Are the Laws Forbidding Euthanasia and Assisted Suicide in the UK Taking Away the Personal Autonomy of Terminally Ill Citizens?

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Abstract

The purpose of this article is to examine the view that the current blanket ban on assisted suicide in the UK actively takes away the personal autonomy of citizens with terminal illnesses who wish to end their own lives. This work will examine a variety of factors that may contribute to this legal debate such as personal autonomy, end-of-life decisions, human rights and medical ethics. The current problems associated with the law on euthanasia will also be addressed in order to better comprehend the socio-legal debate surrounding whether or not assisted suicide ought to be legalised. This article will also discuss the potential measures that could be implemented in the future to legalise euthanasia and how law-makers can prevent the slippery-slope which is a fear of those against the legalisation of assisted suicide.

Keywords: Euthanasia; Assisted Suicide; Right to Die; Personal Autonomy; Medical Law

1. Introduction

The objective of this work is to critically analyse the current legal approach to euthanasia and assisted suicide in the UK and assess whether or not the laws prohibiting these practices take away the personal autonomy of terminally ill citizens. This article will discuss in detail the ways in which a patient's suffering may be prolonged if they are denied euthanasia as well as the potential impact the legalisation of assisted suicide would have on the rest of society.

The first part of this article will discuss the different end-of-life decisions and how they differ or relate to assisted suicide. In order to better understand the nature of the law of assisted suicide we must look at the concept of suicide as whole, particularly its recent decriminalisation in 1961. Although the act of suicide is still a cause for concern

in today's society, the principles behind its legalisation actively sets the scene for the euthanasia debate.

As personal autonomy is the central focus in this discussion on assisted-dying, it is important to consider its importance both in law and in society. The issue of autonomy and consent have always been significant in medical law and bioethics as it can mark the difference between successful medical treatment and assault. With this in mind, it is palpable that voluntary euthanasia requires the patient to exercise their autonomy, otherwise it would be classed as murder. However, the issue lies with the blanket ban on assisted suicide and how this actively strips terminally ill patients of their right to exercise their autonomy.

In order to examine the suspected hypocrisy of the law on assisted-dying, end-of-life decisions such as the withdrawal of life-sustaining treatment and the implementation of DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) notices will be considered to compare how courts deal with similar cases in different ways. The reason for this is that the end which is achieved through these methods is the death of the patient and consequently the end to their suffering. However, due to the law prohibiting assisted suicide, terminally ill people who wish to end their own lives cannot do so legally but patients with no consciousness are able to die peacefully.

The second part of this article will evaluate the current legal approach to euthanasia and assisted suicide by referring to the relevant case law of people petitioning for the right to die. It is important that we first establish what constitutes murder in relation to assisted suicide to better understand what is at stake for those who are prosecuted for assisting the death of another. Further, as human rights are frequently used to contest the law on euthanasia, this work will assess how these rights are balanced during the law-making process and the various inconsistencies in language which have led to the quashing of right to die arguments in court. It is apparent that although there have been admissions that some patient's rights have been interfered to allow for other rights to be fulfilled, there has been no significant shift in the legal position towards assisted suicide in the UK. Thishas led to more questions surrounding the rationale of the UK's law-making process.

2. End of Life Decisions

As discussed throughout history, we as humans have a fundamental right to make decisions regarding our own lives such as what we wish to eat for breakfast, or whether or not to have children. With this in mind, many would agree that we should be able to have a say in how we die. However, the current societal attitudes towards suicide and assisted dying have always sparked various debates surrounding our end-of-life rights.[1] therefore, the first part of the article will discuss the different ways in which a person may voluntarily end their own life and how these are recognised by society.

2.1 Suicide

Assisted suicide is one of the most controversial issues in medical law as it causes many ethical concerns as well as legal debate surrounding human rights and personal autonomy. It has already been established that suicide is no longer a crime in the UK through the implementation of Suicide Act 1961. Prior to this Act, suicide was held as one of the most heinous crimes a person could commit.[2] Despite the moral dilemma associated with letting someone take their own life, one must look at this Act as a way of giving back control and allowing people to decide their own fate rather than it resting on the values of State. However, whilst section 1 completely decriminalises suicide, section 2 goes on to criminalise assisted suicide, thus creating a new crime of helping another person end their own life.[3] One of the main problems with this Act is that most terminally-ill people would be physically incapable of ending their own lives and as a result would need assistance to do so. Due to this, the decriminalisation of suicide would be of no significance to such people as they would be unable to end their own lives without asking someone to commit a crime.

