Re T* [1993] Fam. 95.
[8] *Re B (Adult: Refusal of Medical treatment)* [2002] EWHC 429.
[9] *Ibid.*

Suicide Act 1961, and more seriously, intentionally taking the life of an innocent human being amounts to murder. Why, then, is a doctor *legally required* to comply with a competent patient's refusal of treatment, even where this will lead to the inevitable death of that patient? Is it fair that a patient who requires life-sustaining medical treatment may choose to receive assistance when they choose to die, whereas others are legally prohibited to obtain the very same aid? This section explores such questions through an analysis of the current law and an assessment of whether such a distinction can be conceptually or morally defended.

2.2 The Legal Position

It is now a well-established principle of medical law that every competent patient has the right to refuse medical treatment even where death will inevitably result.[10] Furthermore, a medical professional is legally required to comply with such a refusal, as any treatment contrary to the wishes of the patient will be "an assault, a civil trespass to the person and a crime".[11] In *Airedale NHS Trust v Bland,* Lord Goff reiterated the importance of autonomy at the end of life, and stated that where a patient refuses life-sustaining treatment, "the principle of sanctity of human life must yield to the principle of self-determination".[12] Anthony Bland was a victim of the terrible sporting disaster at Hillsborough in 1989. In the accident, his ribs and lungs were crushed, severely restricting oxygen to his brain and causing irreversible damage. As a result, Bland was left in a persistent vegetative state (PVS), meaning that although he was unconscious with no cortical activity, his brain-stem was functioning and he could breathe unaided. Given the futility of Bland's situation, the Trust applied for a court declaration to ascertain whether it would be lawful to remove artificial nutrition and hydration (ANH), administered through a nasogastric tube, which would result in his death. The Lords held that the removal of the tube would be lawful.

Additional evidence that the legal position is one grounded in the importance of end of life decision-making, is that the right to refuse medical treatment is almost absolute, with only limited exceptions made by mental health legislation and by the common law for public policy reasons (such as s.63 of the amended Mental Health Act 1983). For example, again in the case of *Airedale NHS Trust v Bland*, the Lords

[10] *Re T* [1993] Fam. 95.
[11] *Ibid* at 100 per Ward J.
[12] [1993] A.C. 789 at 865 per Lord Goff.

implied that a patient cannot refuse basic care such as warmth and hygiene.[13] The purpose of this minimal exception is to protect the autonomous interests of others. For example, the interests of other patients on the ward, the care staff, nurses, doctors and family members who have to interact with the patient regularly. Hence, Grubb has commented that the "interests of third parties such as nurses…outweigh his interests in this singular situation".[14]

Furthermore, the courts have chosen to interpret the exception extremely narrowly, reiterating the importance of autonomous choice at the end of life. In *Bland*, the issue arose as to whether the administration of artificial nutrition and hydration (ANH) through a nasogastric tube could be lawfully removed. If ANH constituted basic care, it could not lawfully be removed. However, the Lords in this case compared tube-feeding to the use of an artificial ventilator, holding that ANH was in fact medical treatment and could lawfully be removed.[15]

Although this case concerned an incompetent patient, the decision was accepted in *Ms B,* indicating that ANH is outside the scope of the exception for competent patients also. In the case of *Ms B*, the applicant had suffered a ruptured blood vessel rendering her paralysed from the neck down and unable to breathe without the assistance of an artificial ventilator.[16] With no hope of recovery, Ms B repeatedly requested the ventilation be removed. However, the medical professionals and care team, who had grown close to their patient, chose to ignore this wish. Consequently, Ms B applied for a court declaration regarding the lawfulness of the continued ventilation. The Court recognised the inherent tension between beneficence and autonomy in this case, i.e. the difficulties caused by the societal aim to keep people alive and issues this can raise when individuals make the choice to end life. However, the Court reiterated the principle that "the right of the competent patient to request cessation of treatment must prevail over the natural desire of the medical profession to try to keep her alive".[17] Butler-Sloss P. granted the declaration and held that the Trust had acted unlawfully in continuing to ventilate Ms B.

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[13] This is implied through the Lords' lengthy discussion of whether artificial nutrition and hydration can properly be categorised as 'medical treatment'. It was suggested that if ANH could only be considered basic care, then withdrawal would not be permitted. See [1993] A.C. 789 at 819 per Butler-Sloss LJ.
[14] Grubb 2004 at 141.
[15] *Airedale NHS Trust v Bland* [1993] A.C. 789 at 870 per Lord Goff.
[16] *Re B* [2002] EWHC 429.
[17] *Ibid* at 27 per Butler-Sloss P.

The picture this paints of the current legal approach to medical treatment and end of life is one which recognises the importance of patient choice, further evidenced by the Court in *Re T*:

> The patient's interest consists of his right to self-determination - his right to live his own life how he wishes, even if it will damage his health or lead to his premature death.[18]

In sum, the law in this area evidences a strong desire to protect patient decisions regarding end of life. Although there are exceptions to this right of choice (a patient cannot refuse basic care) they are extremely narrow, applying only to care such as hygiene, pain relief and warmth. Moreover, when the Lords were faced with the opportunity to include tube feeding as basic care, they instead allowed this to move into the realm of what a person can lawfully refuse, further indicating the significance of autonomy at the end of life. The legal approach to contemporaneous refusals of life-sustaining medical treatment reinforces the message that recognition of an individual's right to choose death is paramount.

2.3 Murder?

However, the law in this area is not as straightforward as it first appears. When a doctor switches off a ventilator pursuant to a patient's wish, knowing and perhaps intending such action will result in death, why is he not classified as a murderer? The actus reus of murder is an act (or omission amounting to a breach of duty), which results in the death of another and the mens rea is malice aforethought, intent to kill or cause serious bodily harm. Given that consent is not a defence to murder, how is it that the adherence to patient refusals is lawfully required and not considered a crime?

The controversial answer to this question can be located in the judgments given in *Bland*.[19] Although this case concerns an incompetent patient, it not only illustrates why a doctor can lawfully remove treatment from those who are incompetent, but also, why he may lawfully comply with a competent patient's refusal of life-prolonging medical treatment.

[18] *Re T* [1993] Fam. 95 at 100 per Ward J.
[19] *Ibid.*

In arriving at the decision that the removal of the tube providing the patient with artificial nutrition and hydration would be lawful, the Lords recognised that the medical professionals in this case *did* have the intent to end the life of the patient:

> As to the element of intention or mens rea, in my judgment there can be no real doubt that it is present in this case: the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland.[20]

It is therefore clear that the mens rea of murder was satisfied in this case. A charge of murder did not arise, however, because the Lords held that the actus reus of the offence is lacking in a case of withholding or withdrawing treatment where there is no duty to act. The removal of the tube was held to be an omission and, as there was no longer a duty on behalf of the Trust to continue to treat Bland, this omission could not constitute the actus reus. Similarly, in cases where the patient is competent, there is no longer a duty to treat when the patient makes a refusal. Consequently, the withholding or withdrawing of life-prolonging treatment in these cases and in that of *Bland*, are considered lawful.

The judgment in *Bland* proved to be extremely controversial and a point of extensive academic discussion.[21] The distinction made between the legality of an act and an omission has been particularly contentious, both conceptually and morally. It is significant that the Lords themselves recognised the issues with their reasoning, Lord Mustill concluded that the decision would leave the law "morally and intellectually misshapen".[22] Lord Browne-Wilkinson also adopted the distinction with unease:

> How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food, but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question. But it is undoubtedly the law…[23]

[20] *Ibid* at 882 per Lord Browne-Wilkinson.
[21] For example, Finnis 1993; McLachlan 2008.
[22] *Airedale NHS Trust v Bland* [1993] A.C. 789 at 888.
[23] *Ibid* at 886.

This section will seek to assess the controversy surrounding the decision in *Bland* by questioning whether firstly, the Court correctly conceptualised a withdrawal as an omission, and secondly, whether the distinction the Court made between acts and omissions has any moral relevance.

2.4 Conceptually Valid?

The first issue raised by the distinction made between acts and omissions in *Bland,* is whether withdrawal of treatment is rightly classified as an omission. While most would agree that withholding treatment from a patient initially, for example, failing to perform a heart operation, is rightly categorised as an omission, withdrawal of treatment already being administered is much more contentious. Many commentators have contended that withdrawing treatment, such as turning off a ventilator or removing a nasogastric tube, is in fact a state of action rather than inaction.[24] In assessing this claim, the starting point must be the definition of an act itself and there are many descriptions provided in the literature: "something done or performed",[25] a "willed-muscular contraction"[26] or "affirmative conduct".[27] Although differing, all these suggestions indicate that physical movement is required. On this literal application, withdrawal of life-prolonging medical treatment is in fact an act, and any suggestion that it is an omission "does some considerable damage to the ordinary English usage".[28]

However, as Harris notes, creating a strict boundary between what is an act and what is an omission is extremely problematic. He suggests that it is possible to reconceptualise anything as either an act or omission. He uses the illustration, "I can for example shoot you or fail not to shoot you".[29] In the same way, withdrawal of the feeding tube from Bland in this case could be seen as omitting to continue to administer ANH or acting to cessate such treatment. However, it is clear that withdrawal of treatment is in fact a physical intervention and as Pattinson notes, "the situation is simply not one of inaction".[30]

[24] For a small sample of the debate see Elliot and Omerod 2008; McGee 2005; Williams 2008.
[25] *Collins English Dictionary and Thesaurus* 2000 at 13.
[26] Moore 1993 at 78.
[27] Cantor 1987 at 32.
[28] Kennedy 1991 at 351.
[29] Harris 1985 at 29.
[30] Pattinson 2009 at 557.

Further evidence that the withdrawal of treatment is wrongly classified as an omission stems from the Lords in *Bland* who acknowledge that the same conduct by an interloper (rather than the doctor in charge) would constitute an act. Lord Goff explains that,

> whereas the doctor, in discontinuing life support, is simply allowing his patient to die of his pre-existing condition, the interloper is actively intervening to stop the doctor from prolonging the patient's life, and such conduct cannot possibly be categorised as an omission.[31]

Elliot and Omerod contend that to regard the same conduct as a lawful omission if committed by a medical practitioner and a murderous act if committed by another individual, "is surely untenable".[32] They rightly assert that withdrawals are in fact acts, regardless of who undertakes them.

A final point of discussion cements the assertion that withdrawals were wrongly categorised in *Bland*. In the case of *Ms B* the medical professionals who had refused to remove the ventilator at their patient's request were not forced to remove her treatment – they could conscientiously object to doing so.[33] Consequently, Ms B was transferred to a different hospital where the treatment was removed and she passed away. The question raised is this: if withdrawing the ventilation is an omission to act, how could the medical professionals object to failing to treat Ms B? The reality is that the doctors could not bring themselves to *act* to effectuate the end of Ms B's life, someone they had become extremely close to during the course of her treatment at the hospital. As Butler-Sloss P. noted, the clinicians could not "bring themselves to contemplate that they should be part of bringing Ms B's life to an end by the dramatic step of turning off the ventilator".[34] It is clear that medical professionals view withdrawal of treatment as an act, rather than an omission.

It is evident on this analysis that the Court in *Bland* used the act/omission distinction to classify the withholding or withdrawing of life-prolonging medical treatment as lawful. It is apparent that the withdrawal of treatment was wrongly held to be an omission, when in fact it involves a physical action. The question remains,

[31] *Airedale NHS Trust v Bland* [1993] A.C. 789 at 867.
[32] Elliot and Omerod 2008 at 44.
[33] *Re B* [2002] EWHC 429.
[34] *Ibid* at [58] per Butler-Sloss P.

however (as it is accepted that the *withholding* of treatment is an omission) is there a morally relevant distinction between an act which brings about a patient's death and an omission which does the very same?

2.5 Morally Valid?

When applying the distinction between acts and omissions to the case of *Bland*, even the Lords themselves struggled to find a moral grounding. To reiterate the words of Lord Browne-Wilkinson:

> How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food, but unlawful to produce his immediate death by a lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question.[35]

The example given in this extract is particularly compelling given that both situations produce the same result – death. Surely the quick, pain-free option is morally preferable to allowing the patient to slowly starve, yet this is completely antithetical to the current legal situation we face. Nevertheless, some academics revere the act/omission distinction as one which is built on sturdy moral foundations.

The most common argument in defence of the distinction is that an act is an interference with the normal course of nature, whereas an omission merely allows nature to take its course.[36] McGee, a proponent of the argument from nature, explains the moral difference:

> What is proposed in euthanasia is that we wrest from nature control of our ultimate fate: we decide when and how we should die, and we ensure thereby that we have the last word. In lawful withdrawal, by contrast, the very opposite is the case: we interfere with nature, not in killing the patient but *in keeping the patient alive*, and the question of whether or not we should withdraw treatment is at the bottom of the question of whether we should restore to nature her dominion, allowing nature finally to take its course, with the patient dying a natural death.[37]

[35] *Airedale NHS Trust v Bland* [1993] A.C. 789 at 886.
[36] See Kass and Lund 1996; McGee 2005.
[37] McGee 2005 at 383.

In application, let us imagine Jane, who is suffering from cancer. The disease has spread through the entirety of her body and is causing her agonising pain, leaving her unable to sleep, eat (without the assistance of a nasogastric tube), or enjoy the smallest activity. On McGee's analysis, administering a lethal injection to Jane, on her request, would be an interference with nature and morally wrong. If, on the other hand, doctors removed the nasogastric tube being used to administer ANH to Jane on her request and she slowly died of starvation and dehydration, this would be morally acceptable as the doctors were allowing nature to take its course. Of course such an analysis appears absurd, because although McGee suggests that 'interfering with nature' is morally undesirable, he fails to explain *why*, quite possibly because any attempt to do so would be virtually impossible. If this were the case, keeping Jane alive with ANH to begin with would be immoral, treating an infection with antibiotics would be immoral, flood defences in place to prevent a natural disaster would be immoral and sending aid packages to countries suffering from drought would be immoral. The reality, as highlighted by Harris, is that,

> There is undoubtedly a widespread, but equally undoubtedly irrational respect for what is natural or part of the course of nature. Famines, floods droughts and storms are all natural and all disastrous. We only, and rightly, want the natural when it is good for us. What is natural is morally inert and progress-dependent. It was only natural for people to die of infected wounds before antibiotics were available.…[38]

There is a second criticism of the argument from nature. McGee explains that what distinguishes euthanasia from withdrawal of treatment is that in the former we "wrest from nature control of our fate" and "have the last word".[39] However, in requesting the removal of a tube which she knows is sustaining her life, surely Jane is doing exactly that – taking control and deciding the time of her death. It is a fallacy to say that it was 'nature' which ended her life, when Jane could potentially live for months, possibly years longer *with* the medical treatment. In reality, it was Jane's decision to request the intervention that ended her life, *she* had "the last word".

[38] Harris 1985 at 38.
[39] McGee 2005 at 383.

Kass and Lund suggest that this analysis is incorrect and that it *is* nature which ends life in these cases, evidenced by the fact that patients who request withdrawals do not always die as a result.[40] They use the case of Karen Ann Quinlan who continued to live for ten years after the removal of her respirator, in claiming "the right to discontinue treatment cannot be part of some larger right to 'determine the time and manner of one's own death'".[41] However, this argument is unconvincing. This occurrence is extremely rare and in almost all cases, such as removal of ANH or ventilation, the patient believes that their life will end as a result. What is more, whether or not Quinlan's case is extremely rare, the possibility that a suicide attempt will fail exists even where the attempt is unequivocally an act. For example, when an able-bodied person takes what they believe to be a lethal dose of paracetamol in order to end their life, the chance that such an attempt will fail exists and is higher, I would suggest, than the chance of failure where a request is made to remove an artificial ventilation system. In taking life without any medical assistance, individuals arguable face a greater risk of a 'botched suicide', hence why there exists a range of books, websites and leaflets which aim to help people commit suicide successfully.[42] Thus, the possibility of survival after a suicide attempt cannot, as Kass and Lund suggest, mark a moral difference between acts and omissions.

This leads us to a second explanation of the moral distinction between acts and omissions. Stauch claims that an omission is morally different to an act because it cannot have causative impact.[43] He suggests that, without a duty to act, an omission cannot be a crime because there is no "authorship" over the result, the individual cannot be said to be responsible for the outcome. The moral relevance of this distinction for end of life is that where a person acts to bring about the death of another, he assumes authorship of that death, and in turn, breaches the equality principle. According to this principle, "the life of each individual has an equal claim to a minimum respect possessing irreducible value", and thus, by actively ending the life of another, a person fails to show this respect for human life.[44] He uses the example from Brock's work of a patient dying from terminal cancer, who has

[40] Kass and Lund 1996 at 420.
[41] *Ibid* at 420.
[42] For example see James 2010 and Miller, Vandome and McBrewster 2011.
[43] Stauch 2000.
[44] *Ibid* at 240.

indicated his desire to have his life ended.[45] There are two outcomes, in the first the man's wife uses a pillow to suffocate him while he sleeps. In the second, the man develops breathing difficulties which require immediate medical attention, but the wife fails to alert the medical staff and her husband consequently dies. According to Stauch, the moral difference between the two outcomes is "simply that in the first instance, by assuming authorship over the man's death, she infringes the equality principle. In the second instance she does not".[46]

Unfortunately Stauch's analysis ends there. He fails to demonstrate *why* there can be no authorship in the second situation, simply claiming that the wife can have no causative impact on the death of her husband in failing to alert the doctor of his breathing difficulty. However, this suggestion is ridiculous. If the wife *had* sought medical assistance, her husband would have lived. Applying the most basic legal rules of causation, 'but for' the wife's omission, the man would be alive. It is absurd to suggest that an omission cannot have causative impact, simply because it is an omission. If, due to indolence, I omit to write a thesis before the given deadline and fail my degree, *I have caused my failure*. I am just as much a cause as if I had submitted a terrible piece that could not possibly have been successful. Stauch may well reply that I would have a causative impact in this case, because I had a duty to complete my work. However, the factual link between the omission and the end result remains valid, regardless of any duty on my part. To suggest otherwise manipulates the common understanding of 'cause' in order to frame an omission as morally preferable to an act which produces the exact same result.

The above analysis reveals that the act/omission distinction is not coterminous with moral responsibility. Simply because something is classified as "an act", does not make it more morally culpable than something classified as "an omission". It is a fact that every action *and* inaction has a consequence. If I choose to hit my boss, the consequence is likely to be the termination of my employment. If I choose to ignore my mother's phone calls, the consequence is likely to be damage to our relationship. Everything a person chooses to do or not to do has an impact on the world, however small. What is more, the consequences which arise from omissions can be just as vital and important as those that arise from acts. I gave the example of omitting to complete my thesis on time, Professor Harris gives the example of a doctor who fails

[45] Brock 1993 at 187-188.
[46] Stauch 2000 at 241.

to administer glucose to a patient in a hypoglycaemic coma, but the principle is the same: omissions have consequences and those who fail to do something can be responsible for those outcomes.[47]

Moreover, the *way* in which we make this impression is irrelevant, rather, it is the impression itself that is morally important. Again Harris maintains the same position. He terms acts as "positive responsibility" and omissions as "negative responsibility", and uses these to show that,

> if the occurrence of a particular event or state of affairs would be a disaster it makes no moral difference whether our responsibility for that disaster is positive or negative.[48]

So (using a particularly emotive example given by Rachels)[49] imagine you are in a room with a starving and skeletal child with a sandwich that you do not need and you omit to give the sandwich to the child, who subsequently dies; it is clear that you are just as morally culpable as a person who kills the child through an act. Although it is not a positive act, withholding the food would undoubtedly be classified as "morally monstrous".[50] This shows that an omission can be just as morally abhorrent as an act.

Taking Harris' example, children born with severe spina bifida face an extremely poor quality of life and as a result, many doctors offer selective treatment to the families of such babies.[51] Selective treatment is a programme of non-treatments which are intended to result in death. The doctors may choose from a range of non-treatment such as non-feeding, non-treatment of infection or non-ventilation if the baby develops breathing difficulties. Consequently, the family will be forced to watch the baby dying slowly over a number of weeks. The question is this: how is selective treatment of babies with spina bifida morally preferable to a quick and painless death? In this instance, surely the better course of action would be to end the life of the baby swiftly and avoid the agonising heartache of a drawn out death for family members. It is clear that in some cases, actions which bring about death can be morally preferable to omissions which have the very same outcome.

