Legalising assisted dying: Cross-purposes and unintended consequences

Emily Jackson

LSE THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

Efforts to change the law in the UK since 2001

Judicial review actions

- Dianne Pretty (2001)
- Debbie Purdy (2009)
- Tony Nicklinson (2014)
- ‘Martin’ (2014)
- Paul Lamb (2014)
- Omid T (2017)
- Noel Conway (2018)
- Phil Newby (2019)

Parliamentary Reform

- Assisted Dying for the Terminally Ill Bill 2003 and 2004
- House of Lords Select Committee on Assisted Dying (2005)
- Demos/Falconer Commission (2012)
- Assisted Dying Bills 2013, 2014, 2015, 2016, 2020, 2021…
- Health and Social Care Committee Inquiry into Assisted Suicide & Assisted Dying 2023

Suicide Act 1961

- Decriminalised suicide, but assisted suicide remains a criminal offence.
- Odd for assisting a non-crime to be criminal.
- Conflates encouraging and assisting suicide.
- Up to 14 years imprisonment.
- But no prosecution can take place without the DPP's consent.
- Since Debbie Purdy's case, a specific CPS policy sets out factors in favour and factors against prosecution.
- JR challenges to blanket prohibition of assisted suicide, ie no exceptions for people who are not vulnerable.

R (Nicklinson and Another) v Ministry of Justice [2014] UKSC 38.

Lord Neuberger: In their impressive judgments in the courts below, Toulson LJ and Lord Dyson MR cited extensively from prior authority cautioning against courts' interference in difficult ethical and social issues better fitted for Parliamentary resolution under our democratic traditions…

Parliament now has the opportunity to address the issue of whether section 2 should be relaxed or modified, and if so how, in the knowledge that, if it is not satisfactorily addressed, there is a real prospect that a further, and successful, application for a declaration of incompatibility may be made.…

R (on the application of Conway) v Secretary of State for Justice [2018] EWCA Civ 1431

Sir Terence Etherton MR, Sir Brian Leveson P, and King LJ

There can be no doubt that Parliament is a far better body for determining the difficult policy issue in relation to assisted suicide in view of the conflicting, and highly contested, views within our society on the ethical and moral issues and the risks and potential consequences of a change in the law and the implementation of a scheme such as that proposed by Mr Conway.

Assisted Dying Bill 2021

1 Assisted dying

(1) Subject to the consent of the High Court (Family Division) pursuant to subsection (2), a person who is terminally ill may request and lawfully be provided with assistance to end his or her own life.

(2) Subsection (1) applies only if the High Court (Family Division), by order, confirms that it is satisfied that the person—

(a) has a voluntary, clear, settled and informed wish to end his or her own life;

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

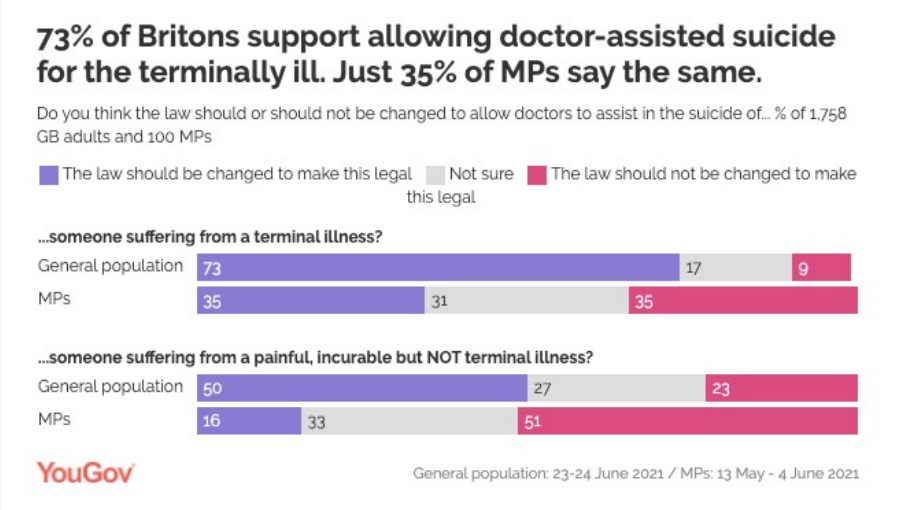
(c) on the day the declaration is made—

(i) is aged 18 or over;

(ii) has capacity to make the decision to end his or her own life; and

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

Terminal illness?



Capacity requirement?

- Rules out advance decisions for AD
- Unintended consequence = earlier assisted suicides or assisted suicides overseas?

Consent of High Court judge?

- does the High Court have capacity?
- Is it sensible/humane?

What can we learn from jurisdictions that have legalised assisted dying?

- Netherlands, Belgium, Luxembourg
- Canada
- California, Colorado, District of Columbia, Hawaii, Montana, Maine, New Jersey, Oregon, Vermont, Washington, Montana.
- Victoria, Western Australia, South Australia, Tasmania, Queensland, New Zealand
- Spain, Portugal
- (tbc) Germany, Jersey …

- For many patients, legalised assisted dying represents ‘an insurance policy against future suffering’, and may never be used.

