The Ethics and Legality of Assisted Dying: A Critical Analysis of Regulatory Frameworks, Human Rights Implications, and Impact on Vulnerable Groups

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Abstract

This study considered the contentious issue of legalising assisted dying in the United Kingdom (UK), examining arguments for and against, analysing legal frameworks in the UK, Canada, the Netherlands, and Oregon, and considering the influence of human rights on the debate. This research aimed to propose recommendations regarding the potential legalisation of assisted dying in the UK and its scope.

The study critically assessed various perspectives, revealing the multifaceted nature of the debate. Despite attempts to change legislation, the UK's legal framework has remained mostly unchanged, with minimal prosecutions for assisted dying. The experience of other jurisdictions that have legalised assisted dying have been mostly positive but are not without criticism. The Netherlands allows for children as young as 12 to receive assistance and Canada has very permissive guidelines, allowing for patients with non-terminal illnesses, and soon mental illnesses, to request assisted dying.

Despite several cases arguing that prohibitions on assisted dying infringe human rights, it has been held that they are not disproportionate. The impact on vulnerable groups was found to be minimal without increased risks compared to the general population. The findings of this project indicate the need for careful consideration of assisted dying to ensure all views are considered, the frameworks of other jurisdictions are learned from, and vulnerable populations are respected and protected. It is recommended that assisted dying be legalised in the UK in limited circumstances for people with terminal illnesses, and slowly expanded over time.

Keywords: Suicide Act 1961; Medical assistance in dying; Death with Dignity Act 1997; Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001; Right to die

1. Introduction

In the United Kingdom, assisted dying is illegal under the Suicide Act 1961. The prohibition has been challenged by individuals who argue that it infringes their human rights.[1] There have also been attempts to change the law to allow for assisted dying in certain situations, but all have been unsuccessful, with the major concern being that it would disproportionately affect vulnerable groups.[2] Meanwhile, the Netherlands, Canada, and Oregon have legalised assisted dying in different circumstances to try and address the issue in accordance with their own social and legal considerations.[3] The research will delve into the legislative provisions and safeguards in each jurisdiction and their implications, highlighting key similarities and differences in legal approaches to assisted dying and discussing arguments for and against legalising it. The article will also consider how international human rights norms and legal principles such as the right to life and the right to autonomy inform the debate on assisted dying in the UK and how legalisation of assisted dying might affect vulnerable populations who need special care, support, or protection because of age, disability, risk of abuse, or neglect.[4]

Assisted dying, death controlled by a patient with support to take the final act voluntarily,[5] is the main term that will be used in this article. It covers assisted suicide, which is deliberately assisting another person to end their life, often through the prescription of lethal drugs they take themselves;[6] and voluntary euthanasia, which involves injecting someone with a lethal dose of a drug at their request with the aim of ending their life.[7] The term assisted dying also includes non-voluntary euthanasia

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[1] *Pretty v United Kingdom* (2002) 35 EHRR 1.
[2] Ben Colburn, 'Disability-Based Arguments Against Assisted Dying Laws' (2022) 36(6) Bioethics 680.
[3] Death with Dignity Act 1997 (Oregon) (OR); Termination of Life on Request and Assisted Suicide (Review Procedure) Act 2001 (the Netherlands) (NL); Bill C-14 (Medical Assistance In Dying) 2016 (Canada) (CA).
[4] Office for Health Improvement and Disparities 'Vulnerabilities: Applying All Our Health' (*GOV.UK*, 29 March 2022) <https://www.gov.uk/government/publications/vulnerabilities-applying-all-our-health/vulnerabilities-applying-all-our-health#:~:text=Being%20vulnerable%20is%20defined%20as,risk%20of%20abuse%20or%20neglect> accessed 31 July 2023.
[5] Royal Pharmaceutical Society, 'Assisted Dying' (*RPS*, August 2021) <https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/assisted-dying> accessed 13 July 2023.
[6] NHS, 'Euthanasia and Assisted Suicide' (*NHS*, 28 July 2020) <https://www.nhs.uk/conditions/euthanasia-and-assisted-suicide/#:~:text=Assisted%20suicide%20is%20the%20act,considered%20to%20be%20assisting%20suicide.> accessed 13 July 2023.
[7] Ibid.

where a patient is unable to consent to euthanasia and another person makes the decision on their behalf;[8] and physician assisted suicide, which involves a physician prescribing lethal drugs at the request of a patient who meets eligibility criteria in order to end their life.[9] Each term describes very different practices and methods of assisting someone in suicide despite the same outcome in each instance.

A major argument for assisted dying legalisation is that it would be respectful of a patient's autonomy. Patients make the decision about the medical treatments that they receive or forgo and as such should also have control over the manner and time of death.[10] However, some argue that patients in pain are not autonomous and therefore cannot make an informed request for assisted dying as they are compelled by pain.[11] Another argument for legalisation is that it is a compassionate way to relieve suffering and that legal methods to shorten life can cause more pain.[12]

However, a major argument against legalisation is that it will lead to a "slippery slope" where the eligibility criteria will be gradually widened to the point where vulnerable groups are involuntarily euthanised. There are also concerns that it may lead to society viewing interdependency as a burden and that the lives of the terminally ill are not worth living.[13] Concerns over how safeguards and regulations will be implemented, such as how prognosis of death will be determined and how long patients will have to change their mind, have also been raised.[14]

These arguments for and against assisted dying will feature in some form in the following discussions of legal frameworks, human rights, and the impact of assisted dying legalisation on vulnerable groups.