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[47] Harris 1985 at 32.
[48] *Ibid* at 30.
[49] Rachels 1979 at 160.
[50] Using the parlance from Rachels 1979 at 160.
[51] Harris 1985 at 33-45.

However, it is a common counter argument that whether something is an act or an omission does have an impact morally. It can be argued that in many instances, an omission is less morally culpable that an act, *because it is an omission*. This is because, in those cases where a person omits to do something, there would be costs or risks involved in acting. For example, imagine you push a person into an electric fence, resulting in their death. It is reasonable to assert that had the person already become entangled in the fence, and was being electrocuted, your omission to attempt to free them from the wires would be much less morally abhorrent than pushing them. The risk of you also becoming a victim of the fence would be too great and the cost of helping the person could be your life. In this instance, there is a moral difference between the two scenarios which exists *because the latter is an omission*. This establishes that there can be different moral considerations which are applicable to omissions and not to acts, these considerations being cost and risk.

However, it is suggested that such costs and risks were not relevant in the discussion surrounding *Bland*, and are not relevant to the debate regarding the withholding or withdrawing of life-sustaining medical treatment. In *Bland,* there would be no disproportionate physical risk to the doctor in acting to bring about the death of Tony Bland, as oppose to removing his feeding tube. Similarly, if assisted suicide were legalised, there would not be a disproportionate risk to the doctor in actively ending the life of a patient that would exist should they omit to treat in order to end life. In this situation, whether the doctor acts or omits to act is not morally relevant, as there are no different risks or costs to the doctor in each situation.

It has been established that the Lords were right to feel uneasy in applying the act/omission distinction in *Bland*, owing to both its conceptual uncertainty and the absence of any moral justification in this instance. Administering a lethal injection to Tony Bland would have resulted in the very same outcome as removing the feeding tube, and in fact, the former is the morally preferable route, as it would have been the quicker option, the latter involving a slow death through starvation.

It is suggested that the reason why the Lords in *Bland* adopted a distinction they could neither defend nor explain was to achieve a particular aim. Although the Lords were not directly dealing with the issue of suicide, in establishing this legal fiction through interpreting the doctor's conduct as an omission, they were able to effectively deem this form of assistance with ending life legal. Williams also acknowledges that "interpreting the doctor's conduct as an omission to treat is a

useful fiction used by the courts to absolve medical professionals from criminal liability".[52] The problem this judicial step has created is that, as it has been established that there is no moral difference between an act and an omission in this instance, logically there is no reason why helping a person to end their own life through a positive act should not be considered lawful. Indeed, the law has been left "morally and intellectually misshapen" by the judiciary's attempt to become more permissive regarding end of life conduct.[53] The imposition of an arbitrary distinction has created legal inconsistency: the law recognises the importance of the ability to refuse life-sustaining treatment, but in instances where such an individual does not have need of such treatment, the distinction between acts and omissions prohibits the very same exercise of choice it so valiantly defends.

2.6 Summary

Analysis of just one area of legal regulation has already unearthed inconsistencies. The law not only permits, but *requires* that a doctor act upon a patient's decision to refuse medical treatment which is keeping them alive, effectively compelling a doctor to assist in death.[54] However, where the situation is that a person no longer wishes to live, but is not being kept alive by medical treatment, a doctor is prohibited from assisting them directly. The difference? Removing life-sustaining treatment is classified as an omission and directly assisting in death is an act. Two people who desire the same outcome - assistance in death – are treated differently because of a distinction which I have established, in this situation, holds no moral or logical weight. Already the tensions in the legal approach to end of life are revealing themselves. It is useful to end this chapter with a hypothetical example in order to highlight the unfairness created by the law.

Tom is a long-distance lorry driver and has unfortunately been involved in a terrible motorway accident. As a result Tom has been left paralysed from the neck down and in need of round-the-clock care. While Tom remains intellectually unscathed and retains the ability to swallow food, he is unable to breathe unaided and has been attached to an artificial ventilation system. After three weeks of continual

[52] Williams 2008 at 94.
[53] *Airedale NHS Trust v Bland* [1993] A.C. 789 at 887 per Lord Mustill.
[54] Or to conscientiously object and transfer the patient to another doctor as was the case in *Re B (Adult: Refusal of Medical treatment)* [2002] EWHC 429.

care at the hospital, Tom expresses that he no longer wishes to live. With little close family, driving is Tom's passion, and thus, he feels that facing a life without such pleasure would be worthless. Consequently, Tom requests that in three days time, after he has had chance to say goodbye to the family he does have, doctors detach the ventilation system keeping him alive. The doctors agree, as they are legally bound to comply with such a refusal. Tom's decision to die is legally respected. However, in an unusual turn of events, on the second day before the treatment was due to be removed, Tom regains the ability to breathe unassisted and no longer requires the ventilator. Tom still wishes to end his life and he asks the doctor of his options. He is informed that there is nothing now that the doctor can do to help him. Placing a lethal pill on his tongue would amount to an offence under s.2 Suicide Act 1961 and directly taking Tom's life would render the doctor liable for murder. Tom's decision to die is no longer protected, a mere medical technicality standing between him and respect for his autonomy. Is it fair that the need for artificial ventilation be the deciding factor in whether Tom can lawfully end his life?

3.
ARBITRARY DISTINCTION TWO:
PALLIATIVE CARE vs NO PALLIATIVE CARE

3.1 Introduction

If we recall the hypothetical story from the introduction to this thesis, we will remember Candice. Candice suffered from terminal bone cancer and eventually made the decision to end her life. Consequently, she requested that her doctor administer a lethal dose of a palliative drug, which resulted in her death. You were asked to imagine that you are a sufferer of Motor Neurone disease. As you are paralysed from the neck down with only months to live, you wish to end your life but cannot make that same choice. Your pain is mental, rather than physical, and thus, you do not require palliative care. How is it fair that Candice can legally choose to end her suffering, but you, simply because of circumstance, must suffer until the very end against your will? This chapter seeks to explore the justifications given as to why those in Candice's situation *can* make the choice to end their life, but others may not. Can such reasoning withstand critical analysis? If not, we face an extremely unfair legal position which permits certain categories of people to make the choice to end life, but arbitrarily prohibits others.

It has been established in the preceding chapter that a doctor may lawfully remove life-sustaining medical treatment, but may not directly take the life of a patient, for example, through administration of a lethal dose of medication. This section engages in a deeper analysis of this prohibition and reveals that it is not as absolute as it may first appear. There are, in fact, some instances where a doctor may lawfully inject a patient with a fatal dose of drugs. So then, what is the distinction between the acceptable practices and the unacceptable, and moreover, is this differentiation justifiable or just another arbitrary legal imposition?

3.2 The Legal Position

Any person who intentionally takes the life of another innocent human being commits murder.[55] Consequently, if a doctor assists a patient who is unable to take their own life, by injecting them with a lethal substance, he has committed the crime of murder and potentially faces a mandatory life sentence. The injection constitutes the actus reus (an act which results in the death of another) and the doctor's intention to bring about the death, forms the mens rea (intention to kill or cause grievous bodily harm).

Despite how unambiguously the doctor's conduct falls under this offence, it is rare for a murder charge to actually arise. In the few instances where a charge *has been* brought, there is considerable judicial reluctance to punish a doctor who acts out of compassion. In *R v Cox* a doctor administered a lethal dose of potassium chloride to an elderly patient who had repeatedly begged him to end her life.[56] As the body had been cremated, it could not be assessed whether the chemical had been the cause of her death, and thus, the doctor was charged and convicted of attempted murder as opposed to murder. In this case, Dr Cox received a minimal twelve-month suspended prison sentence and was even allowed to continue practising, provided he work under supervision and attend additional training courses. The apparent judicial sympathy for the doctor in this case suggests that instances in which a doctor complies compassionately with a patient's request are distinct from those where a killer maliciously shoots his victim through the skull.

The question is then raised: how can a doctor's behaviour be justified where there is evident causation between his act and the death of the patient? In *R v Adams*, the doctor administered lethal doses of morphine and heroin to his elderly patient (of whose will he was a beneficiary).[57] Dr Adams was subsequently charged with her murder. However, the jury swiftly acquitted Dr Adams, having been directed in accordance with the controversial doctrine of double effect.[58] This principle explains that an act which has both a positive and a negative outcome may be permissible providing that the intention is to achieve the positive outcome and the negative is an unavoidable side effect. In *R v Adams*, the intended positive result was pain relief and

[55] Murder is a common law offence whereby an individual kills another innocent human being with intent to cause serious injury or death (originally termed 'malice aforethought').
[56] *R v Cox* (1992) 12 B.M.L.R. 38.
[57] *R v Adams* [1957] *Criminal Law Review* 365.
[58] *Ibid.*

the negative unavoidable side effect was the death of the elderly patient. Accordingly, Devlin J. justified the acquittal on the grounds that a medical professional may "do all that is proper and necessary to relieve pain and suffering, even if the measures taken may incidentally shorten human life".[59]

Thirty-five years later, the case of *Annie Lindsell* reaffirmed the lawfulness of the administration of life-shortening drugs for palliative care.[60] Ms Lindsell was a sufferer of the progressive neurological disease, Motor Neurone disease. She subsequently sought a court declaration to ensure that when she lost the ability to swallow, and could no longer face the terrible prospect of further deterioration, it would be lawful for her doctor to administer a lethal dose of diamorphine to ease her pain. The Court heard how "English law (and in particular, the English law of murder) undoubtedly recognises and gives effect to the doctrine of double effect" and, as the life shortening aspect of the drug was a mere side effect of the pain relief, the case was discontinued.[61] The judge stated that he "thoroughly approved and endorsed the discontinuance" of Ms Lindsell's case.[62]

The following case of Dr Moor further entrenched the doctrine of double effect into criminal law. Dr Moor was convicted of murder after administering a lethal dose of diamorphine to an elderly male cancer patient. However, in court, Hooper J spoke favourably of the accused, describing him as "a man of excellent character" who has "many admirable qualities", persuading the jury to reach a unanimous verdict of acquittal in less than one hour.[63]

3.3 Morally Valid?

The question is this: is the doctrine of double effect a morally justifiable distinction? Does the doctor who administers a fatal dose of potassium chloride with the intent of ending the patient's life, do something more morally abhorrent than the doctor who uses heroin to relieve pain in the knowledge that death will be a virtually certain result? Keown strongly asserts that there *is* a moral difference between these two courses of action, as the former doctor intends death and the latter intends palliative

[59] *R v Adams* [1957] *Criminal Law Review* 365 at 375.
[60] *Ann Lindsell v Simon Holmes* unreported, see Keown 2002 at 22-25.
[61] *Ibid.*
[62] *Ibid* at 24.
[63] Unreported, see Dyer 1999.

effects.[64] He uses the example of two dentists: Mr Fill and Mr Drill. A patient with a decaying tooth visits Mr Fill, who then drills a hole in the tooth and closes it with a filling. Another patient, with an identical ailment, visits Mr Drill who also drills a hole in the tooth and closes it with a filling. In both cases, Keown highlights, the dentists have repaired the decaying tooth, but the moral difference lies in the intention. Mr Fill's direct intent was to repair the tooth and the pain suffered was an unavoidable side effect of this. However, for the cruel Mr Drill, his primary intention was to cause pain, and the therapeutic benefits were a mere side effect. Keown explains "[c]learly, whereas Mr Fill has done nothing morally questionable, Mr Drill has. And the reason is solely to be found in Mr Drill's *intending* the bad consequence".[65]

The most obvious response to such an argument is that the outcome in both cases is identical. Both patients have their tooth repaired regardless of their dentist's intention. Harris agrees, claiming that where the consequences are identical, the distinction between a direct effect and a side effect is "without moral significance".[66] Harris reuses the example employed by the Linacre Centre of a potholer who is stuck underground with people trapped behind him.[67] In the cave the water is rising rapidly and the group will all drown unless one of two actions are taken: the potholer can be blown up, or a rock can be moved to create an escape route but this will consequently crush the potholer. The Linacre Centre hold that those people who would choose to move the rock rather than blow up the man do so because they are people who "will absolutely reject a policy making the death of innocent people a means or an end".[68] However, Harris describes this as an example of "the most comprehensive sophistry".[69] Actions are indefinitely expandable, and thus, to exclude all other consequences that are not the direct intention of the action is ridiculous. To Harris, what is relevant is not whether our actions are direct or indirect, but how they affect the world around us.

Keown may well respond that the consequences of actions are irrelevant if the means employed are immoral, but I suggest that his explanation of the moral

[64] Keown 2002 at 18-30.
[65] *Ibid at* 19.
[66] Harris 1985 at 44.
[67] The Linacre Centre for Healthcare Ethics is a Roman Catholic association that engages in the ethical and legal debates surrounding modern medicine.
[68] The Linacre Centre 1982 at 34-35.
[69] Harris 1985 at 44.

significance of double effect is flawed nonetheless. Keown's argument is based on an assumption which is neither discussed, nor rationally justified. Keown bases his discussion on the assertion that intending to kill another human being is *always* morally repugnant. If it is not (the view I wish to support) then surely it is irrelevant as to whether a patient's life is ended by direct or indirect means. The idea that the intentional death of another is always wrong is embedded in the sanctity of life principle (a position held by Keown himself analysed in depth in Chapter Five). The difficulty arises when this viewpoint can no longer be defended. Given the decline of established religion in the UK, there is substantially less support for the belief that human life is valuable in and of itself, and greater support for idea that it is the right to shape one's life which makes it so precious.[70] Moreover, given that in this medically advanced era people are living longer with a range of debilitating illnesses, more and more people are adopting the view that it is not *always* morally wrong to intervene to deliberately end a life prematurely.[71] In fact, 80% of people in the UK support a change in the current law prohibiting assisted dying, evidencing the growing ideology that intending the death of another is not always immoral.[72] Moreover, in recent years the UK has seen a number of bills and amendments before Parliament seeking to implement such a change and there has been a significant rise in the number of pressure and lobby groups who aim to stimulate the legalisation of assisted death.[73] Consequently, Keown's defence of the doctrine of double effect relies on the belief that life is valuable in itself as it is God-given or simply because it is human life.

The view that the doctrine of double effect lacks moral justification seems to be mirrored in the case of *R v Woollin* where it was held that knowledge of a virtually certain consequence could be used by a jury to infer intention.[74] The Court in this case appears to have conflated the notions of intention and foresight, indicating the lack of judicial belief in any moral distinction. The difficulty being, that both intention and

[70] See BBC News (2000) 'UK is 'losing' its Religion' available at http://news.bbc.co.uk/1/hi/uk/1043986.stm <Accessed 13/01/2012>.
[71] It must be noted that while public opinion of what is morally acceptable is influential in this debate, particularly regarding faith, the mere existence of that opinion is not persuasive without further justification explanation. The law should not, and does not, always mirror public opinion, as is the case with the death penalty for example. See Cafe, Rebecca (4 August 2011). "Does the public want the death penalty brought back?". *BBC News* (BBC) <accessed 7/08/2011>.
[72] See Dignity In Dying campaign. Their extensive website is located at http://www.dignityindying.org.uk/ <accessed 12/12/2010>.
[73] Again see Dignity in Dying and their ever-increasing member-base. However, it should be noted that the DPP nevertheless made the decision not to change the law in this area, evidenced by the prosecutorial guidelines see Crown Prosecution Service (2010).
[74] [1999] 1 A.C. 82.

foresight are now both equally legally culpable. In application to the medical arena, *Woollin* casts doubt "on the lawfulness of palliative care which doctors foresee will shorten life".[75] It is not possible that such foresight could be used to infer intention and doctors, who end patients' lives through administering fatal doses of palliative drugs, could now potentially face a murder charge. *Woollin* evidences that in the eyes of the law, intention and foresight are equally morally culpable with regard to taking the life of another. Unfortunately, it is suggested that the Court in this case failed to consider the effect on the medical profession, meaning that a doctor, due to fear of prosecution, may now be unwilling to assist in a patient's death through any fatal dose of drugs, palliative or otherwise.

In Re A, the Court was given the opportunity to attempt to reconcile the case of *Woolin* with the doctrine of double effect.[76] In this case, the Court was faced with the difficult question of whether the doctors could lawfully operate to separate conjoined twins, in the knowledge that one baby would die as a result. In ruling that the operation would be lawful, the majority felt that the doctrine of double effect did not apply in the circumstances, and instead the doctrine of necessity should be applied to defend the doctors' actions.[77] In doing so, the Court was able to avoid tackling the difficult question of whether the doctrine of double effect is compatible with the decision in Woolin, and instead, as Pattinson suggests, "knocks the problem of explaining why palliative care is not unlawful onto another aspect of the law of murder".[78] It appears then, that Re A does little to reconcile *Woolin* with the doctrine, merely suggesting that in future the doctrine of necessity may be used to protect doctors from murder charges. It is still currently unclear as to how, if at all, *Woollin* will affect medical law and until this is confirmed the artificial distinction between intent and foresight is one which remains.

3.4 Summary

On closer inspection of the law prohibiting a doctor's direct taking of life, it is evident that there are some instances where such behaviour is permitted – where the drugs

[75] Keown 2002 at 27.
[76] *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 147.
[77] Robert Walker L.J. did feel that a distinction could be made between intent and foresight in the facts. See [2001] Fam. 147 at 259.
[78] Pattinson 2009 at 525.

have a palliative effect. The justification provided by the law is the doctrine of double effect: a doctor may not intend a patient's death, but he may intend pain relief whereby death is an unintended side effect. Analysis of the intention-foresight distinction has revealed that it is based upon the idea that the intentional taking of innocent human life is always morally wrong, a sanctity of life based position. However, this position assumes that all human life is valuable in itself, as all life has an inherent sanctity or value. The difficulty arises (as explored in greater depth in Part 2) where people do not value life simply because it is human life, but because of the ability we have to change and shape our own lives and furthermore, where the law directly contradicts the claim that human life is inherently valuable.[79] Thus, this fails to justify the distinction between intent and foresight, and consequently, the law imposes another arbitrary distinction on the regulation of end of life practices. To explicate the unfairness such a position causes, it is again useful to turn to a hypothetical example.

Imagine two sisters, Lara and Clara, both of whom are suffering from equally devastating conditions. Lara has terminal cancer and after over two years of intensive treatment, has decided that her pain is too much to bear. With only months to live, Lara makes the decision to bring her life to a premature and dignified end. She requests that her doctor administer a fatal dose of morphine, a palliative drug, which will result in her death. The doctor complies with her wish and providing he does not intend her death (only the pain relief) and assuming *Woollin* has no effect on the medical profession, he acts lawfully. Consequently, Lara dies with her closest family by her side. Clara was involved in a tragic accident where she fell down three flights of concrete steps. After the accident Clara was left paralysed from the neck downwards. Although she feels no physical pain, Clara's pain is emotional and psychological and she too wishes to end her life. However, if a doctor were to assist in her death through the administration of a fatal dose of drugs, his actions would be unlawful as his primary intent would not be palliative care. Consequently, no doctor will agree to assist her and Clara is forced to continue living against her will. Is it fair that the need for palliative care be a determining factor in whether one can lawfully end life?

[79] See Chapter Five.

4.
ARBITRARY DISTINCTION THREE:
ABLE-BODIED vs. DISABLED

4.1 Introduction

Let us, again, return to the hypothetical story mapped out in the introduction to this thesis, and in particular, Alice. Alice lost her husband and three children in a car accident and subsequently discovered she was left with £200 000 of debt. Thus, Alice took a lethal dose of paracetamol and ended her life. You will remember that I asked you to imagine you are a sufferer of Motor Neurone disease. Given that you are paralysed from the neck down with only months to live, you wish to end your life, but cannot make that same choice. You have no life-sustaining treatment to refuse and nobody can legally assist you. How is it fair that Alice can legally choose to end her suffering, but you, simply because of circumstance, must suffer until the very end against your will? This chapter seeks to explore the justifications given as to why those in Alice's situation *can* make the choice to end their life, but others cannot. Can such reasoning withstand critical analysis? If not, we face an extremely unfair legal position which permits certain categories of people to make the choice to end life, but arbitrarily prohibits others.

The preceding chapters have established that a doctor may lawfully remove life-sustaining medical treatment from a patient, or inject them with a fatal dose of palliative medication with the effect of ending life, but where medication is not palliative or the patient does not require medical treatment to keep them alive, assistance is prohibited by s.2 of the Suicide Act 1961. What is more, the law essentially permits the suicide of an able-bodied person through s.1 of the same Act, yet prohibits an individual to "assist or encourage" the suicide or attempted suicide of another, meaning a decision to end life is afforded less protection to persons who are disabled. It is undoubtedly unfair that the law treats the same decision so differently: where a person is able-bodied their choice is permitted, yet where a person is physically or mentally disabled, they face a legal barrier. Again, this chapter seeks to

grapple with the current law in order to ascertain whether this unjust position can be defended, or whether we have encountered yet another arbitrary distinction.