To medicalise or not medicalise assisted dying?

Involvement of healthcare professionals in legalised assisted dying is mandatory and optional.

- Must confirm medicalised eligibility criteria.
- Must prescribe medicines.
- Where euthanasia is lawful, must also administer medicines.

Right to conscientiously object to participation.

Good reasons to involve doctors:

1. Necessary knowledge and skill to diagnose and confirm medical eligibility criteria.
2. Skills to end lives effectively and painlessly.
3. Continuity of care.
4. Broader purpose of legitimation.
5. Easier for relatives/loved ones?

And good reasons *not* to involve doctors:

1. Counter arguments against legalisation grounded in its impact on doctor/patient relationship.
2. Support for legalisation is generally lower among doctors than the general public.
3. Some doctors find involvement in AD especially difficult when the patient's suffering is psychosocial or mental (cf cases in which the patient is dying from cancer).
4. Advance decisions can also be difficult for doctors, and even when they are lawful, their use is rare.

Doctor's professional organisations?

- Following polls of their members, the Royal College of Physicians (RCP) and the British Medical Association have now formally adopted a position of neutrality.
- The Royal College of General Practitioners (RCGP) and the Association for Palliative Medicine of Great Britain and Ireland (APM) continue to oppose a change in the law on assisted dying.

- In the RCP survey:
  - 43% thought the RCP should be opposed to a change in the law
  - 32% thought the RCP should be in favour of a change in the law
  - 25% thought the RCP should be neutral.

- In the RCGP survey:
  - 47% thought the RCGP should be opposed to a change in the law
  - 40% thought the RCGP should be in favour of a change in the law
  - 11% thought the RCGP should be neutral.

Vulnerable or not vulnerable?

- House of Lords Select Committee on Assisted Dying: 'We were also concerned that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death'.
- Lady Hale (in *Nicklinson)*: 'The only legitimate aim which has been advanced for this interference is the protection of vulnerable people, those who feel that their lives are worthless or that they are a burden to others and therefore that they ought to end their own lives even though they do not really want to.'
- Rob Marris MP (House of Commons, 11 Sep 2015): 'coercion of the vulnerable is the most difficult issue, for me and many people in the House and outside'

Evidence from Europe/US?

Requests come more frequently from those who:

- have no religious affiliation
- are well-educated and middle class
- live alone
- live in urban rather than rural areas, and in more affluent neighbourhoods.

'I offer a new conception of vulnerability, one that demonstrates how rich, educated, white males … are just as, if not more, vulnerable to threats posed by PAS/VAE' (Erik Krag, 'Rich, White, and Vulnerable: Rethinking Oppressive Socialization in the Euthanasia Debate' (2014) 39 *Journal of Medicine and Philosophy* 406–429.

Interest in assisted dying more generally:

'A shared theme seems to be that those who support assistance in dying value control'. They are 'not prepared to accept paternalistic attitudes on the part of health staff', and see access to assisted dying 'as a way of rising above one's circumstances'. (Natasja J H Raijmakers et al, 'Assistance in dying for older people without a serious medical condition who have a wish to die: a national cross-sectional survey' (2015) 41 *Journal of Medical Ethics* 145-150.

Smith et al found that requesters of assisted dying had 'dismissive styles of attachment', that is they prioritise 'self-reliance, autonomy and independence', and are interested in AD to 'maintain an ultimate sense of control and autonomy within a process that allows very little opportunity for either'. (Kathryn A Smith et al, 'Predictors of pursuit of physician-assisted death' (2015) 49 *Journal of pain and symptom management* 555-561.)

Slippery Slopes:

- Rather than arguing that a person with full capacity, who is not vulnerable and has a settled decision to die should not be allowed access to AD because it is morally wrong, a slippery slope claim is that this should not be allowed because *someone else*, who is vulnerable, would be more likely to end their life.
- Deflect attention from case at top of slope?
- Cf other cases where we allow people to make decisions for themselves.
- Regulation better?
- More likely to be effective than argument that assisted dying would be morally wrong for everyone.
- Using non-vulnerable patients as a means to an end…

Importance of being able to talk openly about the desire to hasten death

- May have multiple meanings (letting loved ones know one has accepted death, recognition of what lies ahead, test others' reactions, asking for reassurance, cry for help, attempt to regain agency)
- Legal status of assisted dying may shape response: "I can't help you with that".

- Difficulty of proactively raising question of assisted dying?
- Signal loss of hope *vs* only available to the privileged?

Pressure on the status quo in the UK?

- Reasonable expectation of access to AD in Switzerland?
- What if Switzerland closed this ‘safety valve’?
- Discrimination (Swiss option only if have sufficient financial and social resources)?
- Must die when still fit enough to travel.
- Must die abroad, can’t die at home.
- Few safeguards (assisted suicide is a crime in Switzerland only if the motive is selfish)

- UK is increasingly an outlier on AD.
- Demographic changes?