Although many feel that the decriminalisation of suicide was a loosening of control by the Conservative government,[4] it is possible that others may view this as a reform to deter people from taking their own lives from a moral stand point rather than a legal

[1] Kathleen M Foley and Herbert Hendin, *The Case Against Assisted Suicide: For the Right to End-Of-Life Care* (Josh Hopkins University Press 2002) 2.
[2] Sheila Moore, 'The Decriminalisation of Suicide (PhD Thesis, London School of Economics and Political Science 2000) 6.
[3] Suicide Act 1961.
[4] Moore (n 2).

one. However, it is important to note the change in views on other moral issues since the 1960s, such as same-sex marriage which was not legalised until 2013.[5] Due to this, it is important that we recognise that whilst morals and values change, the law must also adapt to these changes as its function is to serve and protect the people of the land.[6] Although there is no definite right to suicide or assisted dying, there is significant support for the legalisation of assisted suicide around the world.[7] One of the many arguments for legal change is that religious views on the sanctity of life have no place in law and should not be imposed upon everyone.[8] However, those who are against the decriminalisation of assisted suicide believe that any relaxation of the law would create a 'slippery slope' which many feel could lead to people without any illness or impairment wishing to end their own lives to avoid being a burden on their families.[9] Therefore, if Parliament were to legalise assisted suicide, the legislation would have to be tightly drafted in order to prevent the exploitation of individual citizens. With this in mind, we must consider whether or not a person's autonomy could be wrongfully influenced by certain pressures that may come with the legalisation of assisted suicide.

2.2 Autonomy

The issue of autonomy has been commonplace in medical law due to its direct influence on bioethics and medical ethics; it has shaped individuals' expectations and wishes in a way which favours individual rights and self-governance.[10] Onora O'Neil is among those who view personal autonomy as a hindrance on medical ethics as it has marginalised issues like the fair distribution of healthcare.[11] For this reason, one must avoid looking at the idea of personal autonomy through rose-tinted glasses as an individualistic approach to medical ethics allows for wider problems to be overlooked. Although it is still important that individuals are able to exercise their

[5] Marriage (Same Sex Couples) Act 2013.
[6] Harlee Holbrook, *Purpose of Law* (Great Falls Tribune 2010).
[7] Carol HJ Lee, Isabelle M Duck and Chris G Sibley, 'Demographic and Psychological Correlates of New Zealanders' Support for Euthanasia' (2017) 130 The New Zealand Medical Journal 9.
[8] UK Parliament, 'The Right to Die and Assisted Suicide' <https://www.parliament.uk/business/publications/research/key-issues-parliament-2015/social-change/debating-assisted-suicide/> accessed 28 March 2021.
[9] Ibid.
[10] Oliver Sensen, *Kant on Moral Autonomy* (Cambridge University Press 2012) 16.
[11] Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge University Press 2002) 20.

autonomy, safeguards should be put in place to ensure that this is not at a detriment to the wider public.

Whilst autonomy is a key factor in deciding whether or not one wishes to end their own life, an individual's autonomy cannot be respected unless they have the capacity to make such decisions. Similar to any medical treatment or procedure, patients must be able to give informed consent and this can only be done if they have capacity to do so; otherwise the medical professionals are required to act in the patient's best interests. Although some may question whether or not a terminally ill person would have capacity to consent, the Mental Capacity Act 2005 states that 'a person must be assumed to have capacity unless it is established that he lacks capacity.'[12] Therefore, it is important that we assume all adults have capacity to exercise their autonomy unless they are unable to understand the information in relation to the decision, retain the information, weigh up the information or communicate their decision.[13] It is also important to note that the reasoning behind a person's decision cannot dictate whether or not they have capacity. This is outlined by Jackson J in *Heart of England NHS Trust v JB*: 'Anyone capable of making decisions has an absolute right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision.' Despite this seemingly reasonable position on the issue of autonomy, it is important to remember that although an individual may have capacity to consent to assisted dying, it still remains illegal to do so, thus any consent given would be invalid.

2.3 Withholding Life-Sustaining Treatment

As it has been established that the law condemns assisted dying regardless of the wishes of the patient. The matter of withholding life-saving treatment is one of great interest in this discussion as it is not illegal like assisted suicide but fulfils the same objective of ending suffering and allowing a patient to die. As mentioned above, patients have the right to make decisions regarding their treatment and care in accordance with their own personal views and this includes the right to refuse life-saving treatment even though this would lead to them dying.[14] Although the

[12] Mental Capacity Act 2005, s 2.
[13] Ibid.
[14] Louise Campbell, 'Current Debates About Legislating for Assisted Dying: Ethical Concerns' (2018) 24(1) Medico – Legal Journal of Ireland 20.