4.2 The Legal Position

4.2.1 Suicide

Historically, the development of the Christian religion had a significant impact on attitudes towards end of life, including suicide. With an initial opposition to all forms of killing, which developed into the rejection of all intentional killing of innocent human beings, the Christian approach is essentially proscriptive.[80] The justification behind such a ban is that God is the supreme giver and remover of life, and thus, any attempt to terminate life prematurely is an insult to His power. Consequently, committing suicide was strictly forbidden and the religious rejection of such practices was reflected in the law:

> (T)he law of England wisely and religiously considers that no man hath a power to destroy life but by commission from God - the author of it. And as suicide is guilty of 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. The law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on one's self....[81]

The law held that a person who unsuccessfully attempted to take their own life would be guilty of an offence. Although those who were successful could not be directly punished, they would however, be subject to a public and degrading burial and the family of the deceased would indirectly suffer, as all goods and land would be forfeited to the king. Such a law was an attempt to dissuade the general public from "so desperate and wicked an act" as suicide.[82]

However, in 1961 suicide was eventually decriminalised by s.1 of Suicide Act, which states, "The rule of law whereby it is a crime for a person to commit suicide is

[80] See Rachels 1986.
[81] Blackstone 1775 at vol. IV.
[82] Blackstone 1832 at vol. II.

hereby abrogated". Although it may seem that such a legislative move was undertaken in order to show respect for individual choice regarding the end of life, careful analysis of parliamentary debates indicates that the purpose of the Act was, in fact, the opposite: "to help the suicidal not to commit suicide by enabling them to avoid the stigma of the crime…" and not to in any way encourage suicide.[83] This intent is evidenced in Hansard Reports where it was explained that decriminalisation "in no way lessens, nor should it lessen, the respect for the sanctity of human life which we all share"[84] and that "suicide will still remain a mortal sin".[85]

Keown agrees, adding that although suicide has been decriminalised, it remains unlawful.[86] However, while it is accepted that the Act was not an endorsement of any self-destructive behaviour, Keown's assertion is a contradiction in terms. The very fact that suicide was "decriminalised" evidences that it is no longer unlawful (with the absence of any civil wrong). For a practice to be considered unlawful, surely either a civil or criminal standard must be breached. On this widely accepted definition, suicide is not unlawful. There can be no legal repercussions for committing or attempting to commit suicide. Despite the Parliamentary intention when drafting s.1 of the Suicide Act, the effect of this provision is that a person may now take their own life prematurely, in the knowledge that there will be no legal ramifications. Notwithstanding the claims that suicide remains undesirable, the reality is that the law permits the self-destruction of any capable person.

4.2.2 Assisted Suicide

Section 1 of the Suicide Act 1961 decriminalised the act of suicide, however, assisting another to take their own life remains unlawful. Prior to the Coroners and Justice Act 2009, s.2(1) of the Suicide Act 1961 prohibited behaviour which "aids, abets, counsels or procures the suicide of another". Given the ambiguous nature of these terms, the judiciary attempted to define the scope of the offence and in doing so, severely restricted it.[87] Consequently, Parliament has amended the Act in an attempt to make clearer the type of conduct prohibited, without making a change to the

[83] Lord Brennan (when debating the legal requirements of an advance decision of Mental Capacity Bill) HL Deb 27 January 2005 vol 668 cols 443-512.
[84] Mr Charles Fletcher-Cooke MP (1960-1) 645 Parl. Deb., HC, cols. 822-3.
[85] Mr Eric Fletcher HC Deb 28 July 1961 vol 645 cols 824-825.
[86] Keown 1995 at 65.
[87] *Attorney-General v Able and Others* [1984] Q.B. 795.; *R v Chard* (1993) The Times 23 September.

substantive law.[88] Section 2 of the Act, as amended by the Coroners and Justice Act 2009, now states:

> (1) A person ("D") commits an offence if—
>
> (a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and
>
> (b) D's act was intended to encourage or assist suicide or an attempt at suicide.

Section 2A, entitled "Acts capable of encouraging or assisting", seeks to indicate the types of action that will fall under this offence. "Threatening another person" and "putting pressure on another person" are included, and s.2B explains that it need not be a single act; a course of conduct can also constitute an offence. The explanatory notes to the Coroners and Justice Act 2009 give the example of an author of a website promoting suicide, intending to assist or encourage others to commit suicide.[89] The notes explain that that she would be guilty of assisted suicide even if she does not know the readers and even where suicide does not actually take place. Moreover, the notes explain that a person is guilty of the offence if she intends to encourage or assist, even where the facts are not as she believes them to be.[90] For example, supplying pills she believes to be lethal which, in fact, are not. Beyond this information, however, the Act provides no further information regarding conduct that will fall under this offence. Given the potentially ever-expanding category of liability, this has proven problematic. Is accompanying a loved one to Switzerland to end their life an "act capable of encouraging or assisting" suicide? Does the taxi driver, who in full knowledge of the nature of the trip, drives the couple to the airport, also commit this offence? Could the family friend who helps to load the suitcases into the boot of the car be acting unlawfully? Although these people do not automatically commit the offence (they must also *intend* to encourage or assist in the suicide of that person), the line between permissible and impermissible behaviour is far from clear. Evidently the provisions set out by the Suicide Act 1961 as amended, do little to remedy the definitional issues pre-2009. What is more, to further complicate the question of what

[88] Hansard HL col. 631 (7th July 2009) per Lord Bach.
[89] Available at http://www.legislation.gov.uk/ukpga/2009/25/notes/contents <accessed 13/07/2011> at [357].
[90] *Ibid* at [359].

conduct constitutes "assisting suicide", the Director of Public Prosecutions (hereafter DPP) must consent to the institution of any proceedings under this offence.[91]

4.3 Can the Prohibition of Assisted Suicide be Justified?

Despite the difficulty in determining the precise conduct the Act is aimed at, the legal position is clear in its prohibition of assisting in another's suicide. Given that it has been established that a person may lawfully commit suicide, why then, may a person not lawfully invoke the help of another in ending life? What is the justification the law gives for making a distinction which clearly results in such an unfair situation?

In assessing such a question, it is useful to turn to the cases which have been thrust under the media-spotlight. In 1999 Diane Pretty was diagnosed with Motor Neurone disease. Her condition rapidly deteriorated, leaving her paralysed from the neck down with only months to live. Fearing an undignified death, she sought confirmation from the DPP that her husband would not face prosecution if he assisted her to commit suicide. The DPP refused to make such an assurance. Pretty sought judicial review of the Suicide Act and of this decision, claiming a breach of her rights under the ECHR.[92]

The House of Lords, in agreement with the Divisional Court, unanimously rejected her claim, stating that the DPP has no power for such an undertaking.[93] Furthermore, it was held that none of her Convention rights were engaged, and with regard to the right to private life, the Court noted that Art.8 prohibits interference with the way in which an individual leads their *life* and it does not relate to the manner in which they wish to *die*.[94] For this reason, the case collapsed at the first hurdle, and thus, it was unnecessary for the Court to explain in any depth the justification for the offence of assisted suicide. However, the Court did note that even if Pretty's Convention Rights were engaged, the Suicide Act would nevertheless be a justified interference with this right as it is a proportionate means of protecting the weak and the vulnerable.[95]

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[91] Suicide Act 1961 s.2.4.
[92] Pretty sought to rely upon Art.2, Art.3, Art.8, Art.9 and Art.14 ECHR.
[93] *R (on the application of Pretty) v DPP* [2001] UKHL 61.
[94] *Ibid* at [61].
[95] *Ibid* at [97] per Lord Hope.

The ECtHR, unlike the House of Lords, found that Art.8(1) *was* engaged because "the ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned".[96] However, they also held that interference fell within the margin of appreciation afforded to the state under Art.8(2), as it is necessary in a democratic society to protect the rights of others.[97] The Court explained that s.2 of the Suicide Act 1961,

> was designed to safeguard life by protecting the weak and the vulnerable and especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending dying. Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of the class which provides the rationale for the law in question.[98]

It was further explained that there is a risk to this group of people which justifies the imposition of a ban on assisted suicide.

The same appeal to the protection of the rights of others was used in the later case of *R (Purdy) v DPP*.[99] The facts in Purdy appear similar to those in Pretty, but there is a substantial difference, in the former the applicant's request was for legal clarity, whereas in the latter the claim was for immunity from a legal provision. Debbie Purdy suffers from Multiple Sclerosis, a chronic progressive nervous disorder and subsequently feels that in the future, when her health has deteriorated further, she may wish to end her life prematurely. As a result, Purdy requested the DPP clarify the law on assisted suicide, so she could assess whether her husband would face prosecution if he accompanied her in her trip to the Dignitas clinic in Switzerland where she would spend her final days.[100] She felt that the law in its existing state failed to clearly determine when a prosecution would arise. The DPP declined to clarify the legal position and consequently Purdy filed a judicial review action.

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[96] *Ibid* at [62].
[97] *Pretty v UK* (No. 2346/02) (2002) 35 E.H.R.R. 1.
[98] *Ibid* at [74].
[99] [2008] EWHC 2565; [2009] EWCA Civ 92.
[100] Dignitas is a Swiss assisted dying organisation which aims to help individuals end their lives. The organisation provides qualified nurses and doctors who are based at specialist clinics who will assist in the dying process.

Purdy claimed that her rights under the ECHR were breached by the legal uncertainty, namely Art.8, the right to private and family life. The High Court and Court of Appeal regarded themselves bound to follow the decision of the House of Lords in *Pretty*, and thus, both rejected that her right under Art.8(1) was engaged. Moreover, both the High Court and Court of Appeal stated that even if Art.8(1) was found to be engaged, the limitation would be justified under Art.8(2), for the protection of the rights of others.[101] Nevertheless, surprising many academics,[102] in their final judgment before the establishment of the Supreme Court, the Lords reversed the decision of the Court of Appeal and followed the ECtHR in *Pretty*.[103] Baroness Hale explained that the ECtHR in *Pretty* were correct to include end of life decisions within the scope of Art.8(1), as the notion of personal autonomy is integral to this right.[104] The Court further held that this right was unjustifiably infringed under Art.8(2) by the failure of the DPP to clarify the law. Baroness Hale explained that,

> the way in which the DPP had to explain his decision in the case of Daniel James… shows that some of the listed factors have to be turned on their head and other unlisted factors introduced in order to cater for these difficult decisions. Furthermore, as it seems to me, the object of the exercise should be to focus, not upon a generalised concept of "the public interest", but upon the features which will distinguish those cases in which deterrence will be disproportionate from those cases in which it will not.[105]

Consequently, the DPP was ordered to create an offence-specific policy outlining when prosecutions will occur.[106]

In both these pivotal cases, the Court has defended s.2 of the Suicide Act 1961 with reference to the rights of others. Although this justification is addressed in much greater depth in Part Two of this thesis, it is useful to engage in some analysis of this claim. The fear is this: that permitting individuals to seek assistance in committing suicide will put vulnerable and weak people at risk of being forced to take their lives prematurely. More specifically, "legal machinery initially designed to kill those who

[101] *R (Purdy) v DPP* [2008] EWHC 2565; [2009] EWCA Civ 92.
[102] Stephens 2008 at 268.
[103] *R (Purdy) v DPP* [2009] UKHL 45.
[104] *Ibid* at [60]-[62] per Baroness Hale.
[105] *Ibid* at [64] per Baroness Hale.
[106] Published in February 2010, see Crown Prosecution Service 2010.

are a nuisance to themselves may someday engulf those who are a nuisance to others".[107] There are three criticisms of this approach I would like make.

4.3.1 A Failure to Fully Justify Their Decision

Firstly, the courts in both cases failed to fully explore their appeal to the rights of others, providing no evidence of the degree of any such risk. What is more, they failed to fully explain why a complete ban on assisted suicide is a justified means of protecting others. The courts did not address in any real depth whether adequate safeguards could be used in order to protect others, or whether exceptions could be made in cases where the decision is clearly not one made under pressure.

4.3.2 Overlooking Situations Where the Vulnerable Can Already Obtain Assistance

Secondly, the courts argued that permitting assisted suicide would endanger the weak and the elderly, yet they failed to acknowledge that there are already instances where vulnerable people can obtain assistance in taking their own life. As discussed in the previous chapters, a person may lawfully refuse life-sustaining medical treatment or request a doctor inject them with a fatal dose of palliative drugs. Surely the permissibility of such practices would be subject to the same concerns, yet they are lawful without being subject to any regulation or safeguards to protect the rights of others. Surely if the law were to be consistent in its approach and for the appeal to the rights of others to have any real argumentative force, these other areas of law would need to have some protection in place for the weak and vulnerable, protection that simply does not exist. These arguments will be addressed in much greater depth in the following Part of this thesis, but already it has been established that the complete prohibition of assisted suicide cannot be justified with merely a passing reference to protecting the rights of the vulnerable.

4.3.3 The Focus on Society as 'Vulnerable'

[107] Kamisar 1958.

In the cases of both *Pretty* and *Purdy*, the courts put a great emphasis on the rights of other vulnerable persons in society. To reiterate the words of the Court in *Pretty*, it was explained that s.2 of the Suicide Act 1961,

> was designed to safeguard life by *protecting the weak and the vulnerable* and especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life.[108]

Similarly, in *Purdy*, both the High Court and Court of Appeal expressed that even if Art.8(1) was engaged, the legal position would be justified under Art.8(2), for the protection of the rights of others.[109] There is a tendency in the end of life debate, to focus on others in society as vulnerable and weak, as was the case in both *Pretty* and *Purdy*. In doing so, the rights of 'others' in society are thrust centre-stage, while the rights of those requiring assistance in their suicide are sidelined. I suggest that the word 'vulnerable' is so often attached to 'others' that it is often forgotten that those who desire a change in the law are often extremely vulnerable themselves. Was Diane Pretty, in her debilitated physical state, with her inability to lawfully seek assistance in her suicide, not weak and vulnerable? Was Debbie Purdy, in her terrible physical state, with her lack of certainty over the current legal position, not also weak and vulnerable? What is more, the fact that both women were willing to fight through the court hierarchy to acquire more control and information regarding their positions evidences this very point. Both women were vulnerable, and were trying to alter this and regain some independence through arguing their case in a court of law.

It is argued that the courts in both cases assume the common mindset that it is 'others' who are vulnerable, and thus, underplay the terrible position that those who are restricted access to assisted suicide find themselves enduring. In doing so, it was possible to justify the current legal position. However, there is an alternative that has not yet been fully explored. Given that it has been established that those who are denied access to assisted suicide are, in fact, extremely vulnerable, it is surely possible to reconceptualise them as such. The focus could be shifted from 'others' onto the horrifying situation those who desire assisted suicide find themselves in. The question is: how could this be achieved?

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[108] *Pretty v UK* (No. 2346/02) (2002) 35 E.H.R.R. 1 at [74].
[109] *R (Purdy) v DPP* [2008] EWHC 2565; [2009] EWCA Civ 92.

Article 3 of the ECHR prohibits torture, or inhumane or degrading treatment of any person and there are no qualifications to this human right. Those who are prevented access to assisted suicide regularly claim that their situation is degrading,[110] and given the emotional strain caused by slow physical deterioration, it is not incongruous to suggest that such a situation is also inhumane. Why, then, is more emphasis not put on Art.3 when taking assisted suicide issues to court? While Pretty relied on Art.3, the Lords swiftly dismissed this argument. In reasoning that the positive obligation of the state in this case did not extend to preventing the inhumane and degrading situation of those requiring assisted suicide, Lord Bingham stated,

> while states may be absolutely forbidden to inflict the proscribed treatment on individuals within their jurisdictions, the steps appropriate or necessary to discharge a positive obligation will be more judgmental, more prone to variation from state to state, more dependent on the opinions and beliefs of the people and less susceptible to any universal injunction.[111]

Lord Steyn claimed Art.3 was not engaged because the word 'treatment' does not include such circumstances[112] and Lord Hope reasoned that Pretty's situation did not reach the required level of severity.[113] With respect, the judges again underplay the severity of the situation Mrs Pretty and others find themselves in, and while they explain that the positive duty of the state does not extend this far, they fail to discuss why. Each judge spends only a short amount of time addressing Art.3 – this issue was brushed over in order to focus more exclusively on Art.8. Unfortunately, due to the nature of Purdy's claim (focussing on the clarity of the law as opposed to requesting exemption) she was unable to invoke Art.3. However, it is suggested that the possibility of reconceptualising 'vulnerability' in light of Art.3 of the ECHR has yet to reach its full potential. Denying those who cannot assist themselves access to assisted suicide can be inhumane and degrading, and thus, it is surprising that this avenue has not yet been fully investigated.

[110] See Dyer 2002.
[111] *R (on the application of Pretty) v DPP* [2001] UKHL 61 at [15].
[112] *Ibid* at [60].
[113] *Ibid* at [91].

4.4 Evidence of Unfairness

This and the previous two chapters have sought to illustrate that the current legal position is unfair. Whilst it is clear that the law allows some people to exercise the choice to end their lives and denies others the very same, if the distinctions between the situations could be justified, this difference in treatment would not be unfair. Unfortunately, as this thesis has sought to reveal, the distinctions used are arbitrary and crumble under any critical analysis, and thus, the legal position *is* unfair. What is more, the reality of the current position is that the law side steps prosecuting those who assist in suicide, further revealing this unfairness.

4.4.1 The DPP's Guidelines

The assertion that the law is unfair in distinguishing between those who are able to commit suicide and those who require assistance, is supported by the reality of the current legal position. It is contended that the law inherently recognises the unfairness caused if s.2 were to be followed dogmatically as there is an obvious attempt to side-step such injustice. Despite the fact that s.2 of the Suicide Act 1961 renders assisting suicide unlawful, the DPP will rarely consent to the institution of proceedings under this offence. Although there have been many instances where the actions of family members have clearly amounted to "assisting", of over one-hundred Britons that have travelled overseas to receive assistance to commit suicide, not one successful prosecution has resulted.[114] The situation presented is one in which the law prohibits a particular action in theory, but in practice, the prosecutorial discretion is exercised to overlook such behaviour, in order to avoid unfairness between those able to commit suicide unaided and those who require assistance.

This issue has been particularly pertinent in recent years, as more terminally ill individuals have chosen to travel abroad to a country where assisted suicide is legally permitted. In most cases such individuals require another to accompany them in their journey, as often illness renders them unable to travel unaided, and where it does not, most require emotional support at such a significant time. For these people, anticipating whether the conduct of their loved one constitutes "encouraging or

[114] Dignity in Dying 2010.

assisting suicide", and whether they will consequently face prosecution, is of paramount importance. Given that such individuals are being forced to make grave decisions about ending their lives, further legal complexities about the nature of such conduct are especially unwelcome, hence, the case brought by Debbie Purdy demanding legal clarity. As previously mentioned, following this case the DPP was ordered to create a policy document outlining when prosecutions will be instituted under the assisted suicide offence.[115] An interim policy was introduced in September 2009 and following a public consultation, the full guidelines were published in February 2010. They include a list of sixteen factors in favour of prosecution and six against prosecution:

A prosecution is more likely to be required if:

(1) the victim was under 18 years of age;

(2) the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;

(3) the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;

(4) the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;

(5) the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;

(6) the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;

(7) the suspect pressured the victim to commit suicide;

(8) the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;

(9) the suspect had a history of violence or abuse against the victim;

(10) the victim was physically able to undertake the act that constituted the assistance him or herself;

(11) the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication;

[115] Crown Prosecution Service 2010.

(12) the suspect gave encouragement or assistance to more than one victim who were not known to each other;

(13) the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;

(14) the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care;

(15) the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;

(16) the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

A prosecution is less likely to be required if:

(1) the victim had reached a voluntary, clear, settled and informed decision to commit suicide;

(2) the suspect was wholly motivated by compassion;

(3) the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;

(4) the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;

(5) the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;

(6) the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.[116]

Despite the insistence that *Purdy* and the subsequent prosecutorial guidance did "not change the law",[117] and that the list of relevant factors is "not exhaustive",[118] many have commented that the policy effectively legalises compassionately motivated assisted suicide.[119] Mullock explains that in reading the policy guidelines, compassion

[116] Crown Prosecution Service 2010.
[117] *Ibid* at [5].
[118] *Ibid* at [47].
[119] See in particular Mullock 2010.

is "the key determining factor" in assessing whether to prosecute.[120] She explains how this factor, which relies on the suicidal individual acting autonomously, is pivotal in the prosecution and if it is present, no charge will be brought. Is it possible then, that if an individual acts solely out of compassion for another in assisting them to commit suicide, they are essentially acting legally?