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[8] Ibid.
[9] BMA, 'Physician-Assisted Dying' (*BMA*, September 2021) <https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying> accessed 20 June 2023.
[10] Lydia S Dugdale, Barron H Lerner, and Daniel Callahan 'Pros and Cons of Physician Aid in Dying' (2019) 92(4) Yale Journal of Biology and Medicine 747.
[11] Paul J Van Der Maas and others, 'Euthanasia and Other Medical Decisions Concerning the End of Life' (1991) 338(8768) Lancet 669.
[12] James Rachels, 'Active and Passive Euthanasia' (1975) 292(2) New England Journal of Medicine 78.
[13] Andreas Fontalis, Ethymia Prousali, and Kunal Kulkarni, 'Euthanasia and Assisted Dying: What is the Current Position and What are the Key Arguments Informing the Debate?' (2018) 111(11) Journal of the Royal Society of Medicine 407.
[14] D Harris, B Richard, and P Khanna, 'Assisted Dying: The Ongoing Debate' (2006) 82(970) Postgraduate Medical Journal 479.

2. Legal Frameworks Governing Assisted Dying

This part of the article will analyse the assisted dying legal framework in the UK and how it has changed over time. This will be compared with the Netherlands, Oregon, and Canada which have taken different approaches to legalising assisted dying in recent years. By looking at and comparing the past, present, and future of assisted dying laws, the successes and failings of different systems can be identified and learned from. This could help to improve assisted dying implementation and regulation if it were to be legalised in the UK.

2.1 The UK

Assisted dying has been illegal in the UK for over 200 years. In the 19th century, both suicide and assisted dying were part of the same offence at common law.[15] In 1961, the Suicide Act was passed, which legalised suicide,[16] but retained assisted dying as an offence with a sentence of up to 14 years imprisonment.[17] However, it was recognised that the circumstances surrounding assistance will vary and that prosecution may not always be in the public interest, so the Act requires the Director of Public Prosecutions (DPP) to consent to prosecutions.[18] Successful prosecutions for assisted dying are rare. From the 1st April 2009 to 31st March 2023, there were only 182 assisted dying cases referred to the Crown Prosecution Service (CPS) and of these cases, 125 were not proceeded with by the CPS and 35 were withdrawn by the police. Only four of those cases were successfully prosecuted.[19]

The Debbie Purdy case brought significant changes to the law, where it was held that her Article 8 rights to privacy and family life had been engaged by the DPP not having open and transparent guidelines on how they exercised their discretion to prosecute assisted dying.[20] The House of Lords (HL) agreed that an offence-specific policy identifying factors that would be considered when deciding whether prosecution was

[15] *R v Henry Russell* (1832) 1 Mood 356, 168 ER 1302.
[16] Suicide Act 1961, s 1.
[17] Suicide Act (n 16), s 2 (1).
[18] Suicide Act (n 16), s 2(4).
[19] CPS, 'Assisted Suicide' (*CPS*, 18th April 2023) <https://www.cps.gov.uk/publication/assisted-suicide#:~:text=From%201%20April%202009%20up,are%20currently%20four%20ongoing%20cases> accessed 27 June 2023.
[20] *R (on the application of Purdy) v DPP* [2009] UKHL 45, [2010] 1 AC 345.

in the public interest should be created.[21] The current policy states, among other factors, that a person is less likely to be prosecuted if they assist out of compassion or are a close family member. However, a person will more likely be prosecuted if the victim was under 18 and lacked capacity.[22] The vast number of factors has been criticised for making it hard to determine whether someone will be prosecuted. Though the guidelines aim to protect people, the policy makes it less likely that friends or relatives of victims, who are more likely to gain from their death, will be prosecuted than physicians who have little to gain.[23] It may also encourage people to seek assisted dying in other jurisdictions sooner than necessary because of the need to travel to places like Switzerland while they are able to.[24]

There have been attempts to amend the law to allow terminally ill adults to request assisted dying as recently as 2021, but have all failed.[25] In 2014, Lord Falconer introduced an Assisted Dying Bill into the HL, arguing that limited assisted dying legalisation would lead to less suffering and not more deaths.[26] The 2021 Assisted Dying Bill laid out several requirements that needed to be satisfied. The need for patients to have an irreversible progressive condition and be expected to die within six months[27] was criticised for greatly limiting its application. It would only help a minority of individuals and exclude many who were not dying but in great pain from requesting a peaceful death.[28] Disabled peer, Baroness Campbell, argued that the Bill would alter society's view of vulnerable people and make assisted dying something they should consider.[29] However, Lord Neuberger, a retired judge who oversaw the assisted dying case of *Nicklinson*, supported the Bill, stating the importance of autonomy and how people should be able to end their lives with assistance if needed.[30]