withholding of life-saving treatment would somewhat appear to be an active ending of an individual's life, if this has been done in the best interests of a patient it does not constitute a deprivation of life.[15] *Airedale NHS Trust v Bland* is a significant case in this discussion whereby a seventeen year-old boy was injured in the Hillsborough disaster. His lungs were crushed and punctured which resulted in the oxygen supply to the brain being interrupted.[16] Due to this, the damage to his brain was extreme and irreversible which left him in a persistent vegetative state (PVS). The medical professionals found that there was no hope of recovery and they made the decision to withhold all life-sustaining treatment including ventilation, nutrition and hydration.[17] It was held that the withdrawal of life-saving treatment was lawful in this case as Mr Bland did not have capacity to make a decision about his treatment so the medical practitioners were obligated to act in his best interests.[18] As his condition was permanent and there was no chance of recovery, allowing him to remain in a PVS would not have been in his best interests and as a result the principle of the sanctity of life was not violated.[19] Although this case does not engage with the issue of autonomy at the end of life, it conveys the importance of dying with dignity and the relief of suffering that is one of the supporting arguments in favour of assisted dying and euthanasia. However, it is quite confusing that a patient in a PVS with no capacity to make a decision was granted a dignified death, but a fully conscious person would not be given the same treatment even if their terminal illness was causing them great suffering.

The judgement in this case is noteworthy as we see how the test in *Bolam v Friern Hospital Management Committee* was applied to determine whether or not the removal of life-sustaining treatment was in the patient's best interests.[20] It was held that the doctor in *Bland* was correct in deciding to withdraw treatment as he was 'rightly guided by the value of the treatment given and the lack of value of other treatment'.[21] In the case of *Bolam*, a man who suffered from depression underwent Electroconvulsive Shock Therapy (ECT). He was unrestrained throughout the

[15] *Airedale NHS Trust v Bland* [1993] 2 W.L.R 316 (Bland).
[16] Ibid.
[17] *Bland* (n 15).
[18] *Bland* (n 15).
[19] *Bland* (n 15).
[20] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
[21] *Bland* (n 15) [54].

procedure and was not given any muscle relaxants, as a result he experienced extreme muscle spasms and fractured both of his hips.[22] During the proceedings, McNair J held that just because one doctor's judgement differs from another does not mean that he has acted negligently.[23] The test that stemmed from this case was that a medical professional's actions were not to be considered negligent if they 'had acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question'.[24] Therefore, the use of *Bolam* shows acceptance that the decision to withdraw or continue life-sustaining treatment was supported by a body of other medical professionals in *Bland.*[25] However, whilst *Bolam* may fail to advise courts on the best interests of a patient, it attempts to provide a safety-net for medical professional's actions to be justified by their colleagues. In *Bland*, it was established by the Court of Appeal that the issue was not about euthanasia nor was it about eliminating the old, vulnerable or physically defective.[26] The main issue was whether or not it is lawful to withhold life-saving treatment from a patient in a PVS who has no hope of recovery. With this in mind, one would view the removal of life-sustaining treatment in *Bland* as necessary and in the patient's best interests as the continuation of such treatment would have left Mr Bland in a degrading and undignified state which would have been against his wishes, according to his father.[27]

Although the Court of Appeal dismissed the idea that this case was about euthanasia, a connection can be made between deliberate removal of life-saving treatment and assisted suicide.[28] The issue of consciousness in this case and the best interests of the patient should be applied equally to assisted suicide cases as it would be inconsistent to allow a patient in a PVS with no consciousness to die with dignity but not allow a fully conscious patient the same courtesy. It is both saddening and shocking that a patient without capacity can avoid agony and suffering but if another

[22] *Bolam* (n 20).
[23] *Bolam* (n 20) [2-02].
[24] Bolam (n 20) [2-02].
[25] Jo Samanta, 'Enforcing Human rights at the End of Life: Is There a Better Approach?' in Alice Diver and Jacinta Miller (eds), *Justiciability of Human Rights Law in Domestic Jurisdictions* (Springer International Publishing Switzerland 2016).
[26] *Bland* (n 15).
[27] *Bland* (n 15) [6].
[28] *Bland* (n 15) [8].

patient wishes to exercise their autonomy through assisted suicide it is prohibited by law.

2.4 DNACPR Notices

Although DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) notices are considered lawful and do not involve the deliberate ending of a life, they do provide people with the right to refuse medical assistance with regards to saving their life.[29] Unlike the issue of removing life-sustaining treatment from a patient with no capacity in *Bland*, DNACPR notices are anticipatory and therefore allow patients to discuss their wishes with their family in advance.[30] Due to this, one would hold the view that DNACPR notices are an excellent way for terminally ill patients to take charge of their end-of-life rights and make arrangements that will prevent unnecessary suffering or further affliction.