Let us consider a hypothetical couple, Jane and Kevin. Kevin suffers from Motor Neurone disease and his condition has deteriorated to unbearable levels. As a result, he requests Jane, accompany him to Switzerland where he plans to seek medical assistance in ending his life. Jane, distraught, repeatedly begs Kevin to reconsider, but Kevin is determined that this is his final wish and eventually she agrees. She, under close instruction from Kevin, books the appropriate flights and accompanies him on his final journey. When Jane returns, alone, she is weary and heartbroken. Is it possible, given the guidelines published, that Jane would face criminal prosecution for her actions? It is suggested that this would be an extremely unlikely turn of events. Given that Kevin instigated the discussion regarding ending his life and unequivocally expressed this decision, and that Jane first attempted to dissuade her husband and her subsequent involvement was reluctant, it seems almost impossible that in cases such as this a prosecution would be brought. What is more, the House of Lords left the question of whether an offence is committed in this situation open[121] and that Jane was "wholly motivated by compassion". Considering that a vast number of cases where UK citizens travel abroad to commit suicide mirror this familial pattern of emotion, it appears that these types of cases have been excluded from the grasp of the criminal law altogether. Mullock agrees, expressing that "the policy has precisely the effect of sanctioning compassionately motivated assisted suicide".[122]

Others have noted that it is the demedicalised nature of assisted suicide committed by family members travelling abroad, which has pushed this behaviour beyond the scope of the criminal law.[123] Ost explains that this type of assisted death, as oppose to physician-assisted death, is more "emotive and empathetic" and

[120] *Ibid* at 470.
[121] *R (Purdy) v DPP* [2009] UKHL 45.
[122] Note that this is providing the person providing assistance is not a healthcare professional see Mullock 2010 at 445.
[123] Ost 2010 at 413.

"recognises the social and emotional aspects of assisted suicide".[124] Again this theory places great emphasis on the idea that "at the basis of compassion lies an identification with the sufferer as a fellow human being, a recognition the similar misfortunes may also befall one, insofar as one is human".[125] In taking assisted suicide out of the medical context, the onlooker is in a much better position to imagine how they might cope if they faced such a dilemma. Ost argues that it is this relatable quality in relatives facilitating assisted suicide abroad, which, through the DPP's prosecutorial policy, has "moved the law on assisted suicide forward".[126]

However, even if the claims of Mullock and Ost are accepted and the prosecutorial policy governing assisted suicide does have the effect of legalising compassionately motivated assisted suicide, the playing field can by no means be described as level. The reality remains that the policy factors "are not exhaustive" and that discretion remains with the Director of Public Prosecutions.[127] Although it has been suggested that such a prosecution is very unlikely, it is not impossible, and this lack of reassurance may be something that affects an individual's decision. Such a person already has to address a plethora of difficult questions: whether to prematurely take their life, whether to travel over 700 miles to do so and whether to put their family through such an ordeal. It is not, therefore, unreasonable to suggest that the risk of prosecution for close family members may be the factor which dissuades an individual from making the final journey. Furthermore, the behaviour of the family members is stigmatised by the very existence of the offence, their actions being clearly defined as 'criminal', providing yet more reasons for an individual to wait for death to occur naturally against their will. An able-bodied person, on the other hand, has the ability to commit suicide free from fear of prosecution or legal stigma.

A second, more compelling, difference between the ability of the able and disabled to make a choice to commit suicide, is that the latter must make a long and exhausting journey overseas to fulfil their wish. Such individuals must spend their final moments in an unfamiliar country, miles from home, usually with a minimal number of family members present. For a person suffering from a painful or debilitating illness this journey will be particularly unpleasant. In contrast, those of us who are physically able can commit suicide in our own homes if we desire. It is quite

[124] *Ibid* at 514.
[125] Van Zyl 2000 at 165.
[126] Ost 2010 at 513.
[127] Crown Prosecution Service at [47] and [13]-[14].

clear that unfairness persists, despite the prosecutorial attempt to exclude compassionate assistors from the scope of the criminal law.

4.4.2 Death Tourism

The legality of accessing suicide in another European country coupled with the restrictive legal position in the UK, has seen a rise in death tourism. Each year more people travel abroad to receive assistance to commit suicide and following the DPP's guidelines, it is extremely unlikely that a family member who helps to effect such a journey will face prosecution. Since the new guidelines were introduced, there have been at least thirty cases reported to the Crown Prosecution Service of individuals suspected of helping a loved one to die, but not one has been prosecuted.[128] If this is the case then, you may question how the situation is unfair. An able bodied person can commit suicide, an individual receiving life-sustaining treatment can refuse it, a person requiring palliative care can request a lethal dose and those who fall outside these categories can travel abroad. In theory, then, everyone has the ability to bring about the end of his or her own life, and thus, there is no unfairness.

However, this is not the case. Travelling abroad to receive assistance in ending life has numerous costs and risks which are not involved in the former three situations. Such costs can be financial, emotional, mental or even physical. What is more, the individual who wishes to journey abroad cannot do so unaided, which raises the question: what about those without friends or family to accompany them? What about those whose family refuses to accompany them? The current case of a 46-year-old man Martin, who wishes to remain anonymous, mirrors this exact problem.[129] Since suffering a severe stroke which left him almost completely paralysed, Martin has been requesting assistance to end his life. His wife, although willing to be present when Martin dies, refuses to help him in any way, including travelling abroad. Martin's lawyer is currently applying for an interim declaration that doctors would not be prosecuted for preparing his case, but at present, Martin is enduring the very unfairness I have been seeking to expose. While theoretically individuals can travel abroad free from prosecution, in reality, the costs endured by these individuals are far higher than those who can end their lives in the UK. Furthermore, those without a

[128] Gibb 2011.
[129] Bosely 2011.

family to help them remain trapped. Death tourism, rather than providing a loophole through which the legal unfairness at end of life is remedied, in fact serves to highlight the tremendous grievance inflicted upon those unable to assist themselves.

4.5 Summary

It has been established that s.2 of the Suicide Act 1961 creates another arbitrary distinction governing end of life practices. The law permits suicide, but assisted suicide is a criminal offence and the result is that able-bodied individuals are permitted to end their lives prematurely, without risk of criminal prosecution, yet persons who are disabled may only make the same choice if they are willing to risk that a family member be prosecuted. Following the House of Lords' decision in *Purdy*, the DPP was forced to create a document clarifying when a prosecution is likely to be brought under s.2 of the Act. It appears that there is legal recognition of the unfair nature of the Suicide Act 1961, as this document has had the effect of essentially exempting from the offence, family members who act compassionately. However, it has been suggested that such injustice has not been fully remedied by the policy. Individuals who are not physically fit must still travel abroad, with all the costs and risks involved, and even then the risk of prosecution for family members is not entirely non-existent. An arbitrary distinction continues to create an unfairness at end of life. To elucidate the injustice that such a position causes, it is useful to turn to a final hypothetical example for Part One.

Bill was a successful businessman until the recent economic climate when his entire enterprise collapsed and he was declared bankrupt. Furthermore, his wife and children were tragically killed in a horrific train accident that same year. For twelve months, Bill attempted to piece his life together, but finally made the decision that without his passion for business, and without his family, his life was no longer worth living. Will was on the very train that killed Bill's family, surviving the accident but left unable to move any part of his body from the neck downwards. Will's family were travelling with him too, but unfortunately did not make it out of the wreck alive. Like Bill, Will has made the decision that his life is no longer of any value to him. In

this scenario, in the comfort of his own home and with the memories of his family surrounding him, Bill takes a lethal dose of paracetamol and ends his life. Will, however, needs somewhat more assistance if he is to accomplish the same end and he calls upon a close friend to place a fatal dose of pills on his tongue. However, the friend refuses for fear of prosecution under s.2 of the Suicide Act 1961. Eventually, after much persuasion, Will convinces the friend to accompany him to Switzerland to end his life. Will and his friend are both uneasy about the legality of their trip, but make the venture in the hope that the prosecutorial guidelines will exempt their actions from prosecution. Will finally arrives in Switzerland, an unfamiliar country, and passes away in the foreign surroundings of a Dignitas Clinic. Is it fair that the physical ability of an individual be a deciding factor in whether one can lawfully end life?

PART TWO

POSSIBLE JUSTIFICATIONS FOR THE CURRENT UNFAIRNESS

INTRODUCTION

Part Two of this thesis serves to build upon the findings displayed in Part One: that the current legal position regarding end of life is unfair. It is possible that such unfairness could be excused if a valid justification could be found for the distinctions made, and thus, an analysis of two potential rationales will be made in this second half of the thesis. There are broadly two appeals made in defence of the current legal proscription of assisted suicide: the first makes a claim to 'the rights of the self' and the second, to 'the rights of others'. The former is the idea that a person possesses rights over their body, some of which cannot be waived by the rights-holder. The right not to be killed, for example, cannot be waived and thus, another human being may not intentionally take your life even if you make a request. The latter is the claim that permitting assisted suicide would cause a greater harm to the rights of other human beings in society, and for this reason, should be prohibited in order to their rights.

Chapter Five will assess the appeal to the 'rights of the self' and Chapter Six will examine the appeal to the 'rights of others' in order to establish that neither can coherently defend the current legal position.

5.
AN APPEAL TO THE RIGHTS OF THE SELF

5.1 Introduction

A common defence of the current legal position, which prohibits assisted suicide, is an appeal to 'the rights of the self'. The suggestion that every individual has a set of rights, some of which are non-waivable by the rights-holder, means that by extension certain types of behaviour must remain prohibited. The right to life, for example, is often classified as non-waivable. Thus, an appeal to the rights of the self would hold that human life should never intentionally be taken, even where an individual *wants* to end their life.

The 'rights of the self' standpoint takes various forms, all of which invoke different reasoning as to *why* certain rights cannot be relinquished. This chapter will first focus on the claim that particular rights cannot be waived, because to do so would offend human dignity (classified as Beyleveld and Brownsword as the 'Dignity as Constraint' argument).[130] The definitional weaknesses of the broader 'Dignity as Constraint' argument will be exposed and it will be evidenced that the current law is in fact incompatible with this position. The second claim to be addressed, which is a more specific variant of the human dignity position, is the sanctity of life position. This is the belief that certain rights cannot be surrendered, because to do so would undermine the sanctity of human life. An analysis of this position will reveal conceptual difficulties with the sanctity of life and evidence that this position is incompatible with the current law. Evidencing that the current law directly contradicts both these principle will demonstrate that appeals to 'the rights of the self', in these two forms, cannot sufficiently defend the current legal unfairness illustrated in Part One.

[130] Beyleveld and Brownsword 2001 at 29-47.

5.2 Dignity as Constraint

The first appeal to the rights of the self addressed by this chapter is described by Beyleveld and Brownsword as "Dignity as Constraint", and holds that some decisions should always be prohibited, regardless of autonomy or resulting consequences, because they are inherently damaging of human dignity.[131] For example, in 1995 the mayor of a small French town prohibited dwarf-throwing, an activity where participants compete to throw dwarves wearing padded Velcro suits, the furthest distance. One participant appealed the ban, claiming that he and the other dwarves who were involved consented to participate. However, when the application reached the *Conseil d'État*, it was held that the ban was lawful in order to protect public order and human dignity.[132]

Similarly, in Germany, Armin Meiwes was charged and convicted of murder after killing and eating a willing and consenting victim.[133] Bernd Jürgen Brandes had responded to Meiwes advertisement on the Internet, which requested a victim who would be willing to die for his cannibalistic desires. Despite the consent of the deceased, the Court found Meiwes guilty of murder and he was sentenced to life imprisonment.[134] Although not directly addressed by the court, cannibalism is commonly viewed as offensive to human dignity, and so the decision of the court in this case *is* compatible with the Dignity as Constraint position, providing the reasoning is based on a protection of Brandes himself, despite his consent.

A final example emerges from the English case of *R v Brown*, the decision from which is compatible with the Dignity as Constraint position. In 1994 a group of young men were convicted of participating in sadomasochistic acts which amounted to criminal assault and wounding.[135] The question was whether the participants' consent could amount to a defence – essentially, whether their autonomous right

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[131] *Ibid* at 29-47.
[132] See the French case Conseil d'État (October 27, 1995) req. nos. 136-727 (Commine de Morsang-sur-Orge) and 143-578 (Ville d'Aix-en-Provence). Please note that while 'public order' is the direct translation of the term 'ordre public' used by the French Court, the two terms are not identical in legal meaning. The French term 'ordre public' is much wider in meaning, incorporating rules governing the economy, morals, health, security, peace and human rights. In English law, public order is much narrower, relating more specifically to society.
[133] See the case of the German, Armin Meiwes, who was found guilty of murder after killing and eating another consenting individual. Succinctly recorded at BBC News (2006) 'German cannibal guilty of murder' available at http://news.bbc.co.uk/1/hi/world/europe/4752797.stm <Accessed 13/12/10>.
[134] *Ibid.*
[135] *R v Brown* [1993] 2 All ER 75.

extended to choosing severe harm. The House of Lords answered this question in the negative, and although their reasoning fails to directly address the notion of human dignity, it is possible to read it as compatible with Dignity as Constraint if the aim is to protect the individual actually consenting.[136] The same interpretation of the reasoning can be made at the ECtHR, where it was again decided that consent cannot be a defence to severe harm caused by sadomasochistic activity.[137]

5.2.1 A Valid Defence?

It is possible that the 'Dignity as Constraint' position can defend the unfairness created by the law with regard to ending one's own life, providing it can be proven that unlawful end of life practices (such as assisted suicide) undermine human dignity, whereas the lawful practices do not undermine human dignity (for example refusal of life-sustaining medical treatment). In order to ascertain whether this is the case, it is necessary to define 'human dignity' and the types of behaviour that will offend it more closely. This task is, however, far from uncomplicated. In assessing whether an action is permitted or prohibited, how are we to distinguish actions which offend human dignity from those which do not? Why is intentionally harming another perfectly acceptable in a boxing arena but destructive of human dignity when throwing a dwarf? Unfortunately, the approach offers little in terms of defining human dignity, a concept often criticised as "especially vague and ambiguous".[138] Such a subjective term requires explanation if this argument is to hold any weight.

One suggestion offered is that an action will offend human dignity when it is contrary to 'human nature'. Beyleveld and Brownsword offer an explanation of this reasoning:

> All human beings have dignity simply by virtue of being human. Dignity is thus an essential part of human nature. Therefore, to act contrary to human nature is to act contrary to human dignity…[139]

[136] *Ibid.*
[137] *Laskey, Jaggard and Brown v United Kingdom* (1997) 24 EHRR 39.
[138] Jackson 2010 at 25.
[139] Beyleveld and Brownsword 2001at 229.

However, surely we are no closer to clearing the fog surrounding the actual definition of 'human dignity'. This explanation, in fact, merely serves to replace one ambiguous concept with another. A new set of questions are posed: what is human nature and when is an act considered to offend human nature? The first suggestion is that it is an action which opposes the laws of nature. But, as Beyleveld and Brownsword observe, "if something is contrary to the laws of nature then it cannot (physically) happen".[140] A second submission is that an action offends human nature if it cannot occur without human intervention. Again, this suggestion is problematic as is classes almost all acts as contrary to human nature, suggesting that "human action itself is contrary to human nature".[141] Clearly such an explanation is also absurd. Evidently, the argument that utilises human dignity with reference to human nature is not fully reasoned. What is more, the idea of human dignity can be used to the completely opposite effect, evidencing that the way in which human dignity is defined can radically alter the types of behaviour which should be prohibited. This opposing view is classified by Beyleveld and Brownsword as 'Dignity as Empowerment'.[142]

'Dignity as Empowerment' is the idea that human dignity requires respect for others in providing them with conditions where they can exercise and experience dignity. One of these necessary conditions is the freedom and ability to make decisions – individual autonomy. Instead of constraining choices to protect human dignity (as is the practice with 'Dignity as Constraint'), this position upholds autonomous choice. Joseph Raz explains how human dignity is defined by the 'Dignity as Empowerment' ideology:

> Respecting human dignity entails treating humans as persons capable of planning and plotting their future. Thus, respecting people's dignity includes respecting their autonomy, their right to control their future…. An insult offends a person's dignity if it consists of or implies a denial that he is an autonomous person or that he deserves to be treated as one.[143]

This opposite conception of human dignity can be seen in the previous examples given, in objecting to the dwarf-throwing ban, the dwarves claimed that the ban

[140] *Ibid* at 230.
[141] *Ibid.*
[142] Beyleveld and Brownsword 2001at 9-27.
[143] Raz 1979 at 221.

represented a lack of respect for their dignity, because it was inconsistent with their free choice. Similarly, in the courtroom Meiwes defence claimed that convicting the cannibal despite Brandes consent "is an invasion of Mr. Meiwe's human dignity".[144] The very existence of these opposing views of human dignity highlights how integral the definition is for this type of appeal to 'the rights of the self'. If respecting human dignity is defined as upholding a particular set of common values, the type of behaviour to be prohibited will be different than if the definition is said to involve respecting autonomous choice. The former would be likely to prohibit sadomasochistic acts such as those seen in *Brown*, whereas the latter would permit them, providing the rights of others were not endangered by such actions. As such, without a clear definition the theory does not specify which actions are acceptable or unacceptable, and thus, cannot adequately defend the current legal position with regard to end of life.

Moreover, it is argued that even if such a definition could be clearly identified, the appeal to human dignity would still fail to adequately explain why some people are prevented from making the end of life choices that others can so freely make. This is because, for the theory to provide an adequate justification for the current legal position, a person making the choice to end their life through swallowing a lethal dose of paracetamol must not offend human dignity; a person who refuses further artificial ventilation in order to end their life must also not offend human dignity, neither must a cancer patient who requests the doctor inject her with a lethal dose of a palliative drug. On the other hand, however, a person who seeks assistance with their suicide, as they are too disabled to take their own life, must act in a way which insults human dignity. Of course such a suggestion appears absurd. In each case the individual is seeking to end their own life, the only difference being in the final case the individual requires the direct assistance of a third party. It is possible to suggest that it is this third party involvement which renders the latter situation unacceptable, but this is a weak argument given that the doctor must play some part in switching off a ventilator or injecting the morphine.

I suggest that the human dignity position, in fact, serves to reveal the scale of the unfairness caused by the current prohibition on assisted suicide – surely turning our back on those who are suffering and in real need of help is offending human

[144] Stampf 2008 at 326.

dignity, rather than upholding it. There is both an increasing support and common linguistic usage of this idea, evidenced by the increasing desire of those who want to take their lives prematurely, to have a "*dignified* death".[145] Moreover, given that people are now living longer with a variety of illnesses and diseases, the idea of a calm and peaceful death as the dignified option has gained ground in recent years – the belief that ending life prematurely offends human dignity loses its power in such a medically advanced society.

In sum, I have evidenced that the broader 'Dignity as Constraint' position is flawed as it fails to clearly define human dignity and explain what actions will offend it. Furthermore, I have argued that even if such a concept had a clear definition, it is extremely unlikely that this would serve to defend the unfairness of the current legal position with regard to end of life. Such a definition would have to be extremely obscure in order that suicide, death by refusal of treatment and death by request for life-shortening drugs be compatible with human dignity and assisted suicide offend it. What is more, modern understandings of human dignity include dying peacefully at the time of one's own choosing, rendering it even more unlikely that an appeal to 'Dignity as Constraint' could be invoked as a defence of the prohibition on assisted suicide.

The next section will analyse a more specific and clearly defined version of the human dignity position, the sanctity of life, in order to further illustrate the point that even where definition is unproblematic, arguments from human dignity still fail to defend the current legal unfairness with regard to end of life.