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[21] *R (on the application of Purdy)* (n 20) [86] (Lord Brown).
[22] DPP, 'Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide' (*CPS*, Feb 2010) <https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide> accessed 18 June 2023.
[23] Andrew Sanders, 'The CPS, Policy-Making and Assisted Dying: Towards a "Freedom" Approach in Criminal Law Reform Now: Proposals and Critique' in JJ Child and RA Duff (eds), *Criminal Law Reform Now: Proposals and Critiques* (Hart Publishing, 2018).
[24] Alexandra Mullock, 'Overlooking The Criminally Compassionate: What are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide' (2010) 18(4) Medical Law Review 442.
[25] Assisted Dying HL Bill (2021-22) [13].
[26] HL Deb 18 July 2014, vol 755, col 776.
[27] Assisted Dying HL Bill (n 25) [13] cl 2.
[28] Elizabeth Peel and Rosie Harding, 'A Right to "Dying Well" with Dementia? Capacity, 'Choice' and Relationality' (2015) 25(1) Feminism and Psychology 137.
[29] HL Deb 22 October 2021, vol 815, col 418.
[30] HL Deb 22 October 2021 (n 29), col 462-3.

2.2 Oregon

Oregon was one of the first states in the United States of America (USA or US) to legalise assisted dying with the passing of the Death with Dignity Act (DWDA) in 1997. It allows for mentally capable adults with terminal illness residing in Oregon who have voluntarily expressed their wish to die to make a written request for medication for the purpose of ending their life.[31] The request must be signed by the patient and witnessed by at least two individuals who can attest that the patient is capable, acting voluntarily, and not being coerced into signing the request.[32]

Due to high cost of healthcare in the US, there were fears that poorer terminally ill patients who could not afford palliative care or health insurance would choose assisted dying but evidence does not support this.[33] The most recent data shows that, out of 278 deaths in 2022, 49% had at least an undergraduate degree, 91% were enrolled in hospice care, and all patients had some form of health insurance.[34] The data also shows that patients are mostly requesting assisted dying because of psychological and existential reasons, not pain. The three most frequently reported end-of-life concerns were decreasing ability to participate in activities that made life enjoyable, loss of autonomy, and loss of dignity.[35]

However, the safeguards and review procedures have been criticised. The Oregon Health Authority (OHA) reviews all reported cases of assisted dying under the DWDA 1997. After a prescription of drugs has been authorised, the prescribing physician must either submit Death with Dignity forms or provide relevant portions of the patient's medical records so that the OHA can determine whether legislative requirements were complied with.[36] Cases of non-compliance must be referred to the Oregon Medical Board which decides whether to sanction physicians.[37] Physicians are not required to

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[31] Death with Dignity Act (n 3), s 2.01(1).
[32] Death with Dignity Act (n 3), s 2.02(1).
[33] Lois L Miller and others, 'Attitudes and Experiences of Oregon Hospice Nurses and Social Workers Regarding Assisted Suicide' (2004) 18(8) Palliative Medicine 685.
[34] Public Health Division, Center for Health Statistics, 'Oregon Death with Dignity Act 2022 Data Summary' (OHA 2023)
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf> accessed 25 June 2023.
[35] Public Health Division (n 34), 8.
[36] Oregon Health Authority, 'Public Health's Role: Oregon's Death with Dignity Act' (*Oregon.Gov*)
<https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ohdrole.aspx> accessed 1 August 2023.
[37] Oregon Health Authority, 'Frequently Asked Questions: Oregon's Death With Dignity Act (DWDA)' (*Oregon.Gov*)

rigorously defend how they determined a patient was acting voluntarily. They only have to tick a box indicating that they determined the person was acting voluntarily.[38]

The witness requirement may also be flawed as witnesses do not need to personally know the patient which seems important when assessing the voluntariness of decisions and reduces its protective effect. Some assert that at least one witness should personally know the patient as they can make a proper assessment of voluntariness.[39]

2.3 The Netherlands

Much like in the UK, assisted dying was illegal for many years and remains a criminal offence in most instances under the Dutch Criminal Code.[40] In 2001, the Netherlands passed the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 to amend their Criminal Code. It introduced exceptions in Sections 293(2) and 294(2) of the Criminal Code. Euthanasia and assisted dying will not be an offence if done by a physician in accordance with the due care criteria in Section 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 and the municipal forensic pathologist is notified of this act.[41] Doctors must be convinced of the patient's voluntary request, enduring and unbearable suffering, informed understanding of their prognosis, absence of alternative solutions, consultation with an independent physician who provides a written opinion on these requirements, and assistance is with due care.[42] Unlike in Oregon, there is no requirement for a patient to have a terminal illness that will lead to death within six months and minors can request assisted dying. Children between the ages of 12 and 15 can request assisted dying with parental consent.[43] Children aged 16 and 17 can make a request with parents having no right to veto the decision.[44]

<https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/faqs.aspx#participating> accessed 1 August 2023.