However, like all end-of-life decisions there is always the possibility that the wishes of the patient are not taken into account. In *R (Tracey) v Cambridge University Hospitals NHS* the claimant's wife had been diagnosed with terminal lung cancer and was admitted to hospital following a car accident.[31] The family discovered that the Trust had placed a DNACPR notice on her file without her knowledge but it was subsequently removed after they expressed concern about it.[32] However, after three days, her condition worsened and another DNACPR notice was placed after consulting with her family and she died shortly after.[33] Mr Tracey brought an action against the Trust and the Secretary of State for Health respectively, claiming that both had breached her Article 8[34] right to respect for family and private life under the ECHR.[35] The claim advanced on the grounds that the Trust failed to consult with her family or her to notify her of the decision to place the DNACPR notice or to offer an

[29] Lynne Pearce, 'DNACPR Notices: What the Guidance Says' (2021) 36 (6) Nursing Standard 55.
[30] *Bland* (n 15).
[31] *R (David Tracey) v Cambridge University Hospitals NHS Foundation Trust* [2014] 3 WLR 1054.
[32] Ibid.
[33] *R (David Tracey)* (n 31).
[34] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR), art 8.
[35] *R (David Tracey)* (n 31).

alternative, and that the Secretary of State had failed to issue a clear national policy on the implementation of DNACPR notices.[36]

It was held by the Court that the Trust had breached the claimant's Article 8 right in respect to the first notice for failing to involve her in the process leading up to it.[37] However, it was also held that it would not be necessary under Article 8 to involve the patient or their family if it would cause physical or psychological harm.[38] Further, the clinician was not obliged under Article 8 to arrange to offer a second opinion as 'there is no positive article 8 obligation to ensure access to resuscitation'.[39] It was also established that the Trust's policy whilst the claimant's wife was in hospital was only designed to provide guidance to clinicians and was not issued to patients unless requested.[40] However, the current policy had rectified those problems and was clear. Thus, there was no longer a need for the Court to grant a declaration that the Trust ought to have a clear and accessible policy. Despite this, the separate claim against the Secretary of State was dismissed as it was held that the Secretary of State was not obligated under Article 8 to issue a mandatory national DNACPR policy but was merely entitled to encourage decision-making at a local level.[41]

What we see in this case is that the use of blanket DNACPR notices without the knowledge of the patients is an active abuse of patient autonomy as terminally-ill patients such as Mrs Tracey had been stripped of their right to choose what happens to them in the event that they may require resuscitation. This issue has given rise to various concerns for individuals with ongoing medical conditions as it is possible that they too have a DNACPR notice on their medical records without knowing it which is a strict violation of their Article 8 human right.[42] It seems that the unlawful placing of DNACPR notices highlights that patient's fundamental rights are put at risk by medical professionals who are in charge of their patient's wellbeing. Although these issues surrounding DNACPR notices are worrying, it shows that the laws prohibiting assisted

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[36] Ibid.
[37] *R (David Tracey)* (n 31) [29].
[38] Ibid.
[39] *R (David Tracey)* (n 31) [31].
[40] *R (David Tracey)* (n 31) [48].
[41] Ibid (n 31) [84].
[42] Clare Dyer, 'DNACPR Notices: Campaigner for Patient's Right to be Consulted Says Government has Misunderstood her Demands' (2020) 369 British Medical Journal <https://www.proquest.com/docview/2441287916?pq-origsite=primo&accountid=12118> accessed 6 April 2022.

suicide are not the only ones that take away the personal autonomy of terminally-ill citizens.

In terms of the laws regarding various end-of-life decisions, it is difficult to unsee the contradictory approach to assisted suicide in comparison to withholding life-saving treatment and DNACPR notices. The way in which courts have dealt with the withholding of life-sustaining treatment suggests that they may favour a consequentialist approach as the removal of all artificial means of feeding, hydration and ventilation from the patient in *Bland* when they were not in the patient's best interests achieved a better outcome than they would if they had remained. Although it was known that the removal of such treatment would lead to Mr Bland's death, that end was deemed more justifiable that leaving him a PVS which further demonstrates the consequentialist approach of the UK courts. However, it is difficult to see how this outlook is maintained as the approach to DNACPR notices appears to be more deontological. However this is not as clear cut due to Article 8 issues as highlighted in *Tracey.* It is important to note that the Human Rights Act 1998 was not passed at the time of the *Bland* case which allowed the courts to take a different approach than that of *Tracey*. If the Human Rights Act was in force at the time of *Bland*, it would have been possible that Article 8 would have been advanced in that case.