5.3 The Sanctity of Life

A second appeal to 'the rights of the self', which is actually a variant of the 'Dignity as Constraint' position discussed above, is the sanctity of life view. This position is worthy of analysis, given that it is more detailed and extensive than the broader 'Dignity as Constraint' argument, as it outlines which behaviours offend human dignity and why. The doctrine of the sanctity of life holds that innocent human life is sacred and thus, should never intentionally be taken. Where an action offends this

[145] As evidenced by the name of the national campaign group in the UK, 'Dignity in Dying'. See http://www.dignityindying.org.uk/ <accessed 16/03/11>.

doctrine, that action must be curtailed. Originally, this was a solely religious position, but more recently it has gained a secular supporting. This section will analyse each of these strands to ascertain whether either can sufficiently defend the current legal unfairness with regard to ending one's own life.

5.3.1 The Religious Sanctity of Life Position

In the UK, the doctrine of the sanctity of life has surfaced through the teachings of the dominant religion, Christianity. The doctrine holds that the intentional killing of innocent human beings is always wrong, owing to the great value religion affords human life. Christianity holds that human life is sacred for a number of reasons, perhaps the most well known being the sixth commandment handed down to Moses on Mount Sinai: "thou shalt not kill".[146] Pope John Paul II outlined two other reasons as to why the Christian religion affords human life such a special status:

> Man's life comes from God; it is his gift, his image and imprint, a sharing in his breath of life. God therefore is the sole Lord of this life: Man cannot do with it as he wills … the sacredness of life has its foundation in God and his creative activity: 'For God made man in his own image'.[147]

This passage demonstrates that the Christian religion asserts that human life is created in God's image. Thus, to take life would dishonour God. Furthermore, it is claimed that life is a gift given to us by God, which only He has the power to take away. Thus, to end life prematurely is to usurp God's control over us.[148] Consequently, Christians often claim that humans have stewardship, not dominion, over their lives.[149] We merely occupy our bodies until we are called to death and consequently, do not have absolute control over our lives.

This position is, as with the human dignity position, an essentially duty-based ideology which holds that humans have a right to live which cannot automatically be waived. So, for example, if a terminally ill individual, Alex, requests active

[146] Exodus 20: 2-17.
[147] Wicks 2009.
[148] A law professor at the university of Notre Dame notes, "By aiming at our own deaths we usurp God's proper providence in allotting the span of our lives" in Kaveny 1977.
[149] Battin, Rhodes and Silvers 1998 at 332.

assistance to commit suicide, the doctrine of the sanctity of life would prohibit this. Alex's life was given to him by God and thus, only God has the power to take it away. The illness Alex is suffering from is part of God's plan and as a result, Alex does not have the power to end it prematurely.

As highlighted by Callahan, there are clear benefits from assessing the religious perspective in any moral debate, as religion has a wealth of experience in tackling the difficult questions medical ethics poses.[150] Evidence that there are benefits in incorporating religious opinion into legal debate can be seen in the controversial case of *Re A* where the parents of conjoined twins, Jodie and Mary, refused to consent to an operation which would separate them.[151] They felt that such a separation (which would be sure to end the life of the weaker twin, Mary) offended their beliefs as members of the Roman Catholic religion. Unusually, the Court granted the Archbishop of Canterbury permission to make written submissions with regard to the case. Although the Court of Appeal granted the declaration meaning that a separation would be lawful,[152] contrary to the Archbishop's strong belief in the doctrine of the sanctity of life,[153] this case illustrates that the judiciary are of the belief that religion can provide useful contributions to tricky ethical questions.

However, the first criticism of any doctrine which relies on religion for its justification is that religion is based on faith rather than reason. Thus, belief in the sanctity of life requires that people believe God created man in his own image. It requires that people believe God gave life to us as a gift. More centrally, belief in this ethical standpoint requires a belief in God. While historically Christianity was the dominant religion in the UK, this is no longer the case, as over the decades, a more pluralistic and multicultural society has emerged. Keown admits that we have seen a decline of established religious belief[154] and although in a 2001 consensus 71.8% of people registered as Christian, Wicks questions how many of these actually visit places of worship with any regularity.[155] Furthermore, it is suggested that in the subsequent ten-year period since the study, membership of the Christian religion has

[150] He states that moving towards secularisation would leave us "bereft of the accumulated wisdom and knowledge that are the fruit of long-established religious traditions" in Callahan 1990 at 3.
[151] [2001] Fam. 147.
[152] *Ibid.*
[153] He stated "Human life is sacred, that is inviolable, so that one should never aim to cause an innocent person's death by act or omission" in *Re A* [2000] 4 All ER 961 at 1000.
[154] Keown 2002 at 52.
[155] Wicks 2009 at 417.

seen further decline. Consequently, as we see fewer adherents of the Christian religion, we see a decline in support of the doctrine of the sanctity of life. A theory which requires faith for credibility becomes much less persuasive when belief diminishes.

5.3.2 The Non-Religious Sanctity of Life Position

Although the sanctity of life doctrine finds its origins in religion, there are also secular understandings of the principle that hold human life to be intrinsically valuable, thus, avoiding the above criticism. Most famously, Keown attempts to outline three positions which value human life, in order to advocate his own support for the sanctity of life.

Firstly, vitalism holds that human life is an absolute good, something which all other basic goods must be sacrificed in order to preserve. Therefore, Keown explains, "it is wrong either to shorten the life of a patient or to fail to strive to lengthen it".[156] Quite simply, vitalism requires human life be preserved at all costs. Secondly, the sanctity of life/inviolability of life view is similar to that discussed above in relation to the religious approach to sanctity of life in holding that it is always wrong to intentionally take the life of another innocent human being.[157] However, there is no duty (unlike with vitalism) to preserve life at all costs, treatment can be withheld or withdrawn where it is futile or excessively burdensome. Lastly, the Quality of Life position is explained. What is essential for adherents of the Quality of Life position is whether an individual's life is worthwhile. Keown explains that there is a quality threshold, and when a life is no longer worth living, it slips below this threshold and can permissibly be ended.[158]

It must be noted that the sanctity of life position makes an assessment of the quality of the patient's life before and after the proposed treatment, in order to ascertain whether the treatment would be worthwhile. In contrast, the Quality of life position seeks to assess the quality of the patient's life in order to determine *whether*

[156] Keown 2002 at 39.
[157] Note that these two terms will be used interchangeably, as Keown refers to the Sanctity of Life in 'Beyond Bland: a critique of the BMA guidance on withholding and withdrawing medical treatment' 20 *Legal Studies* 66-84; 'Restoring the sanctity of life and replacing the caricature: a reply to David Price' 26 *Legal Studies* 109-119 but as the Inviolability of Life in *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation.* (Cambridge: Cambridge University Press).
[158] Keown 2002 at 43.

their life is worthwhile. In order to clarify this distinction, Keown refers to the former as 'q'uality of life and the latter as 'Q'uality of life, a diction which will be adopted here to aid analysis. Keown then provides the following examples to illustrate the benefits of the sanctity of life position, and show the weaknesses of the other two positions.

In "Mary's Case", an elderly lady with terminal coronary disease is admitted to hospital after her third heart attack.[159] She is likely to suffer more heart attacks in the very near future and a decision is needed as to whether cardio-pulmonary resuscitation (CPR) should be used or omitted when this occurs. Due to Mary's senile dementia, she lacks the capacity to make such a decision and so three doctors come together to discuss which path to take. Keown presents Dr (V)italism and Dr (Q)uality of life as extreme positions and Dr (I)nviolability of life as the "ethical middle way".[160]

In response to Mary's situation, Dr V explains that human life should be preserved at all costs and so CPR *should* be administered following any subsequent heart attacks. Dr Q explains that human life should only be preserved where it is worthwhile, and because Mary has lost the ability to think rationally, her life is no longer worthwhile. Thus, Dr Q decides that the CPR should not be administered and Mary should be allowed to die. Dr I explains that human life should never intentionally be taken, but there is no duty to preserve life at all costs. So where treatment would be futile or excessively burdensome, it need not be carried out. As Mary is dying, Dr I feels the CPR would be futile and so should be withheld.

In the second hypothetical story, "Angela's Case", (which is strikingly reminiscent of the case of Re B[161]) a baby with Down's syndrome has been diagnosed with an intestinal blockage which will result in her death without a surgical operation to remove it.[162] Dr V again advocates that life should be preserved at all costs, so the operation should go ahead and Angela will live. Dr Q opines that a life with Down's syndrome lacks quality and is not worth living, and thus, the operation should not go ahead and Angela will die. Finally, Dr I advises that, as the treatment will have minimal burdens and will clearly benefit the girl by saving her life, the treatment should go ahead.

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[159] A hypothetical story used by Keown 2002 at 45-48.
[160] *Ibid* at 46.
[161] [1990] 3 All E.R. 927.
[162] A second hypothetical story in Keown 2002 at 48-49.

5.3.3 A Valid Defence?

Using this approach then, the current legal position could potentially be defended with reference to the sanctity of life doctrine. For this to be a satisfactory defence, the situations where individuals are legally permitted to end life must not involve "the intentional taking of an innocent human life", and assisting the suicide of another must involve this practice. However, the distinctions used to differentiate between permitted and prohibited practices collapse under any real scrutiny. Many of the distinctions are arbitrary (such as act/omission or intent/foresight), whereas others are so complex and contested that they would be almost impossible to apply to the law in practice, for example the 'Q'/'q' dichotomy. The second criticism of the sanctity of life as a defence of the current legal unfairness, is that there exist several situations where the intentional taking of human life *is* legally permitted. This evidences that the law is incompatible with the sanctity of life viewpoint regarding its position on end of life, and thus, this doctrine cannot justify the legal position which unfairly provides some with the power to determine their own end and prohibits others that same power.

5.3.3.1 Arbitrary and Unworkable Distinctions

Arbitrary Distinctions

Chapter Two explored the law regarding refusal of life-sustaining medical treatment to show that every competent patient has the right to refuse such treatment, even where their death will result.[163] In fact, doctors in this position are legally required to comply with such a refusal. Surely then, we are once again facing a situation where the law permits the intentional taking of an innocent human life, contradicting the sanctity of life position.

However, as discussed in the previous part of this thesis, proponents of the sanctity of life view argue that the withholding or withdrawing of life-sustaining medical treatment from a patient, where it is certain death will result, *is* compatible with this doctrine. While it is accepted, as the Courts did in *Airedale NHS Trust v*

[163] *Re T* [1993] Fam. 95.

Bland,[164] that the doctor's behaviour in such cases is certainly intentional, the controversial question is whether the doctor is actually *killing* the patient. The justification for this law is that withholding or withdrawing treatment is an omission, not an action, and thus, the doctor is not killing the patient. As a result, there is no intentional killing of another innocent human being, nature is simply allowed to take its course. The act/omission distinction allows proponents of the sanctity of life to claim that the doctrine remains intact despite the legal position permitting intentional killing.

The reality is that the distinction is not conceptually or morally valid. Conceptually, when withdrawing treatment, a doctor *is* performing an act and to suggest otherwise "does some considerable damage to the ordinary English usage".[165] Morally, although the classification of a behaviour as an act or an omission *can* affect its moral quality,[166] in this instance it does not. The doctor achieves the same end whether he removes treatment from a patient, or injects him directly with a lethal substance. In both cases, the patient's life is taken as a result of the doctor's behaviour and the doctor bears no extra risk in directly taking the life of the patient than doing the very same through removal of treatment. As argued in Chapter Two, the classification of the removal or withdrawal of medical treatment as an omission is arbitrary, "a useful fiction used by the courts to absolve medical professionals from criminal liability".[167] The law has used this arbitrary distinction between acts and omissions in order to categorise the withholding and withdrawing of life-sustaining medical treatment as legal, as doing so pushes this conduct outside of what is deemed unacceptable from the sanctity of life perspective.

Similarly, the law regarding the administration of fatal doses of palliative care uses an equally arbitrary distinction in order to render the behaviour compatible with the sanctity of life, and thus, render it legally permissible. As explained in Chapter Three, a doctor who administers a lethal dose of medication to a patient, in the knowledge that it will end life, acts lawfully providing that the treatment has a palliative effect. This is a result of the doctrine of double effect, the idea that an act which has both a positive and a negative outcome, may be permissible providing that the intention is to achieve the positive outcome and the negative is an unavoidable

[164] [1993] A.C. 789.
[165] Kennedy 1991 at 351.
[166] See Chapter Two.
[167] Williams 2008 at 94.

side effect. In this case the doctor must primarily intend the palliative effect of the drug, with death as an unintended yet foreseen consequence. As argued in Chapter Three, I suggest that the doctrine of double effect holds no moral weight. Whether the doctor intends or foresees the death of the patient in these cases, the consequence is the same, and as Harris suggests, what is morally relevant is the effect our actions or inactions have on the world.[168]

Again the law is using a legal fiction to arbitrarily permit certain types of end of life practices (requesting life-shortening medical treatment), yet prohibit others. The sanctity of life is yet again being used as a tool to draw a line between permissible and impermissible behaviours, but unfortunately, the position of this line cannot be properly justified.

Unworkable Distinctions

In addition to their arbitrary nature, the 'Q'/'q' dichotomy is an example of the complex nature of the distinctions made by the sanctity of life. On closer analysis of the dichotomy this difficulty is revealed as Keown himself misconceives the Quality of life position he seeks to reject. Secondly, when the moral basis of the distinction is unpacked, it is demonstrated that the line between quality of life and Quality of life is so hazy that it would be unworkable in practice. Finally, Keown fails in his examples, to address one, central issue – that most adherents of this position believe only the patient can assess whether their own life is worthwhile and thus, the patient must first request termination. For these reasons, the sanctity of life would be an extremely difficult principle for the law to follow in regulating end of life.

Keown Misconceives the 'Quality of life'

Keown's criticism of the Quality of life position, as advocated, is that it involves an assessment of the worthwhileness of a patient's life. Inevitably, such an analysis will, at times, result in the removal or withholding of treatment because a person's life is judged to "lack worth" or, more emotively, because the patient is "better off dead".[169] There are clear complications in allowing doctors to make such subjective

[168] Harris 1985 at 28-47.
[169] Keown 2002 at 78.

judgements. Such determinations do not afford equality to all (only to those deemed to have a certain Quality of life) and, as Keown rightly suggests, "the criteria identifying lives thought to lack benefit are inherently arbitrary and vague".[170] There is an added danger that, as advocated by disability rights activists, able-bodied persons in fact underestimate the quality of a disabled persons life.[171] The Quality of life position, viewed in this way, is inherently discriminatory, unfair and would produce inconsistent treatment decisions in patients with the same underlying condition.

However, in an intensive dialogue with Professor Keown, Professor Price suggests this conception of the Quality of life position is distorted, and "the idea that the QOL position somehow assesses the worth of individuals is fundamentally misconceived".[172] Rather, Price suggests that the Quality of life position merely takes into account the patient's life as a whole in assessing the validity of treatment. For example, in Mary's case (above), the terminal coronary disease, her age, fragility and likelihood of repeat heart attacks would be relevant to the assessment of whether to administer the CPR should she require it. These health issues are not only central to Mary's quality of life, but also fundamental to whether the treatment will be worthwhile *in improving her life*. Thus, the doctor will not be making a judgment about whether he believes her life is worthwhile, but about whether, given all the external circumstances, the treatment is likely to be of benefit. It appears that Price's depiction of the Quality of life position is actually an assessment of the worthwhileness of treatment, not of life, as Keown suggests. If this is the case, both the sanctity of life position and Quality of life position are judgments of the worthwhileness of treatment, yet the Quality of life assessment is much wider, including an assessment of underlying conditions or disabilities. Already, as Price presents an alternative and more persuasive explanation of the Quality of life position, the complexities of this distinction are revealing themselves.

'Q'uality of Life and 'q'uality of Life: A Blurred Distinction?

[170] *Ibid* at 251.
[171] Clements and Read 2008 at 100-101.
[172] Price 2007 at 563.

On Price's interpretation, what remains are two positions regarding the value of life which are not so straightforwardly antithetical. The Quality of life position is no longer as morally objectionable as it first appears. So the question is then raised – which, if either, of these positions are ethically defensible? When assessing whether to treat patients, should doctors refrain from taking into account other aspects of the patient's life (Quality of life), or should the doctor look solely to the worthwhileness of treatment at hand (sanctity of life)?

Price strongly advocates the inclusion of physical and mental disabilities when deciding whether to perform a particular treatment. In fact, he suggests that it is essential to do so, because in attempting to ignore these conditions the doctor is endeavouring to divorce the individual patient from the condition or treatment. He suggests,

> Treatment does not exist in a vacuum. This is an attempt to 'medicalise' such decisions and to (supposedly) sanitise them of any moral element, which is simply unrealistic quite apart from anything else.[173]

Price questions the practicality of making a treatment decision in isolation from the individual themselves, citing Rhoden, who questions, "Can decision makers really disregard handicaps of this magnitude?".[174] For this reason, Price contends that the "('q/Q's) dichotomy is false; it is not feasible to draw any bright line between such notions, either practically or ethically".[175]

In his response, Keown defends the q/Q dichotomy insisting that Price's claims are all "wide of the mark".[176] Rather than denying the appreciation of external conditions, Keown argues it is how the condition is taken into account that is ethically relevant: providing the assessment of the condition is used to ascertain the worthwhileness of treatment (and not worthwhileness of the patient's life) it is morally acceptable:

> It is not a question of *whether* the principle takes physical and mental disabilities into account but of *how* it takes them into account. Such disabilities may well be relevant

[173] Price 2001 at 625.
[174] *Ibid.*
[175] *Ibid* at 621.
[176] Keown 2006 at 110-111.

> in assessing the worthwhileness of a proposed treatment but the principle does not allow their use in and assessment of the supposed worthwhileness of a patient's life.[177]

In illustrating the validity of the distinction between 'Quality of life' and 'quality of life' assessments, Keown refers to the case of Angela, the baby born with both an intestinal blockage and Downs syndrome (discussed above). He forcefully suggests that there is surely a difference in choosing to treat the intestinal blockage because the treatment would be worthwhile (as it will save her life) as oppose to refusing to treat because the doctor does not judge a life with Downs syndrome to be worthwhile.

However, as Price rightly notes, it seems that Keown is rejecting *any* recognition of how Downs's syndrome impacts on the life of the individual.[178] Thus, contra Keown, for the sanctity of life position it is *not* a question of how the condition is taken into account, but *whether it is considered at all*. Another example presented by Keown gives further evidence for this point. Regarding a patient in Permanent Vegetative State (PVS), Keown explains that,

> given the patient's incapacitated condition and the inability of ventilation to restore them to health and well-functioning, ventilation would be futile. A decision to withhold or withdraw a treatment because it cannot restore the patient to health and well-functioning is not a decision that the patient lacks value.[179]

However, this extract highlights a fundamental flaw in Keown's reasoning. Why is it that in Angela's case Downs syndrome is not a relevant consideration as to whether the surgery to remove the blockage will be worthwhile, yet PVS *is* a relevant consideration when deciding whether to ventilate? The purpose of the surgery is to remove the blockage in the intestine and thus, save Angela's life. Equally, the ventilation is required to give oxygen to the patient and save their life. Why then, does Keown accept the recognition of the former condition but not the latter?

It appears that Keown's attempt to extricate judgments about the worthwhileness of treatment from their underlying condition or disability promptly fails when the condition is of such severity that it cannot be ignored. Surely then,

[177] Keown 2006 at 111.
[178] Price 2007 at 556.
[179] Keown 2006 at 113.

permitting an assessment of only those disabilities and conditions which are considered overwhelming is in fact a Quality of life judgment in itself? It appears we are back where we began, at Price's assertion that we cannot practicably separate judgements regarding underlying conditions and disabilities from the treatment at hand. Keown seems to have affirmed the very point he was attempting to disprove. The line between a quality of life judgment and a Quality of life judgment does not seem so clear.

In attacking the Quality of life position, it appears that Keown is, to invoke the common phrasing, 'calling the kettle black'. The sanctity of life doctrine asserts that the Quality of life position is arbitrary and unjust, but in taking into account some conditions and not others when ascertaining the worthwhileness of a proposed treatment, the sanctity of life position is guilty of these exact deficiencies. Surely it is more consistent and appropriate within the medical context to treat each patient as an individual, assessing his or her situation as a whole rather than, in a futile attempt to avoid judging the worthwhileness of a patient's life, arbitrarily acknowledging some disabilities and not others?

In conclusion, the above analysis of the dialogue between Professor Keown and Professor Price highlights that Keown's conception of the Quality of life is misconceived. When properly understood, the Quality of life position seeks to take into account underlying conditions and disabilities in treatment decisions, in an attempt to envisage the individual in their entirety, as oppose to focusing on the treatment question in isolation. What is more, the difficulties in separating out questions of 'q'uality of life from those of 'Q'uality of life have been exposed and the complications this presents for Keown's sanctity of life position have been revealed.