[38] Micheala E Okninski, 'A Comparative Analysis of Voluntariness Safeguards and Review Procedure under Oregon and Netherlands' Physician Assisted Dying Laws' (2018) 14(1) Dalhousie Law Journal 121.

[39] Ibid.

[40] Criminal Code 1881 (NL), s 293, s 294.

[41] Criminal Code (n 40), s 293(2), s 294(2).

[42] Termination of Life on Request and Assisted Suicide (Review Procedure) (n 3), s 2(1).

[43] Termination of Life on Request and Assisted Suicide (Review Procedure) (n 3), s 2(4).

[44] Termination of Life on Request and Assisted Suicide (Review Procedure) (n 3), s 2(3).

After each case of assisted dying, a regional review committee consisting of lawyers, doctors, and ethicists consider whether due care criteria was satisfied and if so, the case is closed.[45] Having a mixed committee ensures that legal, ethical, and medical issues are all properly considered. Unlike the OHA in Oregon, physicians must rigorously defend how they determined the request was voluntary.[46] Findings of non-compliance are extremely rare with only 13 instances out of 8,720 total assisted dying cases in 2022.[47]

Despite robust criteria and review methods, there are concerns among physicians that assisted dying is no longer being used in exceptional circumstances. They also feel the criteria is being compromised in instances where patients were suffering from non-physical illnesses including distress from old age.[48] The committee's discretionary power to interpret the law may have also led to criteria being broaden and to a major increase in the annual rates of assisted dying.[49]

2.4 Canada

In Canada, assisted dying is still a criminal offence and anyone found guilty can face imprisonment of up to 14 years regardless of whether suicide ensues or not.[50] Major changes were made following the case of *Carter v Canada*[51] where it was held that the prohibition on assisted dying was contrary to Section 7 of the Canadian Charter of Rights and Freedoms (CCRF), the right to life, as it forced terminally ill people to take their own lives prematurely while they were still able to.[52] The Canadian Government was required to legalise assisted dying by the Court.[53] In 2016, Bill C-14 was passed

[45] Termination of Life on Request and Assisted Suicide (Review Procedure) (n 3), s 3.
[46] Okninski (n 38).
[47] Regional Euthanasia Review Committees, 'Annual Report 2022' (RERC 2023) (NL) 4.
[48] Timothy Quill, 'Dutch Practice of Euthanasia and Assisted Suicide: A Glimpse at the Edges of the Practice' (2018) 44(5) Journal of Medical Ethics 297.
[49] Jacob J E Koopman and Theo A Boer, 'Turning Points in the Conception and Regulation of Physician-Assisted Dying in the Netherlands' 2016 129(8) The American Journal of Medicine 773.
[50] Criminal Code, RSC 1985, c C-46, (CA), s 241(1).
[51] *Carter v Canada (Attorney General)* [2015] SCC 5, [2015] 1 SCR 331.
[52] Ibid.
[53] *Carter* (n53), [127], [128].

to amend the Criminal Code.[54] It inserted new sections that exempt medical personnel from being prosecuted for assisting in dying.[55]

The law was changed again with the passing of Bill C-7, following *Truchon v Attorney General of Canada* where it was held that restricting euthanasia to individuals whose death was reasonably foreseeable was a violation of the right to life and equal protection under the CCRF.[56] To qualify for medical assistance in dying (MAID), a person must be a resident of Canada, be 18 years old and mentally capable, have a grievous and irremediable medical condition (serious and incurable illness, in an advanced state of irreversible decline in capability etc.), and have made a voluntary and informed request for MAID.[57]

For foreseeable death cases, the patient and a witness must sign the request, the patient can withdraw it anytime, they must have the opportunity to withdraw consent, and expressly confirm consent before receiving MAID.[58] If death is not reasonable foreseeable, the patient must also be informed of means to relieve suffering, agree with the practitioners that they have considered them, and there must be at least 90 days between the first assessment and the day MAID is provided.[59] There are plans to allow people suffering solely from mental illness to access MAID, but these were delayed until March 2024.[60] This move has received criticism as it is hard to determine whether a psychiatric illness will no longer improve, making it difficult to determine when MAID should be offered to patients who could recover.[61]

The MAID criteria has been criticised due to the uncertainty and inconsistency of the meaning of ‘incurable illness’, ‘irreversible decline in capability’, etc.[62] Two people may be treated differently based on their providers interpretation of criteria, who may be

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[54] Bill C-14 (Medical Assistance In Dying) 2016 (n 3), Summary.
[55] Criminal Code, RSC (n 50), s 241(2)-(5).
[56] *Truchon v Attorney General of Canada* [2019] QCCS 3792.
[57] Criminal Code, RSC (n 50), s 241.2(1)-(2).
[58] Criminal Code, RSC (n 50), s 241.2(3).
[59] Criminal Code, RSC (n 50), s 241.2(3.1).
[60] Department of Justice Canada, ‘Eligibility for Medical Assistance in Dying for Person Suffering Solely from Mental Illness Extended to March 17, 2024’ (*Department of Justice Canada*) <https://www.canada.ca/en/department-justice/news/2023/03/eligibility-for-medical-assistance-in-dying-for-persons-suffering-solely-from-mental-illness-extended-to-march-17-2024.html> accessed 3 July 2023.
[61] Marie E Nicolini and others, ‘Irremediability in Psychiatric Euthanasia: Examining the Objective Standard’ [2022] Psychological Medicine 1.
[62] Jocelyn Downie and Jennifer A Chandler, ‘Interpreting Canada’s Medical Assistance in Dying Legislation’ (Institute for Research on Public Policy 2018) 5.