Despite this, any breach of the ECHR would be held as unjustifiable. However, due to the ambiguity of some of the articles it has been difficult for courts to establish if there has been a breach in the first place as seen in *Bland* and *Tracey*. Regardless, it has already been established that the approach towards assisted suicide is deontological as it has been criminalized in the Suicide Act 1961. With this in mind, one would question the logic behind making assisted suicide a crime but making the withdrawal of life-saving treatment and DNACPR notices legal, despite the fact that the latter triggers issues concerning consent, capacity and human rights breaches. Due to this, it is imperative that this area of law be developed further as the issue of life and death should not have so many grey areas.

3. The Legal Approach to Assisted Suicide

There is no doubt that the issue of assisted suicide has received significant legal attention in recent years mainly due to the arguments condemning the current law

prohibiting it. One of the main arguments in favour of the decriminalisation of assisted suicide is that the current laws are a violation of an individual's human rights as many believe that their right to life is also a right to die in whichever way they choose.[43] With this in mind there have been various attempts to change the law on assisted suicide and euthanasia due to the numerous cases where terminally-ill or physically incapacitated people who wish to end their lives have been unable to do so. This part of the article will discuss how the UK and ECHR dealt with these cases.

3.1 Assisted Suicide or Murder?

Although the law on assisted suicide is absolute whereby it is illegal under any circumstances, it is important to reflect upon the criminal law of murder and what constitutes murder. In order for someone to be guilty of murder, the jury must be convinced beyond reasonable doubt that the defendant caused the death of the patient, they intended to cause death or grievous bodily harm and they cannot raise a successful defence.[44] In murder cases it is essential to show that a defendant's action was a substantial and operating cause of the death. Therefore, if a doctor was on trial for the murder of a patient, the doctor's act does not have to be the sole cause of death but merely a substantial cause of death.[45] Therefore, if a doctor were to give a patient a dose of drugs which resulted in them dying, the doctor could be charged with murder as their actions brought about the patient's death.

However, intent can determine whether or not a doctor is guilty of murder. Therefore, if a doctor gave a patient painkilling drugs with the intent of relieving pain and the patient died, they could not be found guilty of murder as they were never intending to cause the patient's death.[46] Instead it is possible that they would be prosecuted for a lesser offence, depending on the circumstances. Furthermore, it must be noted that the concept of harm is often subject to different interpretation and as a result it is difficult to establish whether euthanasia is murder without first determining whether it constitutes harm.[47]

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[43] Kalaivani Annadurai, Raja Danasekaran and Geetha Mani, 'Euthanasia: Right to Die with Dignity' (2014) 3 (4) Journal of Family Medicine and Primary Care 478.
[44] Jonathan Herring, *Medical Law and Ethics* (8th edn, Oxford University Press 2020) 540.
[45] Ibid.
[46] Ibid 542.
[47] Hazel Biggs, *Euthanasia, Death with Dignity and the Law* (1st edn, Bloomsbury 2001) 25.

In our increasingly libertarian society[48] it is unlikely that many people view voluntary euthanasia as harm, as harm can only be inflicted upon an unwilling victim rather than in accordance with their own will.[49]

Hazel Biggs focuses on how the criminal justice system treats doctors, patients and carers who have fallen victim to the non-empathetic and inflexible laws against euthanasia for the crime of wishing to reduce pain and suffering at the end of life by opting for a quick and merciful death.[50] However, we see in the trial of Dr Adams in *R v Adams*[51] how courts deal with such cases involving doctors. Dr John Adams was in charge of the care of an eighty-four-year-old woman who was terminally ill.[52] He administered a large dose of drugs to her and she died afterwards. Dr Adams was found not guilty of murder; whilst it was held that if the first objective of medicine which is to preserve life cannot be fulfilled, the doctor is entitled to do everything in his power to relieve the suffering of the patient even if it may shorten their life.[53] The case of *R v Adams* is a prime example how of the doctrine of double effect can mean the difference between assisted dying and murder. Although the administration of the pain medication caused the patient to die sooner, it did not constitute murder as the intention was to reduce suffering and her death was a side effect of this. This case further emphasises the need for intent in order for the act to constitute murder.

This is also illustrated in *R v Cox*[54] whereby the doctor fulfilled a dying patient's wishes by injecting her with potassium chloride which was intended to bring about her death as it had no other remedial value.[55] Dr Cox was then charged with attempted murder and was found guilty by the jury who had no choice but to convict, despite it being of the patient's own volition.[56]It is evident from this case that the legal approach to euthanasia is an absolute one as it is always considered to be a criminal act, regardless of the wishes of the patient.