Keown Ignores Autonomy

Unfortunately, there is a final gaping flaw in Keown's illustrations: he uses only one, extremely unpopular approach to the Quality of life position. The Quality of life position focuses on the worthwhileness of a person's life, so when life is no longer deemed worthwhile, it can be ended either by act or omission. Keown fails in his examples, to address one, central issue – that most adherents of this position believe only the patient can assess whether their own life is worthwhile and thus, the patient

must first request termination. Thus, a doctor could not make a judgement regarding whether life is worth living. In fact, merely pages before, Keown admits that,

> Some who subscribe to this doctrine would require the patient's request as a precondition of termination on the ground that only the patient is in a position to judge whether life is still worth living.[180]

It is respectfully suggested that "Some" should be replaced with "Most". It is extremely difficult to find an academic, or indeed any person, who would agree that a doctor should intentionally end the life of any patient he feels is no longer worthwhile. If that was the case, your doctor could decide that because you suffer from severe autism, your life is not worth living, and intentionally take your life. Similarly, if you lost both legs in a car accident, another doctor could deem a life without walking, running and dancing as no longer worthwhile and end your life. Of course, there are very few, if any who would support this ideology, yet it is the one which Keown uses in his examples. In doing so, Keown is able to conceptualise the Quality of life doctrine as engaging in "discriminatory judgments, posited on arbitrary criteria such as physical or mental disability",[181] when in reality, most proponents of the Quality of life position only allow such judgements to be made entirely autonomously by the individual in question. Surely, then, Keown's criticism of the Quality of life position as arbitrary and unjust evaporate entirely when the question of whether life is worth living is left to the individual?

Keown quickly dismisses this suggestion, claiming that autonomous choices only warrant respect when they are in accordance with a framework of sound moral values.[182] He explains, "where the choice is immoral, whether because it would harm others or oneself, what claim to moral respect can it have?"[183] Therefore, as Keown sees taking life as harming oneself, this is immoral and should be prohibited. Subsequently, the Quality of life position which advocates autonomy as the deciding factor in ending life cannot stand up in face of this reasoning.

However, a substantial issue rests with the justification presented for respecting only morally desirable decisions. Keown takes an extremely narrow

[180] Keown 2002 at 44.
[181] *Ibid* at 47.
[182] *Ibid* at 53.
[183] *Ibid* at 54.

approach to the scope of autonomous decisions, making no distinction between decisions that harm others and those that do not. He suggests that *any* decision which is immoral should not warrant respect. The reasoning provided is: "The capacity to choose brings with it the responsibility of making not just any old choice, but choices that do in fact promote, rather than undermine, human flourishing".[184] However, Keown fails to explore this notion of 'human flourishing' in any depth. Rather than explain the reasons why only such choices should be respected, Keown proceeds to use extreme examples in order to make his point:

> Is there a 'right to choose… paedophilia'? Or a 'right to choose … cruelty to animals'? Does the mere fact that someone wants to blind ponies or have sex with children carry any moral weight?[185]

While these examples are emotive, they fail to explain why there is no difference between autonomous choices that harm another and those which do not. It is strongly suggested that a decision which causes harm to the self, e.g. assisted suicide, is entirely different to decisions which harm other living beings, e.g. paedophilia or animal cruelty. In failing to explore this distinction, or indeed explain his reasoning more fully, it is difficult to accept Keown's tight restrain on autonomy.

In sum, the distinctions made by the sanctity of life between permissible and impermissible behaviour at the end of life are extremely problematic. Those discussed in Part One of this thesis, and again in this chapter, cannot be fully justified, and thus, place arbitrary restrictions on end of life practices. The 'Q'/'q' dichotomy, when unpacked, is barely a dichotomy at all as the boundaries between the two assessments are blurred. What is more, this distinction is so complex that to use and apply it in the legal context would be almost impossible. For these reasons, the law regarding end of life could not be successfully governed by the sanctity of life doctrine, and the following section reveals this to be true – the current law is *not*, in fact, based on this principle.

[184] *Ibid* at 53.
[185] *Ibid* at 54.

5.3.3.2 The Law Permits the Intentional Taking of an Innocent Human Life

The second criticism of the sanctity of life as a defence of the current legal unfairness, is that the law in certain areas already permits the very behaviour the sanctity of life prohibits: the intentional taking of the life of another innocent human being. Abortion law is one area with which the sanctity of life doctrine is incompatible. Excluding situations where abortion is an unintended yet forseen consequence of another medical procedure, abortion is the *intentional* cessation of the life of the fetus. The more controversial question is whether abortion is the intentional taking of an innocent *human* life. If this is the case, and the fetus is classified as 'human', then the law permitting abortion directly contradicts the sanctity of life doctrine, which prohibits the intentional taking of an innocent human life. If the law contravenes this principle, then the sanctity of life cannot be used as a shield to defend the prohibition of assisted suicide. It is illogical to suggest the justification for the prohibition of assisted suicide is an adherence to the sanctity of life, when the law permits human life to be intentionally taken through specified grounds laid out in the Abortion Act 1967.

What is the definition of a human then? Is it a being that is biologically a member of *Homo sapiens*, or does the status of human require more, something that has all the qualities and functions of a rational being? This issue and the question of the moral status of the fetus are both extremely controversial, and there has been a wealth of academic literature discussing these issues in the medical debate surrounding abortion.[186] However, entering into such a debate directly is beyond the scope of this thesis; the most important issue to address is what is considered 'human' from the sanctity of life perspective – if the fetus *is* a human from this perspective, then abortion contravenes the sanctity of life. Although, as Pattinson highlights, "the duty-based camp is compatible with any criterion of moral status [of the fetus]", the sanctity of life position most commonly advocates that the definition of a human being is their humanity, their belonging to the species of *homo sapiens*.[187] Keown notes that while such a view has its roots in Judeo-Christian religion,

[186] For an extensive explanation of moral status of the fetus see Pattinson 2009 at 234-240.
[187] Pattinson 2009 at 238.

> with or without this theological underpinning, the doctrine that human life possesses an intrinsic dignity grounds the principle that one must never intentionally kill an innocent human being.[188]

Finnis attempts to explore this reasoning further, and explain *why* being a member of the Homo sapiens makes a moral difference. He suggests this is because,

> every living human being has this *radical capacity* for participating in the manner as a person – intelligently and freely – in human goods. That is, every living being which results from human conception and has the epigenetic primordia…of a human body normal enough to be the basis of some intellectual act is truly a human being, a human person.[189]

Thus, Finnis suggests, that a human being is having the *radical capacity* to think and act rationally. It is unimportant if the being in question cannot actually think or act in this way, for example infants or those who are mentally disabled. It is the potential to do so that is key. Keown explains while you may never learn to speak Swahili, as a member of the human race you have the innate capacity to do so.[190]

However, as suggested by Beyleveld and Brownsword, the term 'radical capacity', used by Finnis, must be referring to some kind of 'species potential' if it is to apply to all biological human beings.[191] While the idea that all those who have the potential to become a member of a species (in this case, Homo sapiens) explains why adherents of the sanctity of life prohibit abortion, Finnis' explanation does little more than this. The ideas of 'radical capacity' and 'species potential' do not, as the literature suggests, provide a justification for the view that the fetus counts. On this analysis then, the sanctity of life position does little to explain the moral reasoning behind the status of the fetus.

Nevertheless, although not fully reasoned, the sanctity of life position on the status of the fetus is the one which must be applied. Taking this suggestion that "humanity is one's capacity to live the life, not of a carrot or a cat, but of a human

[188] Keown 2002 at 40.
[189] Finnis 1995 at 31. Emphasis added.
[190] Keown 2002 at 40.
[191] Beyleveld and Brownsword 2001 at 262.

being", an unborn fetus is a human being.[192] While it may not have rational abilities such as autonomy and understanding, the fetus has the *capacity* to act in this way in the future, and thus, according to the sanctity of life perspective, a fetus *is* a human. Consequently, abortion is the intentional taking of an innocent human life, a conflict with the sanctity of life position. What is more, this is not the only area of law where intentional killing of innocent human being is permitted.

A second instance were the law permits the intentional taking of innocent human life, is taking the life of one's self, suicide. To briefly recap Chapter Four of this thesis, s.1 of the Suicide Act 1961 decriminalised suicide, not to encourage or condone such behaviour, but in order to discourage it.[193] The parliamentary reports show that in the 1960s, suicide was still considered a "mortal sin", and thus, its decriminalisation "in no way lessens, nor should it lessen, the respect for the sanctity of human life which we all share".[194] Keown's claim that suicide remains unlawful despite s.1 of the Act, was proven in the previous part of this thesis to be nonsensical.[195] By definition, a behaviour that is 'unlawful' must contravene some criminal or civil standard, yet committing or attempting to commit suicide has no legal ramifications whatsoever. The reality is, whether suicide is viewed as undesirable or not, the law permits the intentional taking of one's own life.

This again illustrates that the law cannot defend the current legal unfairness with reference to the doctrine of the sanctity of life. This doctrine prohibits the intentional taking of an innocent human life, and suicide is exactly that. The law, in permitting suicide, directly contradicts the sanctity of life position with regard to end of life.

In sum, this section has revealed that the sanctity of life argument is flawed as it is based on arbitrary distinctions. Both the act/omission distinction and the doctrine of double effect rely on morally irrelevant criteria, thus fuelling the unfairness exposed in Part One of this thesis. What is more, the sanctity of life doctrine cannot be used to justify the current legal unfairness at end of life, as both abortion legislation and the decriminalisation of suicide demonstrate that the law permits the intentional killing of another innocent human. Thus, the prohibition of assisted suicide cannot logically be

[192] Finnis 1995 at 30.
[193] See Chapter Four in particular pages 30-31.
[194] Mr Charles Fletcher-Cooke MP (1960-1) 645 Parl. Deb, HC, cols. 822-3.
[195] See Chapter Four page 31.

defended with reference to the sanctity of life, given that in other areas of law the doctrine is completely undermined. A school cannot logically prohibit girls smoking cigarettes with reference to the promotion of a healthy lifestyle, if it contradictorily permits boys to smoke.

5.4 Summary

It has been established that the 'rights of the self' arguments presented in this chapter are either flawed or underdeveloped, and thus, are not sufficient to defend the current unfair legal position which permits some end of life choices yet arbitrarily prohibits others. In its current undefined state, the human dignity as constraint approach contributes very little to the debate surrounding end of life. Moreover, modern understandings of what constitutes 'human dignity' suggest that this position is incompatible with the current law.

While the sanctity of life view is more extensive, this position also struggles to defend the current unfairness with regard to ending one's own life. The doctrine itself makes use of arbitrary distinctions to define permissible and impermissible end of life situations. Moreover, the position itself is incompatible with the current law in other areas. Adherents of the sanctity of life prohibit the intentional killing of an innocent human being, yet an examination of both the Abortion Act 1967 and s.1 of the Suicide Act 1961 show that the current law permits just that. For these reasons, both the broader human dignity approach and the sanctity of life position fail to adequately justify the unfair legal position outlined in Part One of this thesis.

6.
AN APPEAL TO THE RIGHTS OF OTHERS

6.1 Introduction

Arguments which appeal to the rights of others take various forms, however, this chapter aims to focus on one particular type of "rights of others" claim. The colourful metaphors used to illustrate this argument are many and varied – "The camel's nose is in the tent", "a foot in the door", "give an inch and they will take a mile", "opening the floodgates" and "the thin end of the wedge".[196] Those in the legal sphere will perhaps be more familiar with the fear of a "slippery slope". Despite their euphemistic disguises, each phrase refers to the same course of action. The idea is that a particular unobjectionable, or even desirable practice (A), should nevertheless remain prohibited, because allowance of A may lead to an undesirable activity or activities (B). This is an extremely basic outline of the structure of a slippery slope argument, and as Smith notes, there may be "several intervening steps before we get to the actual bad consequence."[197]

The slippery slope argument is commonly invoked in many areas, but is perhaps most frequently utilised in the legal sphere, given the future-orientated focus of legislation. This philosophical argument anticipates how the decisions we make now will affect future practices, and thus, is particularly relevant in this debate as the law is perhaps the most prominent decision-making tool used to shape the future.[198] Thus, reference to the slippery slope can be found in a wide range of legal discourse, ranging from human rights law[199] to the medical context,[200] and in particular with regard to end of life decisions.

[196] See Schauer 1985 at 361.
[197] Smith 2005a at 19.
[198] See Schauer 1985 at 382-383.
[199] In particular the debate surrounding freedom of speech. See Schauer 1985.
[200] The slippery slope arguments can be seen emerging in numerous debates regarding medical ethics. For example, the abortion debate (see Keown 2002 at 71-72); the debate regarding reproductive technologies (see Pattinson 2009 at 292-293).

In transferring the slippery slope principle to end of life situations, the argument follows that although assisting in the suicide of another may be an acceptable behaviour in some situations; such a practice should remain prohibited, as legalisation may result in other undesirable types of death. Proponents of the slippery slope allude to numerous negative consequences of permitting assisted suicide, the most extreme being a return to the Nazi-style death camps.[201] More moderately, Keown has suggested that allowing autonomously requested assisted suicide may lead to less acceptable forms of death. The first is non-voluntary active euthanasia (hereafter NVAE) where a doctor takes the life of a patient who is not competent to make such a request. The second is involuntary active euthanasia (hereafter IVAE), where a doctor takes the life of a patient, without their request, where the patient would have been competent to make such a decision.

Part One established that the current law governing end of life decisions is unfair, as it permits certain decisions regarding how and when to end life, but arbitrarily prohibits others. This chapter seeks to ascertain whether such unfairness can be justified by an appeal to the 'rights of others'. This is the contention that although permitting assisted suicide may be beneficial for a particular class of individuals; this practice must be prohibited in order to protect the rights of others in society. This is essentially a claim to the slippery slope, and thus, this section seeks to unpick this argument in order to illustrate that it can hold no weight in defending the current legal position.

John Keown is a particularly prominent academic in the slippery slope arena and his work gives a deep and intellectual insight into this phenomenon.[202] Thus, this chapter uses his understanding of the two types of slippery slope in order to examine the principle more closely. Firstly then, a discussion of both the logical and empirical arms will evidence their fundamental flaws. However, even if it could be proven that there is a risk of a slippery slope movement, the simple existence of this risk is not in itself enough to justify a complete prohibition on assisted suicide. It must be demonstrated that the feared end result is *worse* than the current harm caused by legal proscription. Consequently, the next section will attempt to make such a comparison of the corresponding harms and in doing so will reveal that it is *not* the case that the harms outweigh the benefits. Finally, an analysis of the current law will illustrate that

[201] As noted by Smith 2005a at 23.
[202] Keown 2002 at 70-80.

the slippery slope argument cannot consistently defend the legal unfairness, because a variety of end of life decisions which hold the same risks of abuse are nevertheless legally permissible, despite a lack of safeguarding.

6.2 The Logical Slippery Slope

Through the logical slippery slope argument, Keown claims that a slide from voluntary active euthanasia to NVAE or IVAE is unavoidable, "because the case for euthanasia with those limitations is also, logically, a case for euthanasia without them".[203] Keown explains that if assisted suicide were permitted, a patient would autonomously request assistance from their doctor, who would assess whether the request should be granted. He argues that in making this assessment, doctors would essentially be required to determine whether the patient would be "better off dead".[204] Without such a judgment, the patient's request would not be granted, and for this reason, Keown conceptualises the doctor's conduct as pivotal in the end of life process. He explains,

> the real, rather than the rhetorical, justification for VAE is not the patient's autonomous request *but the doctor's judgment that the request is justified because death would benefit the patient.*[205]

Keown then suggests that if the autonomous request is merely a trigger to the doctor's judgment, it is thus an unimportant requirement that would soon be disposed of.[206] He claims that if assisted suicide were legalised, it would soon be argued that such practices should extend to the incompetent: if doctors have the ability and power to make judgment about the value of their patients' lives when competent, why should this ability and power not extend to the incompetent? The doctor's decision-making could even extend to competent patients who *do not* request it. Keown uses a hypothetical example to bring his argument to life. Dr A has two patients who are identical twins, X and Y. They are both suffering from painful terminal illnesses and are suffering the to the same degree. X is competent and requests Dr A inject him

[203] *Ibid* at 76. (Original italics removed).
[204] *Ibid* at 76.
[205] *Ibid* at 77.
[206] *Ibid*.

with a fatal dose of potassium chloride to end his life. Y is incompetent, and so X requests the same treatment on Y's behalf, given that Y must too be suffering unbearably. Keown asks: "Is Dr A to deny Y the same benefit he has agreed to confer on X?".[207]

Nevertheless, the most obvious response to such an argument is this: it is the autonomous wish of the patient, and not the doctor's assessment, which is pivotal in the decision-making process. The autonomy of the patient is central and without its existence, assisted suicide would not be permitted. For this reason, assisted suicide could not be extended to an incompetent patient such as Y, given that they do not have the mental capabilities to make such a request. Thus, autonomy provides a foothold which prevents a slide down the slope.

However, Keown anticipated such a challenge and in response developed a counter argument, questioning, "if VAE is justified by respect for self-determination, how can it be right to deny any patient who autonomously asks for [assisted suicide] whether or not they are experiencing 'unbearable suffering'?"[208] Thus, if the importance is shifted from the doctor to the patient, and autonomy is then the central moral requirement, there is nothing to prevent a slide down the other side of the slope, allowing assisted suicide to any person who autonomously requests it. Smith highlights how Keown sought to "trap supporters of euthanasia legislation" in presenting his argument in this way.[209] Whether the reader places emphasis on the doctor's role or the patient's request, "Keown has provided an argument that the acceptance of VAE or PAS will lead logically to the acceptance of arguments that few would endorse".[210]

If the logical slippery slope argument presented by Keown can withstand examination (assuming it is accepted that NVAE and IVAE are undesirable endpoints) then it could potentially provide a justification for the current legal unfairness. Assisted suicide would have to remain prohibited as legalisation would logically lead to other undesirable practices.

However, the logical argument is fundamentally flawed, for three reasons, The first is that it is misconceptualised as a slippery slope argument. Secondly, Keown overlooks an obvious solution to the problem his argument poses, and finally, Keown

[207] *Ibid* at 78.
[208] *Ibid* at 79.
[209] Smith 2005b at 228.
[210] *Ibid* at 228-229.

assumes that doctors must necessarily be making a judgment about the value of a patient's life.

6.2.1 Misconceptualised

The first, and most central criticism, is that the logical slippery slope argument is misconceptualised as a slippery slope claim. For an argument to be classified as such, the acceptable practice (A) must be different from the feared outcome (B).[211] The very nature of a slope connotes a downward movement from one set of acceptable circumstances to another set of unacceptable circumstances. If the practice at the top is the same as that at the bottom, we would be dealing something very different, a level surface. However, in this case Keown argues that VAE and NVAE should logically be treated the same because the doctor's role is the same in both circumstances. Smith agrees, "It is because they are the same that Keown suggests that they should be treated in the same manner. In fact, if they were different, Keown's argument would lose all of its force".[212] For this reason, Keown's logical argument is better conceptualised as "argument from consistency".[213] The value of reconfiguring the argument is that any further evaluation can be appropriately and effectively made.

6.2.2 An Obvious Solution

Even when reconfigured as an argument from consistency the logical case is deeply defective. If undesirable consequences arise when placing sole importance on either the autonomous choice of the patient or the decision-making capacity of the doctor, then a potential solution is glaringly obvious – quite simply, moral weight should be afforded to *both* the patient's request *and* the doctor's decision. Each condition is individually necessary for the permissibility of assisted suicide, but they must both be present if they are to be sufficient.[214] Smith explains that Keown has confused a necessary condition and a sufficient condition in the development of the logical

[211] Schauer agrees, explaining that "the slippery slope argument responds to an asserted difference between the instant case [practice A] and the danger cases [practice B]" Schauer 1985 at 369.
[212] Smith 2005b at 230.
[213] *Ibid* at 229.
[214] Lillehammer 2002 argues this very point in his article.

argument, as he treats each individual condition as solely sufficient for assisted suicide to proceed.[215] In fact, I suggest that both conditions must necessarily be present.