less likely to provide MAID for fear of criminal liability.[63] There are also concerns that people with disabilities and mental illness may seek assisted dying, for example due to poverty or homelessness, and not pain.[64]

Doctors in Canada are divided over MAID. A 2015 survey of 1407 Canadian Medical Association members revealed that 29% would assist if requested, while 63% would decline. Of the 29%, 43% would assist in non-terminal cases and only 19% in cases of psychological illness.[65] It indicates that many doctors are not comfortable with providing assisted dying and of those that are, they are reluctant to provide it to patients that do not have a terminal illness.

2.5 Conclusion

The illegality of assisted dying in the UK may have the benefit of protecting vulnerable individuals from being coerced into assisted dying. However, its illegality may lead to some travelling to places such as Switzerland to receive assistance, placing financial and emotional strain on them and their families. The subjectivity of the DPP guidelines may result in inconsistent application, making it difficult for people to determine whether they will be prosecuted for assisting. Each country discussed has widely different approaches to assisted dying. Although the UK has an outright prohibition on assisted dying, it has some similarities with the other jurisdictions. Assisted dying is still a crime in each jurisdiction, although there are exceptions for medical practitioners and prosecutions are rare. Even though they share similarities, such as the need for the request to be informed, Canada, Oregon, and the Netherlands each have vastly different safeguards and practices. In Oregon and Canada, only adults can receive assistance while in the Netherlands, children as young as 13 can access assistance. In Canada, a person's death does not need to be reasonably foreseeable to qualify for MAID, unlike in Oregon where patients must have a terminal illness and be expected to pass within six months. Changing the UK's framework to legalise assisted dying is extremely difficult due to various approaches that each have benefits and drawbacks.

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[63] Downie and Chandler (n 62) 6.
[64] Jocelyn Downie and Udo Schuklenk, 'Social Determinants of Health and Slippery Slopes in Assisted Dying Debates: Lessons from Canada' (2021) 47(10) Journal of Medical Ethics 662.
[65] Lauren Vogel, 'Many Doctors won't Provide Assisted Dying' (2015) 187(13) Canadian Medical Association Journal 409.

For example, a framework like Oregon’s would protect the vulnerable but limit its availability. A framework similar to Canada or the Netherlands could lead to vulnerable individuals being pressured into ending their lives. An important question that requires consideration is how the debate on assisted dying legalisation is informed by human rights as it is often asked whether there is a right to die and therefore a right to assisted dying.

3. International Human Rights Norms and Legal Principles and Their Influence on the Debate on Assisted Dying in the UK

This section of the article will discuss and analyse several European human rights cases where individuals have attempted to argue that there is a right to die and therefore a right to assisted dying under the European Convention on Human Rights (ECHR). There have been many cases in both the UK and the rest of Europe that have attempted to argue that blanket bans on assisted dying are a violation of human rights and should be removed.

3.1 Diane Pretty

In 2001, Diane Pretty brought a case to the HL that argued the blanket ban on assisted dying in the UK was a violation of her human rights under the ECHR.[66] She was diagnosed with motor neurone disease and wanted assistance in suicide from her husband but was concerned that he may be prosecuted under Section 2(1) of the Suicide Act 1961. Pretty asked the DPP to provide an undertaking that they would not consent to prosecution of her husband, but they refused. She sought judicial review of their refusal on the basis that it infringed her rights under the Human Rights Act 1998 (HRA 1998), but the HL found no breach of her rights.[67] Lord Steyn stated that the DPP cannot stop all prosecutions and can only exercise their discretion in respect of past events.[68] Pretty’s request for the DPP to essentially give her husband immunity from prosecution was problematic because, if she changed her mind, it would be

[66] *R (on the application of Pretty) v* DPP [2001] UKHL 61 [2002] 1 AC 800.
[67] Ibid.
[68] *R (on the application of Pretty)* UKHL (n 66), [65] (Lord Steyn).

unacceptable for him to be immune from future prosecution.[69] Pretty appealed to the European Court of Human Rights (ECtHR) arguing that her Article 2, 3, 8, 9, and 14 rights had been infringed by the HL's decision.