We can see through the handling of individual cases how inconsistent the law on euthanasia really is as Dr Cox was treated as a criminal for deliberately euthanizing

[48] Ibid.
[49] Ibid.
[50] Ibid 26.
[51] *R v Adams* [1957] Crim LR 365.
[52] Ibid.
[53] Ibid.
[54] *R v Cox* [1992] 12 BMLR 38.
[55] Ibid.
[56] Ibid.

his patient as she wished, whereas the deliberate removal of life-sustaining treatment as seen in *Bland* was deemed as lawful despite the patient not having the capacity to voice his wishes.[57]

Due to the varying decisions from courts with regards to euthanasia, it is clear that the existing inconsistencies in the law must be reviewed. There needs to be more straightforward guidance for courts to follow when dealing with assisted dying cases as the common law authorities appear to provide more questions than answers due to the varying circumstances such as whether the drugs used were to reduce suffering or end the patient's life quicker, or both. It must also be noted that the demand for the review of the current law is not merely to benefit the pro-euthanasia agenda but rather to provide clinicians, patients and families with the necessary information to avoid any distressing cases in the future where the defendant is being charged with the murder of another person when they simply tried to honour their wishes.

3.2 Human Rights

It comes as no surprise that human rights are a central focus in the assisted suicide debate due to the conflict between the current law and the rights of individuals. Courts have dealt with numerous right-to-die cases with individuals claiming that their human rights have been breached by the refusal to end their own lives with the help of a loved one or clinician. The main cases that will be discussed in here are the cases involving Diane Pretty and Tony Nicklinson who both relied heavily on the articles of the ECHR to appeal for the right to end their own lives lawfully with assistance. Regardless of the outcome of these cases, the fact that such cases have received this degree of judicial attention is already a step in the right direction for the assisted suicide debate.

In *R (Pretty) v DPP,*[58] Diane Pretty was in the stages of a fatal incurable degenerative disease. She had expressed her fear and distress about the suffering that she would endure if the disease progressed and wished to choose how she died to avoid the pain and indignity that she would experience.[59] Due to her disability she was unable to end her own life and thus wished for her husband to help her which he accepted provided

[57] Biggs (n 47) 28.
[58] *R(Pretty) v DPP* [2002] 1 AC 800.
[59] Ibid.

that he would not be prosecuted under section 2(1) of the Suicide Act 1961.[60] This request was denied by the Director of Public Prosecutions as it was argued that he did not have the statutory power required to grant an advance pardon for a future criminal act.[61] Mrs Pretty requested a judicial review by arguing that the decision was a violation of her human rights. It was argued that Article 2 gave her the right of self-determination, which she interpreted as a right to commit suicide with assistance to avoid inhuman and degrading treatment condemned in Article 3.[62] Further, she argued that if this was denied, her rights to privacy and freedom of conscience under Articles 8 and 9 would be infringed. She also contended that she had experienced discrimination that was in breach of Article 14 as an able-bodied person would be able to end their own life. However, her disabilities prevented her from doing so.[63]

In response to these arguments, the appeal was dismissed due to the language in Article 2 emphasising the significance of the sanctity of life and thus could not justify the intentional taking of a life.[64] Furthermore, the ECtHR held that the right to life guaranteed in Article 2 could not be interpreted as a right to die and that Article 2 is not concerned with the quality of a person's life or what they chose to do with it.[65] In relation to Article 8, it was accepted that the right to private life was also the right to self-determination. However, it was argued that whilst Article 8 seeks to protect an individual's autonomy whilst they are alive, it does not give them the right to decide how and when they die.[66] However, the ECtHR held that the law prohibiting assisted suicide prevented Mrs Pretty from avoiding a painful and undignified death and thus could not deny that this interfered with her right to respect for private life.[67] It was held that the UK Government had not strictly violated any of Mrs Pretty's human rights, but rather made a lawful interference with her Article 8 rights.

One of the fundamental details of this case is that whilst the ECtHR accepted that Mrs Pretty's Article 8 right had been interfered with, that interference was justifiable as Article 8 had to yield to Article 2 to guarantee the protection of life. Although the

[60] Ibid.
[61] *R (on the application of Pretty) v DPP* [2001] EWHC Admin 788 [39].
[62] *R (Pretty)* (n 58).
[63] Ibid.
[64] Ibid.
[65] *R (Pretty)* (n 58) [39].
[66] Ibid 1 AC 800.
[67] *Pretty v United Kingdom* [2002] 35 EHRR 1 [67].

decision proved to be unhelpful for Mrs Pretty, it should change the judicial approach to assisted suicide cases significantly as the ECtHR acknowledged that the prohibition of assisted suicide was a prima facie violation of Article 8.[68] With this in mind, one would agree that the current law prohibiting assisted suicide takes away the personal autonomy of terminally ill citizens as their Article 8 right can be obstructed if it interferes with the sanctity of life principle.