If we return to Keown's original presentation of the logical argument, he classifies the patient's request as merely "a trigger" and appears to suggest that for this reason it is unimportant and would eventually be overlooked, causing the slide down the slippery slope.[216] However, I respectfully suggest that to claim the patient's request will eventually be disregarded because it is a trigger, is a *non sequitur*. In fact, the very nature of a trigger suggests that it is *necessary* for the proceeding actions to occur. The dictionary definition describes a trigger as any event that sets a course of action in motion.[217] Without the stimulus of the patient's request, the doctor cannot make any judgment, as his role is simply not initiated. Furthermore, to describe the patient's request as "not decisive" is also misleading.[218] While it is not *the* final deciding factor, it is nevertheless *a* deciding factor. Keown suggests that because the autonomous request does not come second, it is somehow less important, but this is not the case. The patient's request is required before the doctor's role can even commence.

6.2.3 Doctors Will Not Necessarily be Assessing the Worth of a Patient's Life

There is one final criticism of the logical argument I wish to make. Keown assumes that the doctor will necessarily be making a decision about the value and worth of a patient's life before providing them with assistance in suicide. As "doctors are not robots who mindlessly comply with their patients' wishes" they will unavoidably make a judgment of this nature.[219] Moreover, Keown asserts that this must be the function of the doctor, because if the role were confined to assessing whether a patient's request was autonomous, a psychologist or councillor could easily discharge the same function.[220] However, as Smith notes, this argument is weak.[221] Given the close relationship between doctor and patient, especially in situations where there is a

[215] Smith 2005b at 231-232.
[216] Keown 2002 at 77.
[217] *Collins English Dictionary and Thesaurus* (2000) (2nd edn, Glasgow: HarperCollins) at 1276.
[218] Keown 2002 at 77.
[219] *Ibid* at 77.
[220] *Ibid* at 78.
[221] Smith 2005b.

long, protracted illness, the doctor is often extremely well placed to assess the patient's request. Arguably, other healthcare professionals involved in the day-to-day care of the patient may be in an even better position to assess the request. Nevertheless, a doctor is likely to understand the request and whether it is based in autonomous choice much better than a stranger such as a councillor or psychologist who has had no previous dealings with the patient. For this reason is it perfectly reasonable to assume that the role of the doctor will be to assess the autonomous request of the patient, and not whether that patient is "better off dead".[222] If this is the case, the doctor does not possess the transferable power to make judgments about the quality of life, thus preventing a slide to NVAE.

In sum, aside from being misclassified as a slippery slope claim, the logical argument is fundamentally flawed. Keown assumes that the patient's request and the doctor's decision are sufficient, rather than necessary conditions, and thus, when sole importance is attached to either of these claims a fear of a slide down the slippery slope materialises. Fortunately however, I hope to have demonstrated that the solution is simple. If both conditions must be present for assisted suicide to proceed, any risk of a slip towards undesirable end of life practices is remedied. Moreover, the role of the doctor would be confined to an assessment of whether the patient has made an autonomous request, and thus, there is no logical link to suggest that doctors would soon begin to administer assisted suicide to non-competent patients who are unable to make such a request. Thus, Keown's logical slippery slope argument fails, and accordingly, cannot justify the current legal unfairness.

6.3 The Empirical Slippery Slope

Through the empirical slippery slope argument, Keown claims that a slide from voluntary active euthanasia to NVAE or IVAE is unavoidable, because "safeguards to prevent it cannot be made effective".[223] Unfortunately, Keown gives minimal explanation as to why safeguards cannot be successfully enforced, merely suggesting that "perhaps" doctors will break away from regulation for various reasons – they may fail to oversee whether requests are being autonomously made; they may lack the

[222] Keown 2002 at 78.
[223] *Ibid* at 72.

relevant psychiatric expertise; they may lack time and resources; doctors may misdiagnose patients; societal attitudes may change.[224] Keown attempts to illustrate his claim through presenting an analogy with abortion practices in the UK to provide evidence of the existence of this type of slippery slope.

6.3.1 Abortion

Until the Abortion Act 1967 was passed in October of that year, abortion on most grounds was illegal in the UK.[225] Opponents of legal change appealed to a slippery slope argument: it is wrong to permit abortion on health grounds, because in doing so, there will be a slide towards permitting abortion on social grounds. Seven years after legalisation, Dr John Habgood, the then Bishop of Durham, explained how legalisation of abortion has caused a slide to the bottom of the slope as doctors regularly ignore the safeguards and abortion is frequently permitted on social grounds.[226] In application to the end of life context, the Bishop warned of "similarly far-reaching and potentially more dangerous consequences from legalised euthanasia".[227]

However, the argument that abortion provides evidence of the slippery slope is not so straightforward. It is widely accepted that before the legislation permitting abortion on various grounds, backstreet abortions were commonplace. Such practices were extremely dangerous, often resulting in damage to the health of the woman or even in her death.[228] The motivations behind seeking illegal abortions were not only confined to medical and health reasons: women commonly sought abortions for social reasons too. For example, many women already had big families and could not afford to have more children.[229] Such evidence suggests, contrary to Dr John Habgood's assertion, that abortion on social grounds was already being performed years before

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[224] *Ibid* at 73.
[225] Section 58 of the Offences Against the Person Act 1861 makes it a criminal offence to unlawfully and intentionally attempt to procure a miscarriage; s.1(1) Infant Life Preservation Act 1929 creates the offence of "child destruction" which is the intentional destruction of a child "capable of being born alive" (providing the act is not carried out in good faith to preserve the life of the mother).
[226] Habgood 1974 at 126.
[227] *Ibid* at 126.
[228] In 1966 the Home Office estimated that around 100,000 illegal abortions were being performed each year. http://www.efc.org.uk/Foryoungpeople/Factsaboutabortion/Unsafeabortion <accessed 29/05/2011>.
[229] See http://www.efc.org.uk/Foryoungpeople/Factsaboutabortion/Unsafeabortion <accessed 29/05/2011>.

the Abortion Act 1967. Therefore, the Act cannot straightforwardly be said to have resulted in the practice of abortion for social reasons.

However, even if it could be shown that the number of social abortions did increase after the Act was introduced, this evidence alone is not enough to prove the existence of a slide down the slippery slope. For the existence of such a slide to be revealed, it must be proven that the Act *caused* this increase. It is possible that external factors caused this increase in abortion for social reasons, for example, an increase in social acceptance of this practice or a decline in the quality of contraceptive education. Pattinson touches on this idea of causation when he questions whether the Act did not, in fact, bring about a change in social attitudes (and thus cause an increase in social abortion) but whether "wider acceptance of abortion lead to the Act"?[230] Unless it can be shown that the Act caused the increase in social abortions, Habgood's argument fails.

Furthermore, the difficulty in obtaining empirical evidence proving that the Act caused the increase, is extremely problematic. Conducting a social study which can control all extraneous variables is, without breaching ethical standards, extremely difficult. Thus, the possibility of obtaining such objective evidence is extremely unlikely (this issue is discussed further in the next section). What is more, transferring these findings to an end of life context is not uncomplicated. Abortion and end of life are two very different subject areas, for example, while the ethical debate surrounding abortion is split regarding the moral status of the fetus,[231] an individual requesting assisted suicide, (provided they have capacity) will always be 'full status' and able to make a request. For this reason, the Select Committee have agreed that public reaction to the legalisation of assisted suicide would be different to that of abortion, as there is "unlikely to be the same degree of pressure to exploit loopholes" in law permitting assisted suicide because as humans we have "a natural desire to stay alive".[232] In order to successfully argue that abortion can provide a comparison for end of life, more is needed than Habgood's assumption that the experiences of one can be so unquestionably mapped onto the other.

[230] Pattinson 2009 at 567.
[231] *Ibid* at 251.
[232] Select Committee 2004-05 at [95].

6.3.2 Other Jurisdictions

Keown makes a second analogy in an attempt to demonstrate that a slide down the slippery slope cannot be prevented. A sizeable portion of his book, *Euthanasia, Ethics and Public Policy* focuses on gathering and analysing data collected in the Netherlands, where assisted suicide is legal.[233] From around 1970, case law developed to allow a physician to use the defence of necessity when terminating the life of a patient on request, or assisting in their death and eventually this position was codified in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act passed in April 2001, making the Netherlands the first nation to legally condone such practices. As such, three surveys have taken place in 1990, 1995 and 2001 in order to assess the impact of the legislation, the results of which Keown uses to illustrate existence of the empirical slippery slope. The 1990 study revealed 1000 cases where life has been shortened without explicit request – NVAE or IVAE. In response, Twycross contends that this "demonstrates beyond reasonable doubt that in the Netherlands the slippery slope is already a reality"[234] and Keown agrees claiming that "for inhabitants of such a flat country the Dutch have proved remarkably fast skiers".[235]

However, the value of such empirical data is extremely exaggerated by Keown. In analysing the three Dutch studies and a further two studies, I hope to demonstrate the problematic nature of attempting to obtain sound statistical evidence of an empirical slippery slope. To begin with Keown and Twcross' analysis of the 1990 study, the obvious response is that a single statistic cannot possibly show evidence of a slippery slope, by its very nature. A slope is a movement, a decline, from one set of circumstances to another and consequently, in order to prove its existence, figures must be taken from at least two separate points in time. Moreover, when compared with the later years, the surveys fail to even evidence a *rise* in the number of IVAE or NVAE over the eleven year period. Instead, the studies show these numbers have remained steady; in 1990 0.8% of assisted deaths were conducted without an explicit request, 0.7% in 1995 and 0.7% in 2001.[236] Keown challenges these figures, claiming that due to differing definitions of 'euthanasia' and inaccurate

[233] Keown 2002 at 81-136.
[234] Twycross 1995 at 160.
[235] Finnis 1995 at 26.
[236] Smith 2005a at 33.

accounts, the number is likely to be much higher.[237] Admittedly the studies are limited and cannot be conclusive, however, even if the actual numbers of IVAE and NVAE were much higher than those reported, as Keown suggests, we are still no nearer to establishing support for the empirical slippery slope. To do this, there would need to be a comparison of the number of NVAE and IVAE *before* assisted suicide became permissible, with the figures post-legalisation.[238] Only if such a comparison demonstrated a rise in the number of NVAE and IVAE cases after legalisation, would we be any closer to revealing the existence of an empirical slippery slope. At this time, however, no such statistical data is available, and the figures as they stand do little more than show the existence of NVAE and IVAE practices in the Netherlands.

Furthermore, the Kuhse-Singer Survey published in 1997 reported that the number of incidents of NVAE was in fact higher in Australia, a country where voluntary euthanasia is illegal, than in the Netherlands, where voluntary euthanasia is legal.[239] The study compared these two countries as they have similar populations and death rates and similar standards were used in questioning as were employed in the Dutch studies.[240] On analysing this outcome, it has been suggested that this study undermines the credibility of the empirical slippery slope as the legality of voluntary euthanasia appears to have no effect on the number of incidents of NVAE.[241] If the danger of a slippery slope were real, we would expect the Netherlands to have a higher number of NVAE cases in comparison to Australia, where voluntary euthanasia is illegal; otherwise there is no justification for such prohibition. Thus, the Voluntary Euthanasia Society of Victoria claims that the Kuhse-Singer Study findings "undermine the so-called slippery slope arguments".[242]

However, this interpretation of the Kuhse-Singer study has been open to criticism. Bagaric suggests that the study shows exactly the opposite – it "in fact supports the slippery slope argument".[243] In Australia, although voluntary euthanasia practices are prohibited in theory, in reality no doctor is ever prosecuted for such

[237] Keown 2002 see Chapter Nine.
[238] Otlowski 1997 at 439.
[239] Kuhse, Singer, Braume, Clark and Rickard 1997.
[240] Bagaric 2002 at 234-235.
[241] For example see Otlowski, "the practice of bringing about death without explicit request is much more widespread in Australia – a country where the practice of active voluntary euthanasia is prohibited – than it is in the Netherlands where the practice has been quasi-legalized and is regulated" in Otlowski 2000 at *xiv*.
[242] Bagaric 2002 at 235.
[243] *Ibid* at 232.

behaviour. In fact, out of the 6,700 illegal cases reported in the Kuhse-Singer study, not one faced prosecution.[244] Thus, Bagaric explains:

> In substance the law prohibiting euthanasia by doctors is not enforced and the legal situation at the time of the survey was not in any meaningful respect different to that in the Netherlands during the times of the relevant surveys.[245]

As a result,

> The Kuhse-Singer survey in fact supports the slippery slope argument. It provides another piece of evidence that in an environment where euthanasia is condoned, there is a significant level of abuse by doctors in relation to end-of-life decisions.[246]

While it is accepted that the study fails to undermine the slippery slope due to the lax Australian approach to prosecution of voluntary euthanasia, it is by no means accepted that the Kuhse-Singer survey provides support for the empirical slippery slope. A slippery slope refers to a process of circumstances getting worse. While the survey illustrates the level of NVAE or IVAE when voluntary euthanasia is condoned, a comparison of a proscriptive environment is still lacking. Again, this survey fails to either prove or disprove the existence of an empirical slippery slope.

However, Willems et al. succeeded in making such a comparison between a country where voluntary euthanasia is prohibited and one where it is permitted, albeit a comparison of attitudes, as opposed to levels of NVAE and IVAE.[247] This study compared attitudes to end of life decisions of physicians in the US (which criminalises assisted suicide in all but one of the states) and physicians in the Netherlands. Surprisingly, given the difference in legislative positions, the findings indicate extreme similarities between the attitudes of doctors in the two countries. This directly contradicts Keown's assertion that the legalisation of assisted suicide would result in a change in social attitudes (as he claims was the case with legalisation of abortion), as both countries project a similar outlook on end of life practices despite legalisation in the Netherlands. Consequently, Smith has highlighted

[244] *Ibid* at 236 (number 6,700 approximate).
[245] *Ibid* at 236.
[246] Bagaric 2002 at 239.
[247] Willems et al. 2000.

that, "this study provides some evidence *against* the practical slippery slope based on a change in attitudes".[248] However, again this study merely assesses the attitudes of a limited number of physicians from a small sample of just two countries. Thus, this study is also limited and cannot conclusively disprove the existence of a logical slippery slope.

After analysing this range of studies and illuminating their flaws, I hope to have revealed the difficulty of establishing convincing empirical evidence of a slippery slope. Given that every study is different, using varying methods, study groups, definitions and variables, it is almost impossible to make a comparison between them. What is more, given the extremely sensitive subject area and the stringent ethical guidelines attached to studies of this nature, creating an effective study is even more unlikely. As discussed briefly with regard to the abortion analogy,[249] without the power to control extraneous variables (something which I suggest is impossible without contravening ethical guidelines), we are unable to conduct a study which conclusively illustrates that allowing practice A directly *causes* negative practice B. The problematic nature of obtaining concrete 'objective' evidence is the Achilles' Heel of the empirical slippery slope argument.

6.4 The Bottom or the Top of the Slope: Which is Worse?

Presenting a slippery slope argument is not as simple as evidencing that a particular practice carries a risk. Once such a risk is established, it must then be demonstrated that the risk of the feared endpoint outweighs the current harms caused by the proscriptive legal position. Without this part of the analysis, almost every human activity could potentially be prohibited, given the ability to use almost anything for an immoral purpose. Pattinson explains that fire can be used to deliberately burn others, the World Wide Web can be used to distribute bomb-making instructions and germ–line therapy can provide evil dictators with a means of creating mass eugenics programmes.[250] However, each of these practices has far-reaching benefits which have the potential to outweigh such risks. As Pattinson explains:

[248] Smith 2005a at 27. Emphasis added.
[249] See above at 79-80.
[250] Pattinson 2009 at 16.

> Fire has the potential to prevent people from freezing, the World Wide Web has the potential to disseminate medical and educational information, and germ-line therapy has the potential to prevent some otherwise fatal conditions. If we ignore the potential benefits, then we become obliged to prohibit every new development. Such broad-brush claims would require regression to a state of being that is incompatible with human freedom of action, simply because human freedom enables the occurrence of immoral outcomes.[251]

Thus, in order to justify a complete prohibition on assisted suicide, merely asserting that such practices are risky is not enough; a deeper analysis of the potential harms is required. Emanuel has attempted to engage in such a discussion in his article, through comparing the potential benefits of legalising assisted suicide with the likely harms.[252] He seeks to ascertain the number of Americans who would benefit from legalisation, that is, the number of competent individuals suffering in pain, who wish to make the decision to end life:

> I estimate that each year, of the 2.3 million Americans who die, approximately 5,000 to 25,000 patients might have a distinct dying process with a significant and unremitting pain, desire euthanasia or PAS [physician-assisted suicide], and be competent to repeatedly request and consent to euthanasia or PAS.[253]

Subsequently, Emanuel seeks to contrast this number with the number of individuals who could potentially be pressured by such legislation, as they impose a financial or care giving burden upon both society and their family members:

> Among the 1 million competent patients with a dying process who might be eligible to request euthanasia or PAS, these data suggest that 86,000 to 24,000 impose a significant financial burden while 160,000 to 340,000 impose significant care giving burdens on their families.[254]

From this analysis Emanuel asserts that if just a small percentage of those who could potentially be pressured into ending their life prematurely were so coerced, this

[251] Pattinson 2009 at 16-17.
[252] Emanuel 1999.
[253] *Ibid* at 633.
[254] *Ibid* at 638.

number would easily equal, if not exceed the number of individuals who would benefit from legalisation. For this reason, he concludes that the likely harms of legalisation of assisted suicide outweigh the potential benefits, thus, the slippery slope argument prevails.

With respect, I have two major criticisms to make of Emanuel's work. Firstly, the figures Emanuel uses to come to his conclusions are questionable, often reached through a series of guesses. As his assertions are based on these numbers, his argument crumbles if they are proven to be inaccurate. Secondly, and perhaps more importantly, the harm done to those who desire assistance in their suicide is seriously underplayed. Situating ourselves at the top of the slope is causing a great deal of harm that is often overlooked. Thus, the ideas explored in Chapter Four again emerge, highlighting an opportunity to reconceptualise the situation of those prevented access to assistance and view end of life through the lens of Art.3 of the ECHR which prohibits inhumane and degrading treatment.

6.4.1 Numerical Speculation

The first criticism of Emanuel's paper is that the figures he uses largely emerge from guesswork. In estimating that only 5,000 to 25,000 people will benefit from legalisation, Emanuel's starting point was to establish how many people have a distinct and protracted dying process in which requesting assisted suicide would be possible. While he recognises that this number is unclear, Emanuel nevertheless provides his own "crude estimate" of 50 percent of all deaths.[255] No further explanation is given detailing why this number was chosen, a number I believe to be particularly low. An empirical study conducted just four years later indicates that the percentage is in fact higher: across six European countries, two-thirds of the population die from a distinct dying process.[256] In another study, solely focused on death patterns in the Netherlands, it was reported that seventy percent of all deaths have a distinct dying process.[257] Although it is possible that there will be some difference between patterns of death in Europe and the United States, given that the US is a particularly medically advanced country and has the ability to prolong life in

[255] *Ibid* at 632.
[256] Van der Hyde 2003.
[257] Paul van der Maas and colleagues, see Emanuel 1999.

similar ways utilised in Europe, the difference is not likely to be of the degree suggested by Emanuel. If we then refigure the number of Americans who die every year from a distinct dying process in accordance with the empirical data, the figure is closer to 1,610,000 people, 610,000 more than suggested. Emanuel makes other guesses, regarding the percentage of patients who die incompetent and the number of patients who are likely to request assistance in suicide, and consequently, the assertions he makes from the figures become substantially less compelling.[258]

Moreover, Emanuel quantifies the harms and the benefits by adding together the number of persons affected – a strictly utilitarian approach. However, such an attitude is problematic, as minor interests can be aggregated to outweigh a major one. To take a hypothetical example, imagine there are six surgeons and four patients, one patient requires a heart operation which would save his life and three other patients require minor surgery – the removal of an in growing toenail. The heart operation requires all six surgeons to be present, while the toenail removal requires two surgeons per patient. The surgeons have to decide which operations to undertake. In this case, if the benefits and harms were added in the way presented by Emanuel in his work on assisted suicide, the six surgeons must treat the three patients requiring toenail removal, even if this results in the death of the patient with a heart defect because three patients will benefit and just one will be harmed. Obviously aggregating minor interests to outweigh a major one is absurd; the harm committed in allowing a patient to die clearly outweighs the benefit of three patients successfully having a toenail removed. Emanuel fails to address how valuable the corresponding harms and benefits are in making his comparison.