Pretty argued that Article 2, the right to life, contained a right to self-determination of life and death. The ECtHR disagreed as the Article could not be interpreted as providing an opposite right without being distorted.[70] In respect of Article 3, which prohibits torture and cruel and degrading punishment, Pretty argued that it placed a positive duty on the State to provide assistance to alleviate suffering, rather than a negative duty not to inflict suffering. The Court also disagreed with this interpretation as it extended the concept of treatment beyond its ordinary meaning.[71] Similarly, Pretty's argument that Article 9, the right to freedom of thought, had been infringed was rejected as not all opinions constitute beliefs protected by the Article and her claim did not constitute a belief.[72] She also argued that Article 14, protection from discrimination, had been infringed because the law discriminated against those who could not end their own lives without assistance, but this was also rejected.[73]

Pretty's main argument was that her Article 8 rights, the right to respect for your private and family life, were engaged by the prohibition on assisted dying as it prevented her from exercising her autonomy. The Court did agree that autonomy was an important guiding principle and that her Article 8 rights were engaged.[74] However, the ECtHR found that the interference was not disproportionate to protect vulnerable individuals in society and fell within a state's margin of appreciation.[75]

Critics of the ECtHR's decision argue that the Court did not give enough importance to individual autonomy and to the alleviation of suffering while exaggerating difficulties of enforcing adequate safeguards to prevent abuse.[76] However, the case had a major weakness in that Pretty was claiming a right to non-physician assisted dying without carefully defined guidelines.[77] Supporters of the decision argued that the decision was

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[69] Emily Jackson, *Medical Law: Text, Cases, and Materials* (6th edn, OUP, 2022) 942.
[70] *Pretty* (n 1), para 39.
[71] *Pretty* (n 1), para 54-55.
[72] *Pretty* (n 1), para 82.
[73] *Pretty* (n 1), para 32, 89-90 .
[74] *Pretty* (n 1), para 58, 61, 67.
[75] *Pretty* (n 1), para 74, 78.
[76] Michael Freeman, 'Denying Death its Dominion: Thoughts on the Dianne Pretty Case' (2002) 10(3) Medical Law Review 245.
[77] *R (on the application of Pretty) v DPP* [2001] EWHC Admin 788, [2001] All ER (D) 251 (Oct) [60].

principled and prudent because the ECHR protects life and could not be interpreted as conferring a right to die. Recognising non-physician assisted dying as a right could increase the risk of abuse and coercion.[78] The ECtHR's position has not changed, as can be seen in the recent case of *Lings v Denmark*,[79] showing that changes in assisted dying laws will have to come from states and not the ECtHR.

3.2 Tony Nicklinson

Over ten years after the *Pretty* case, another case was brought by Tony Nicklinson on similar grounds. Nicklinson suffered a stroke and became paralysed from the neck down. He sought a declaration that it would be legal for a doctor to assist his suicide or that the present legal regime on assisted dying was incompatible with Article 8 of the ECHR.[80] The case was appealed to the Supreme Court (SC), where a majority of five justices held that the Court had the authority to make a declaration of incompatibility on the prohibition of assisted dying.[81] However, of these five justices, Lord Neuberger, Mance, and Wilson declined to issue a declaration of incompatibility. Lord Neuberger believed the interference with Article 8 was grave and the justification for the prohibition was weak.[82] He was prepared to hold that Article 8 was infringed. However, he felt it was inappropriate to declare incompatibility.[83] He believed the question of whether the law should be modified raised sensitive moral dimensions that require a cautious approach from both the court and the legislature and to issue a declaration would be a total change in the Court's position on the matter.[84] These reasons were brought up again in the later unsuccessful case of *Conway*.[85] However, Lady Hale dissented and stated that she would have made a declaration[86] as it made

[78] John Keown, 'European Court of Human Rights: Death in Strasbourg – Assisted Suicide, the Pretty case, and the European Convention on Human Rights' (2003) 1(4) International Journal of Constitutional Law 722.
[79] *Lings v Denmark* (2023) 76 EHRR 2.
[80] *R (on the application of Nicklinson and another) v Ministry of Justice* [2012] EWHC 2381 (Admin), [2015] AC 657.
[81] *R (on the application of Nicklinson and another) v Ministry of Justice* [2014] UKSC 38, [2015] AC 657 [76].
[82] *R (on the application of Nicklinson and another)* UKSC (n 81), [111] (Lord Neuberger SCJ).
[83] *R (on the application of Nicklinson and another)* UKSC (n 81), [116].
[84] Ibid.
[85] *R (on the application of Conway) v Secretary of State for Justice* [2018] EWCA Civ 1431, [2020] QB 1 [186].
[86] *R (on the application of Conway)* (n85), [300] (Lady Hale SCJ).

no exceptions to the general prohibition for people with terminal illnesses and that a framework could be devised to protect vulnerable individuals from abuse.[87]

The decision not to make a declaration was criticised. By not issuing a declaration, despite finding an incompatibility with Article 8, the protections of the HRA 1998 were undermined and the purpose of making declarations, which is to highlight incompatibilities with the ECHR to Parliament, was ignored as Parliament can decide to retain the current law.[88]

3.3 International Human Rights Views on Assisted Dying

The international human rights position is even more cautious of and opposed to assisted dying. Similarly to the ECHR, there is a right to life in the Universal Declaration of Human Rights 1948 (UDHR)[89] and the International Covenant on Civil and Political Rights 1966 (ICCPR).[90] There are also implied rejections of the right to die by the inclusion of strong protections for people with disabilities. In the United Nations (UN) Convention on the Rights of the Child 1989 (UNCRC), it states that a disabled child should enjoy a full life, in conditions which ensure dignity, promote self-reliance, and facilitate their active participation in the community.[91] UN treaty bodies continue to express concerns over the practice of assisted dying where it is legal, particularly in the Netherlands.[92]