Another landmark case in the assisted-dying debate is that of *Nicklinson.*[69] Tony Nicklinson had been left paralysed and unable to speak after suffering a stroke in 2005.[70] His only method of communication was blinking and slight head movements. Unable to do so himself, he requested that a doctor legally end his life. He also wished for a declaration from the Court stating that the law prohibiting assisted suicide was incompatible with Article 8 ECHR.[71] The second claimant in this case only known as Martin was quadriplegic after suffering a brainstem stroke. Like Mr Nicklinson, he could only communicate through slight movement of his head and eyes.[72] Martin sought an order for the DPP to clarify the policy on assisted suicide as well as a declaration that the law on assisted suicide was incompatible with Article 8.[73]

The Supreme Court held that the interference with the claimant's Article 8 rights had to be balanced with the interests of society in order to protect vulnerable people from feeling pressured to end their own lives.[74] In relation to Mr Nicklinson's claim that the laws on assisted suicide were incompatible with Article 8, the Court pointed out what Strasbourg had held in *Pretty* that a blanket ban was still compatible with the ECHR.[75] Although all the arguments made by the claimants were rejected by the court, this case still represents a shift in the judicial attitudes towards assisted suicide as the Supreme Court issued a direct challenge to Parliament to reflect on the law on assisted suicide.[76] As judges have highlighted their struggles to exercise their jurisdiction under section 4 Human Rights Act 1998 in relation to assisted dying cases, it is evident that

[68] Nataly Papadopoulou, 'From Pretty to Niklinson: Changing Judicial Attitudes to Assisted Dying' (EHRLR 2017) 3 European Human Rights Law Review 6.
[69] *R (Nicklinson) v Ministry of Justice* [2012] EWHC 2381.
[70] Ibid.
[71] Ibid.
[72] Ibid.
[73] Ibid.
[74] *R (Nicklinson) v Ministry of Justice* [2015] AC 657.
[75] Ibid.
[76] *R (Nicklinson)* [2015] (n 74) [103].

the law on assisted suicide ought to be reconsidered by Parliament.[77] This would be necessary not only in changing the laws on euthanasia, but providing guidance to courts as to whether or not they should treat assisted suicide in a similar manner to cases concerning DNACPR notices and withholding life-sustaining treatment.

Here, courts have actively addressed the assisted dying debate. Assisted suicide cases making it to the ECtHR already demonstrates a step towards a formal review of the current law on assisted suicide. Although it was held in both cases that there was an infringement of the claimants' human rights but this was deemed to be lawful, the Strasbourg court admitted that the current ban on assisted suicide did hinder the rights of the claimants. With this in mind, one ought to expect the issue of assisted suicide to be readdressed in the future by Parliament. However it is uncertain whether or not any radical change will come from it.

3.3 Demand for Legal Reform

The cases of Diane Pretty and Tony Nicklinson gave rise to numerous arguments in favour of allowing terminally ill people to decide how and when they die. One of the attempts to change the current law on assisted suicide was the Assisted Dying Bill 2014 which was a private member's bill drafted to 'enable competent adults who are terminally ill to be provided at their request with specified assistance to end their own life'.[78] All those in favour of the Bill pointed out that it came with specific safeguards in place as it was only intended for people with terminal illnesses and needed the approval of a court as well as statements from medical professionals.[79] Although this Bill stemmed from the cases of Diane Pretty and Tony Nicklinson, the proposed criteria would have been so strict that they themselves would not have been eligible as neither of them were 'reasonably expected to die within six months'.[80] With this in mind, one would hold the view that such a criteria would ensure that the law on assisted dying does not encounter a slippery slope as feared by many opposed to assisted suicide. These safeguards would prevent elderly or vulnerable people from feeling pressured

[77] Ibid [104].
[78] Assisted Dying Bill HL (UK Parliament, 19th Jan 2015) <https://bills.parliament.uk/bills/1381> accessed 20 March 2021.
[79] Herring (n 44) 613.
[80] Ibid.

into ending their own lives whilst still allowing terminally ill people the choice to end their suffering and avoid an undignified death.