On the other hand, the harms caused by the potential abuses are nowhere near as great as suggested by Emanuel. In the UK we benefit from the National Heath Service, and thus, in contrast to the US, financial burdens are less likely to be a factor which would cause abuses. Care giving duties will also be less likely to result in abuses than in the US, again, as family members have the opportunity to receive assistance from the welfare state.

[258] Emanuel 1999 at 632-634.

6.4.2 The Harm Caused to Those Requesting Assisted Suicide is Underplayed

The benefit of legalising assisted suicide should not be underestimated, as it is extremely valuable to those individuals who require it, however small the number of people. The significance of this benefit, and the subsequent harm caused by criminalisation, are evidenced by the tenacious court appeals undertaken by both Debbie Purdy and Diane Pretty: for them, this ability would restore some element of control to the lives of those suffering at the hands of a debilitating illness.

As discussed previously in Chapter Four, Emanuel appears to focus solely on the harm that would potentially be done to others if assisted suicide were legalised, at the expense of any discussion of the harm currently being caused. Once again the common construction of 'others' as vulnerable dominates his writing, but as already suggested, surely it is the group of people denied assisted suicide that are the real vulnerable persons? The discussion regarding 'the rights of others' is another area in which this is overlooked, another area where such arguments may be developed.

In assessing the balance between the top and the bottom of the slippery slope, weighing the harms and the benefits against each other, the harm caused to those who require assisted suicide is key. If the debate could be reconceptualised in order to reveal the horrific reality of the harm caused to the vulnerable persons who require assistance, the balance of the scale could potentially be tipped. The nature of the debate on assisted suicide could be altered. It can further be argued that the blanket ban on assisted suicide in the UK breaches Art.3 of the ECHR which prevents inhumane or degrading treatment. Given that many of those who require assisted suicide do so because they feel their situation is degrading, this prospect is not improbable. Exploring this avenue is a potential way forward for the assisted suicide dialogue which so often focuses on 'others' to the detriment of those who are currently suffering.

To summarise, much more than guesswork is required when addressing the question of whether the risks of legalising assisted suicide outweigh the potential benefits. Even when accurate figures are presented, the analysis requires more than a mere aggregation of the numbers of people affected: there must be an in depth examination of the value and weight of the potential harms and benefits. Unfortunately, Emanuel fails to engage in such an assessment, an assessment which

reveals that legalisation would be intensely valuable to those who require it, and that the scope for abuse is much narrower than that anticipated for our transatlantic counterparts. What is more, he focuses mainly on the vulnerability of 'others' in society and ignores the susceptibility of those who are denied access to assistance. The balance of harms and benefits of permitting assisted suicide is likely to be vastly altered when the harm caused to those requesting assistance is acknowledged more fully. Moreover, there is a possibility of using Art.3 ECHR to frame the terrible harm currently being caused.

To contextualise the findings thus far, it has been revealed that the logical slippery slope fails, the empirical slippery slope lacks evidential support, and moreover, when the benefits of legalisation are weighed against the risk of harm, the scale is not heavily tilted towards the risk of harm as opponents of assisted suicide often claim. Accordingly, the suggestion that the slippery slope could serve to justify the current legal unfairness is becoming substantially weaker.

6.5 Current Legal Position

If there was any remaining possibility that the slippery slope could still provide a valid justification for the legal unfairness exposed in Part One, the current legal position itself removes any such possibility. As explained previously, the law requires a doctor comply with a valid refusal of medical treatment even where this will result in the death of a patient[259] and a doctor who administers a life-threatening dose of drugs to a patient acts lawfully providing such medication has a palliative effect.[260] In both these situations the law essentially permits a doctor to help bring the life of the patient to an end. The question then arises: how can the law consistently defend the offence of assisted suicide by appeal to the slippery slope, when such practices which have the same effect are regularly carried out in our hospitals with no safeguards to prevent potential abuses? Surely the removal of life-sustaining medical treatment and the administration of lethal palliative care carry very similar, if not identical, risks as assisted suicide by other methods. There is a possibility that individuals will feel pressured to request either their medical treatment be removed or they be treated with a lethal dose of medication. There is a risk that doctors would eventually extend such

[259] See Chapter Two.
[260] See Chapter Three.

practices to patients who are incompetent, or who have not made a request. The same dangers apply to both the legal and the illegal conduct and it is precisely the role of the law to put adequate safeguards in place to protect from such dangers. Consequently, for the legal position to be defended by reference to the slippery slope, we must be able to make some distinction, a distinction which explains why assisting a patient through the impermissible route resists safeguards and carries more risks than the permissible route.

It is possible to argue that the practices are distinct. The risks do not apply to the types of assisted suicide discussed in Chapters Two and Three, as the ability to end life in these ways is not well known. A patient is unlikely to be persuaded, given that family members will be unaware of this route and the existence of the ability to refuse life-sustaining treatment or request a lethal dose of palliative care is not widely acknowledged by society. Thus, for a patient to receive such assistance, it is necessary that they request it themselves and it is unlikely it will be something at the forefront of their minds. However, such arguments are weak. The doctor is still aware of the legal position regarding such practices and is likely to inform the patient of this as a potential treatment option. What is more, the fear of doctors extending their practices to incompetent and non-competent patients remains. The difference seems slight and is unlikely to have any real effect on the dangers posed by these types of permissible assisted suicide. The reality remains that the practices are extremely similar and it is inconsistent for appeal to be made to the slippery slope in defending the current prohibition of assisted suicide, when assisted suicide is already taking place free from any safeguards.

To review the main points, a hypothetical comparison is useful. Imagine I have two twin daughters aged fifteen: Amy and Anna. Both want to go out with their different set of friends and then walk home alone at midnight. Primarily, I refuse Anna, but permit Amy. However, my approach is not consistent; both girls are fifteen, both are equally streetwise and both would be subject to the same risk of kidnap, mugging, rape or murder. The potential dangers apply to *both girls*. This same principle is reflected in the current law regarding end of life. The law cannot consistently allow some assisted suicide practices, yet prohibit others through an appeal to the slippery slope. Unless it can be established that the former has some special characteristic which excludes it from the dangers of the slope, the law cannot appeal to the 'rights of others' in proscribing the latter.

6.6 Summary

This section has established that the slippery slope arguments presented are flawed, and thus, are not sufficient to defend the current unfair legal position which permits some end of life choices yet arbitrarily prohibits others. The logical slippery slope fails to withstand critical analysis and the empirical slippery slope is based on inconclusive evidence. What is more, the extreme difficulty of conducting a study to obtain valid evidence has been revealed. Moreover, on analysis of the comparison between the dangers of legalisation and the potential benefits, it becomes clear that the harms are often exaggerated while the value of legalisation for those who are suffering unbearably is underplayed. Furthermore, there is a possibility of using Art.3 ECHR to frame this unbearable situation and alter the focus of the debate through realigning the vulnerability construct. Finally, the law cannot consistently use slippery slope arguments to defend the current position, given that there are a number of types of assisted suicide that *are* permitted: if the slippery slope is a real danger, why are such practices legal, and why do they go on without safeguards to prevent abuse? Without significant development, it appears that the current legal position cannot be defended with reference to 'protecting the rights of others'. The slippery slope is unable to defend the current legal position from critical objection.

7.
CONCLUSIONS

This thesis began with an identification of two main aims: firstly, to ascertain the fairness of the current legal position regarding ending one's own life, and secondly, to determine whether such unfairness (if found) could be justified. The introduction established a fictional scenario framing these issues, to which it is useful to briefly return throughout this concluding chapter.[261] You will recall that Alice took a lethal dose of paracetamol and lawfully committed suicide, Beatrice lawfully refused life-sustaining ventilation, dying as a result and Candice requested her doctor lawfully administer a dose of palliative care she knew would be fatal. You, however, a sufferer of Motor Neurone disease, could not commit suicide unaided because of your physical condition. Moreover, you were not receiving any life-sustaining treatment and did not require palliative care and any person who attempted to help you would have committed a crime under s.2 of the Suicide Act 1961. The question posed was this: how can such a situation possibly be fair? What are the distinctions the law makes between these four situations which permit individuals in the first three to end their lives, yet leave those in the final situation tragically trapped?

7.1 The Law *is* Unfair

The first arbitrary distinction the law makes, addressed in Chapter Two, is between those permitted to refuse life-sustaining treatment in order to end life, and those who are not receiving such treatment. Beatrice desired assistance in ending her own life, and as she was attached to an artificial ventilation system, she had the ability to refuse such treatment and effectively receive such help. *Re T* established that a patient may lawfully make such a refusal and the subsequent case of *Re B* determined that a doctor must comply with a refusal of life-sustaining treatment if he is to avoid committing the tort of battery.[262] A sufferer of Motor Neurone disease does not usually require such life-sustaining treatment and any doctor who assists such a person to commit

[261] See Chapter One pages 2-3.
[262] *Re B (Adult: Refusal of Medical treatment)* [2002] EWHC 429.

suicide commits a crime, punishable by a maximum of fourteen years imprisonment.[263] The distinction the law makes between these two situations, expounded in the case of *Bland*, is that the former is an omission to treat while the latter is an act.

For the unfairness caused by this legal position to be justifiable, there must be a moral difference between acts and omissions, and moreover, this moral difference must exist with regard to withholding and withdrawing treatment. It was found that in many instances, an omission is less morally culpable that an act, *because it is an omission.* This is the case where there are more costs or risks to a person involved in acting, than would exist if omitting to act. The example was given of pushing someone into an electric fence versus omitting to attempt to rescue a person already being electrocuted. The latter entails serious physical risks, which render it less morally culpable than the former. However, it was found that such a difference in costs and risks does not exist with in the context of withholding and withdrawing treatment versus assisting in the suicide of another directly. Both carry the same cost and risk to the doctor (providing assisted suicide was legalised), and thus, no moral difference exists. This lack of moral difference between omitting to treat and acting to end life means that the distinction the law makes is arbitrary, unjustifiable and causes grave unfairness.

The second arbitrary distinction the law makes, addressed in Chapter Three, is between those receiving palliative care and those who are not. Candice had extremely painful terminal cancer and lawfully requested her doctor administer a dose of palliative care she knew would be fatal, in order to obtain assistance in ending her life. The doctrine of double effect means that doctors who act in this way do not commit a crime providing their primary intention is to alleviate pain, even if death is an almost certain side-effect.[264] A sufferer of Motor Neurone disease does not usually require such treatment for physical pain and so any doctor who administers a fatal dose of medication commits the crime of assisting suicide, if not murder.[265] The distinction the law makes between these two situations is that in the former, death is foreseen, whereas in the latter, death is intended.

[263] The Suicide Act 1961 s.2.4.
[264] *R v Adams* [1957] Criminal Law Review 365; *Ann Lindsell v Simon Holmes* (Unreported).
[265] See Chapter Three.

While Keown vehemently defends this distinction, claiming that intending death is more morally culpable than foreseeing death as a side-effect, he fails to fully reason why this is the case.[266] This argument is based on the assumption that intending to bring about the death of another human being is *always* morally wrong. However, this is merely a supposition. It has been argued, in fact, that as medical advancements keep us alive much longer with a range of diseases and illnesses, ending life intentionally and prematurely is not always viewed as immoral. If assisting in the suicide of another is not morally undesirable then the intent-foresight distinction collapses and we therefore face another arbitrary, unjustifiable and unfair legal distinction.

Finally, Chapter Four addressed the arbitrary distinction the law makes between those who are able-bodied and those who are disabled. Alice was able to commit suicide after the death of her husband and children, through ingesting a lethal dose of paracetamol. In doing so, Alice acted lawfully, as the crime of suicide was abrogated by s.1 of the Suicide Act 1961. A sufferer of Motor Neurone disease cannot, by the very nature of the illness, physically end their own life, and again, any person who assists them commits a crime.[267] The distinction the law makes between the two situations is that in the former others in society are not at risk, whereas the latter poses a risk to other vulnerable persons.[268]

While the main discussion surrounding the argument from 'the rights of others' is found in Chapter Six, it is argued that (in its current form) this distinction is unpersuasive. Convincing evidence that others in society would be negatively affected by the legalisation of assisted suicide simply does not exist,[269] and what is more, assisted suicide *is* already effectively permitted in the cases discussed above (withholding/withdrawing life-sustaining medical treatment and administration of a lethal dose of palliative care). Again the distinction is proven to be arbitrary, unjustified and the cause of severe unfairness at end of life. This unfairness is further evidenced by the increase in death tourism and the DPP's prosecutorial policy, which I argue, attempts to alleviate the unjust situation by effectively exempting criminal liability for compassionately motivated assisted suicide by a family member.

[266] Keown 2002 at 18-31.
[267] The Suicide Act 1961 s.2.
[268] As explained in *Pretty v UK* (No. 2346/02) (2002) 35 E.H.R.R. 1.
[269] As demonstrated in Chapter Six.

7.2 The Unfairness *is* Unjustifiable

Part Two of the thesis analysed two common defences of the current legal position on end of life, revealing that neither can sufficiently justify this unfairness. The first defence discussed was appeals to 'the rights of the self', which defend the crime of assisted suicide because to allow such practices would harm the rights of the suicidal person. Two of these duty-based approaches were discussed in Chapter Five. Firstly, adherents of the human dignity as constraint position claim that allowing assisted suicide would damage the dignity of the person whose life is taken. However, it was demonstrated that such arguments are deeply flawed, given that no clear and accessible definition of 'human dignity' actually exists.[270] The very existence of the opposing 'dignity as empowerment' theory evidences the extreme disparities between differing definitions. Secondly, the more specific sanctity of life doctrine also failed to act as a persuasive defence of the current, unfair, legal position. Examination of the theory itself shows it uses arbitrary and unworkable distinctions which would be almost impossible to incorporate into the legal regulation of end of life practices.[271] Furthermore, the sanctity of life position itself is incompatible with the current law in other areas. An examination of both the Abortion Act 1967 and s.1 of the Suicide Act 1961 show that the current law permits the intentional killing of an innocent human being, yet this is the very practice the sanctity of life position prohibits. Consequently, this thesis has established that both the broader human dignity approach and the sanctity of life position fail to adequately justify the unfair legal position outlined in Part One.

Chapter Six assessed appeals to the rights of others, and in particular, the slippery slope arguments. As explained, this approach prohibits a seemingly innocuous, or perhaps even desirable practice, because to allow such a practice would inevitably lead to another, undesirable practice. In the end of life context, assisted suicide is the innocuous or even desirable practice which must remain prohibited, in order to prevent a slide down the slippery slope leading to the practice of NVAE, IVAE or even intentional killing of competent persons against their wishes. Again this approach was shown to be insufficient to defend the current legal unfairness. The logical slippery slope, as expounded by Keown, is severely flawed in its reasoning.

[270] See Chapter Five.
[271] *Ibid.*

The empirical slippery slope was also shown to be inherently defective due to the extreme difficulty of obtaining persuasive empirical data in such a controversial domain. What is more, the debate is often framed around the damage that *may* be caused to others in society as oppose to the harm that is *actually* being caused to those denied access to assistance. Claims to the slippery slope are simply not persuasive enough to justify the unfair situation caused by the current law.

7.3 A Way Forward

This thesis has established that the current law regarding ending one's own life is unfair, and this unfairness cannot be defended by reference to a wider concept of the 'rights of the self' or the 'rights of others': there is unjustifiable injustice. The very fact that such unfairness exists, urges a change in the law. The situation whereby a person's medical and physical circumstances affect the legality of their decision to seek assistance in ending life should not be allowed to persist. Those who are able bodied can lawfully commit suicide.[272] Those who are receiving life-sustaining medical treatment can lawfully refuse it.[273] Those requiring palliative care can lawfully request a lethal dose.[274] The small group of individuals who fall outside of these categories are denied access to control over their final moments, a denial which forces them to endure an emotionally horrific end.

Further need for a change in the law is evidenced by the ever-increasing number of people travelling abroad to receive assistance. The current unfair situation caused by the law has seen a rise in death tourism, with many severely disabled people now having no other choice than to travel a foreign country to end their lives. The added financial and emotional burdens this creates for these families are another factor which urges legal change. Moreover, the DPP's prosecutorial guidelines, which I have argued effectively legalise compassionately motivated assistance, further entrench the need for change.[275] Although the document was created to give clarity to individuals (as directed by the Lords in *Purdy*) the situation remains unclear.[276] Would an individual who compassionately and reluctantly assisted in the suicide of a

[272] The Suicide Act 1961 s.1.
[273] *Re T* [1993] Fam. 95.
[274] Through the doctrine of double effect. See Chapter Three.
[275] Crown Prosecution Service (2010).
[276] *R (on the application of Purdy) v DPP* [2009] UKHL.

family member in the UK be prosecuted? If the family member were to receive a large financial gain from the suicide, would this be cause for prosecution? While assumptions can be made over the policy factors for and against, the answers to this, and many other questions, remain speculative. Until there is a greater degree of clarity, individuals are forced, if they wish to remain on the right side of the law, to 'play it safe' and endure the extra financial and emotional burdens of travelling abroad. It is evident that a change in this area of law is long overdue.

The first and most obvious possibility is the introduction of new legislation which decriminalises assisted suicide or permits such practices providing certain conditions are met. However, given the continual rejection of such Bills in Parliament, it is suggested that a change in this bold form is extremely unlikely. For example, Lord Joffe introduced a stream of Bills with the aim of remedying the unfairness at end of life. However, the Patient (Assisted Dying) Bill, introduced in 2003, did not proceed past the 2nd reading. In 2004, a new Bill was initiated - the Assisted Dying for the Terminally Ill Bill, but this Bill was unable to proceed due to a shortage of Parliamentary time.[277] Following this, a third Bill was defeated in the House of Lords by 148 votes to 100 in 2005.[278] More recently, when debating the Coroners and Justice Bill in Parliament, Lord Falconer attempted to make an amendment to the Bill which would have removed the possibility of prosecution from friends or relatives who helped a terminally ill person to go abroad to seek assisted suicide. Again, this suggestion was defeated by 191 votes to 141. Reforming the law on end of life is a daunting and controversial step which Parliament appears reluctant to make.

There is, however, an alternative approach which has been touched upon in this thesis. When addressing the unfairness felt by both Diane Pretty and Debbie Purdy in their legal battles, it became clear that the justification for prohibiting assisted suicide is built upon the idea that other vulnerable people would be at risk if it were legalised. Chapter Six focuses solely on this idea that the current legal position is justified, as it prevents 'harm to others'. However, the discussions revealed that the potential harm that *may* be done by the legalisation of assisted suicide ignores the actual harm that *is* being done to those individuals denied access to assistance. The courts in *Purdy* and *Pretty* focussed on the potential of other weak, vulnerable and

[277] Assisted Dying for the Terminally Ill Bill 2004-05.
[278] Assisted Dying for the Terminally Ill Bill 2005-06.

perhaps elderly people who may be coerced if assisted suicide were legal, but there was no explanation of *why* this risk of harm outweighs the actual harm currently being inflicted.[279]

A possible way forward is to reframe the debate on assisted suicide with the individual who requires assistance being placed at the centre. Instead of focussing on possible future harm, focus on the actual current harm being imposed on the people who cannot exercise free choice over the end of their lives. Recognising the vulnerability of these people provides a possible way of altering the end of life debate. Article 3 of the ECHR, which prohibits the infliction of inhumane or degrading treatment on any individual, is a possible tool in this reconstruction. A potential way forward is to argue that the law which criminalises assisted suicide inflicts an inhumane and degrading life upon those who no longer wish to continue living. Consequently, the law is a breach of this integral human right and must be altered to permit assisted suicide.

A potential criticism of such an approach is the unlikelihood of any court accepting that the state's positive obligation to prevent inhumane or degrading treatment extends to allowing the practice of assisted suicide, a position held by Lord Bingham in *Pretty*.[280] However, considering the significance of the right and the harm being caused, this response is contentious. Moreover, the positive obligation of the state need not go so far as providing such assistance in suicide, merely to permit such practices. In any event, this possibility of reframing the debate on assisted suicide has yet to be fully explored. It is an avenue which could be the much needed initiation for a change in the law on assisted suicide, which is currently indefensibly unfair, hopelessly arbitrary and inflicts severe harm upon those who are trapped in a life they no longer wish to live. Unfortunately, due to constraints of length, the possibility of refocusing the end of life debate has merely been touched upon in this thesis, but is perhaps a proposal for another day.

[279] See Chapter Six.
[280] *R (on the application of Pretty) v DPP* [2001] UKHL 61 at [15].

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