3.4 Conclusion

Attempts to establish a right to assisted dying under the ECHR have largely been unsuccessful. Only arguments under Article 8 by Pretty and Nicklinson have received serious consideration but were still rejected despite agreement that the right was

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[87] *R (on the application of Conway)* (n85), [301], [312], [314].
[88] Elizabeth Wicks, 'The Supreme Court Judgment in Nicklinson: One Step Forward on Assisted Dying; Two Steps Back on Human Rights' (2015) 23(1) Medical Law Review 144.
[89] Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217 A(III) (UDHR), art 3.
[90] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR), art 6(1).
[91] United Nations Convention on the Rights of the Child (adopted 20 November 1989, entry into force 2 September 1990) 1577 UNTS 3 (UNCRC), art 23.
[92] United Nations Human Rights Committee, 'Concluding Observations of the Human Rights Committee: Netherlands' (25 August 2009) CCPR/C/NLD/CO/4.

engaged, as the prohibition was considered to be a necessary and proportionate interference. Though the SC has shown it may be willing to declare incompatibility, they refuse to make the declaration, arguing Parliament is best suited to consider the issue. The ECtHR continues to hold that states have a wide margin of appreciation on the issue. This all shows that assisted dying cannot be viewed as a human right. The cases of *Pretty* and *Nicklinson* have clearly shown that the right to life and autonomy does not extend to a right to assisted dying. Human rights may inform ethical discussions on assisted dying but their impact on the legal debate in the judiciary and legislature has been limited. The courts' reluctance to make a declaration suggests that substantial changes in the law will require parliamentary action.

4 Legalisation of Assisted Dying and its Potential Effect on Vulnerable Populations

This part of the article will analyse the impact assisted dying legalisation has or would potentially have on vulnerable populations. One of the major concerns of assisted dying legalisation in the UK is that it will negatively affect vulnerable populations such as people with disabilities and the elderly because they may be pressured by others or feel obligated to end their lives, while others argue that this is not the case.

4.1 Potential Negative Impacts on Vulnerable Groups

A major concern of assisted dying legalisation is that it would pressure vulnerable people, either consciously or unconsciously, into requesting assisted dying and alter society's perception of people with disabilities and elderly people.[93] This pressure could also come from institutions that view assisted dying as a more cost-effective, cheaper, and less demanding alternative to palliative care.[94]

Others feel that assisted dying must remain illegal because safeguards will never be sufficient and no matter how well drafted the law is, it will never be completely safe.[95]

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[93] RJD George, IG Finlay, and David Jeffrey, 'Legalised Euthanasia will Violate the Rights of Vulnerable Patients' (2005) British Medical Journal 331(7518) 684.

[94] Christopher Kaczor, 'Against Euthanasia for Children: A Response to Bovens' (2016) 42(1) Journal of Medical Ethics 57.

[95] Vicky Robinson and Helen Scott, 'Why Assisted Suicide must Remain Illegal in the UK' (2012) 26(18) Nursing Standard 40.

Although these are real and understandable fears, there is very little up-to-date evidence or data to suggest that assisted dying laws disproportionately impact vulnerable people and lead to a "slippery slope".[96]

4.2 Data on the Impact Legalisation has had on Vulnerable Groups

Several reviews of data have been conducted to consider the uptake of assisted dying in vulnerable groups. A 2016 review considered data from all jurisdictions that had legalised assisted dying at the time and found that there was no evidence of vulnerable people receiving assisted dying at a rate higher than the general population. The belief that people with disabilities would be disproportionately affected was unfounded.[97]

Empirical studies on the impact of assisted dying legalisation on vulnerable groups in Oregon and the Netherlands have also been conducted. Heightened risk to people with disabilities or those with non-terminal conditions as well as factual support for "slippery slope" concerns were not found.[98] Some criticised this study for underestimating the impact on other vulnerable groups.[99] In Canada, there is data showing that uptake of MAID has no correlation with socio-economic disadvantage.[100] All these studies indicate that the fear of vulnerable people being disproportionately impacted is unfounded. The feeling that assisted dying legalisation communicates that the lives of vulnerable groups such as people with disabilities and economically disadvantaged people are not worth living is not universal. In a Canadian study involving people with substance issues and people living in poverty, participants mostly

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[96] Colburn (n 2).
[97] Ezekiel J Emanuel and others, 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe' (2016) 316(1) Journal of the American Medical Association 79.
[98] Margaret P Battin and others, 'Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups' (2007) 33(10) Journal of Medical Ethics 591.
[99] IG Finlay and R George, 'Legal Physician-Assisted Suicide in Oregon and The Netherlands: Evidence Concerning the Impact on Patients in Vulnerable Groups – Another Perspective on Oregon's Data' (2011) 37(3) Journal of Medical Ethics 171.
[100] James Downar and others, 'Early Experience with Medical Assistance in Dying Ontario, Canada: A Cohort Study' (2020) 192(8) Canadian Medical Association Journal 173.

supported MAID and felt that it gave people a sense of control over when and where they die.[101]

There are also widely expressed concerns that assisted dying legalisation will undermine healthcare for people with disabilities by reducing funding and support for palliative care.[102] However, greater support for palliative care often accompanies assisted dying legalisation. In 1999, Oregon physicians implemented substantive palliative intervention for 68 patients including pain control and referral to hospice and almost half of them changed their mind on assisted dying.[103] In Quebec, legislation provides a right to receive end-of-life care which includes a right to palliative care as well as medical assistance in dying.[104]

4.3 Conclusion

To conclude, assisted dying legalisation may pose a real risk to vulnerable groups who may be coerced or unduly influenced into requesting assisted dying regardless of how well the law is drafted and potentially change society's view of these groups. However, data from various countries where assisted dying has been legalised does not support this. Studies have found no clear evidence that vulnerable people have been receiving assisted dying at higher rates than the general population. If assisted dying were legalised in the UK with safeguards similar to Oregon and the Netherlands, risks of coercion would exist but vulnerable groups would unlikely be disproportionately impacted.

5. Conclusion

Throughout this article, the question of whether assisted dying should be legalised has been considered by analysing the arguments for and against legislation, the legal

[101] Jessica Shaw and others, 'Perceptions and Experiences of Medical Assistance in Dying Among Illicit Substance Users and People Living in Poverty' (2021) 84(1) Omega: Journal of Death and Dying 267.
[102] Health and Sport Committee, *Stage 1 Report on Assisted Suicide (Scotland) Bill* (Scottish Parliament 2015) para 66.
[103] Linda Ganzini and others, 'Physicians' Experiences with the Oregon Death with Dignity Act' (2000) 342(8) New England Journal of Medicine 557.
[104] Act Respecting End-of-Life Care 2014 (Quebec) (QC), s 4.

frameworks in the UK, Oregon, the Netherlands and Canada, human rights cases, and the impact on vulnerable groups. The various arguments for and against legalisation are complex and wide ranging. Although arguments from both sides have flaws, they are still compelling arguments that have and continue to be used in debates over legalisation in the UK by people such as Lord Falconer and Baroness Campbell. It is important to consider these arguments as they will be used to push for either legalisation of assisted dying or retention of it as a criminal offence, and it is hoped in future that such arguments will be considered in greater depth.

Major changes in assisted dying laws in the UK were observed, such as the prosecution guidelines introduced after the *Purdy* case. The likelihood of being prosecuted is low, with many cases being dropped by the DPP and police, making it feel like the UK has practically legalised assisted dying. In analysing other jurisdictions, patterns were identified but also major differences. The Netherlands has strict eligibility criteria and rigorous review procedures but has been criticised for allowing children as young as 12 to receive assistance, though it is a rare occurrence. Canada has the most permissive criteria of the jurisdictions considered, allowing for people with non-terminal illnesses to receive assistance with future plans to allow people suffering solely with mental illness to qualify. Oregon is the most restrictive, requiring that patients are adults with terminal illnesses. By examining the development of assisted dying laws in the UK and other countries, the way in which assisted dying legislation in the UK could be implemented in the future can be considered. It is recommended that any future legislation considers the way these jurisdictions have legalised assisted dying to better understand the benefits and flaws of each system. By doing this, the UK can learn from their mistakes and devise a framework that ensures assisted dying is available to all who need it while ensuring those that are vulnerable are protected with adequate safeguards.

In terms of human rights, a right to assisted dying is not recognised under the ECHR, despite prohibitions on assisted dying engaging Article 8. The ECtHR continues to make it clear that complete prohibitions fall within the margin of appreciation and are proportional interferences for the purpose of protecting vulnerable people. Internationally, the UN is very concerned about assisted dying legislation. The UK Supreme Court has been open to finding that the prohibition is incompatible with the ECHR but have decided against it, arguing that Parliament is best suited to consider

the issue. It is important to consider the human rights aspect because, if assisted dying were recognised as a human right, states would have to legalise and facilitate it. It is recommended that if an assisted dying case reaches the SC in the future, a declaration of incompatibility should be issued so that it can be properly considered by Parliament. When looking at the impact assisted dying legalisation had on vulnerable populations it was found that there were potential risks, but such groups were not disproportionately affected.

Overall, trying to answer the question of whether the UK should legalise assisted dying is complex and difficult to definitively answer. The prosecution rate is low; however, the fear of prosecution remains a concern for those who wish to assist people in suicide by helping them travel to Switzerland. It is the recommendation of this study that the UK legalises assisted dying for terminally ill people with safeguards similar to those in the Netherlands. This is because it will enable people to receive the help they need and ensure safeguards are strong enough to protect vulnerable people. Over time, the UK could widen criteria and allow people with non-terminal illnesses to qualify but this should be done carefully and pragmatically, considering all viewpoints and evidence to ensure protections are still sufficient.

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