4. Conclusion

To conclude this work, it is important that we review the key findings in this discussion of whether the laws prohibiting euthanasia in the UK are taking away the personal autonomy of terminally ill citizens. In relation to end-of-life decisions, courts take an almost hypocritical approach towards cases involving the withdrawal of life-sustaining treatment and the use of DNACPR notices. Not only do both practices end with the patient's death, but the absence of consent and the reliance on a patient's best interests contradicts the absolute prohibition of assisted suicide as it does not seem reasonable to deny a competent person the right to end their own life with assistance whilst allowing an incompetent person to be removed from life support if it is in their 'best interests'. Furthermore, the implementation of DNACPR notices can be a positive way for terminally ill people to have some control over how they die. However, the abuse of this practice by doctors who placed DNACPR notices on patients' medical record without their knowledge has led to growing concern for many people with terminal illnesses as they fear that their wishes will not be considered. Due to this, one would argue that the current law on assisted suicide needs to be reviewed as inconsistencies such as these cannot be justified whilst there is a blanket ban on assisted-dying.

As the topic of euthanasia is one of the most widely debated ethical issues in medical law, we must consider how prolonged suffering is one of the fundamental reasons behind the assisted suicide argument. It is clear that the idea of prolonged pain and suffering is heavily depended on when it comes to advocating for the legalisation of assisted suicide. However, as we have seen in previous cases, this has proven ultimately useless when addressed in court. It appears that although the suffering of individuals is deeply upsetting to most people, it is still not a good enough reason to allow a terminally ill person to exercise their autonomy and end their suffering.

As the current legal approach to assisted suicide in the UK in the central theme of this work the concluding remarks are as follows. The notion that an individual who assists another to end their own life is guilty of murder is the catalyst for the influx of right to

die cases in UK courts, as Diane Pretty petitioned for her husband to receive legal immunity if he assisted her in ending her own life. Although, the right to die cases mentioned in this article did not prevail, they opened up a much needed conversation regarding the compatibility between the articles of the ECHR and s.2(1) of the Suicide Act 1961. Although it was held by both the House of Lords and Strasbourg that the UK laws forbidding assisted suicide did not infringe the claimants' human rights, it was still acknowledged that the law on assisted suicide needed reviewing as there was a degree of interference with the plaintiffs' rights. With this in mind, one could draw the conclusion that the laws condemning assisted suicide do in fact take away the personal autonomy of terminally ill citizens as courts allow for other rights to take precedence such as the right to life. On a final note, whilst the law forbidding assisted suicide and euthanasia in the UK interferes with the personal autonomy of terminally ill individuals, the somewhat justifiable reasons for this highlight various inadequacies in the law. Due to this, we can expect the issue of assisted suicide to be readdressed in the near future although it may not lead to full legalisation, further clarification is needed to make the UK's position clear.

Bibliography

UK Cases

Airedale Trust v Bland [1993] 1 All ER 831

Bolam v Friern Hospital Management Committee [1957] 1 WLR 582

R (David Tracey) v Cambridge University Hospitals NHS Foundation Trust [2014] 3 WLR 1054

R v Adams [1957] Crim LR 365

R v Cox [1992] 12 BMLR 38

R(on the application of Pretty) v DPP [2001] EWHC Admin 788

R(Pretty) v DPP [2001] 3 WLR 1598

R(Pretty) v DPP [2002] 1 AC 800

ECtHR Cases

Pretty v United Kingdom [2002] 35 EHRR 1

R (Nicklinson) v Ministry of Justice [2012] EWHC 2381

R (Nicklinson) v Ministry of Justice [2015] AC 657

Legislation and Regional Conventions

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

Human Rights Act 1998

Marriage (Same Sex Couples) Act 2013

Mental Capacity Act 2005

Suicide Act 1961

Books

Biggs H, *Euthanasia, Death with Dignity and the Law* (1st edn, Bloomsbury 2001)

Foley KM and Hendin H, *The Case Against Assisted Suicide: For the Right to End-Of-Life Care* (Josh Hopkins University Press 2002)

Herring J, *Medical Law and Ethics* (8th edn, Oxford University Press 2020)

Holbrook H, *Purpose of Law* (Great Falls Tribune 2010)

O'Neill O, *Autonomy and Trust in Bioethics* (Cambridge University Press 2002)

Sensen O, *Kant on Moral Autonomy* (Cambridge University Press 2012)

Chapters in Edited Books

Samanta J, 'Enforcing Human rights at the End of Life: Is There a Better Approach?' in Alice Diver and Jacinta Miller (eds), *Justiciability of Human Rights Law in Domestic Jurisdictions* (Springer International Publishing Switzerland 2016)

Journal Articles

Annadurai K, Danasekaran, R and Mani, G 'Euthanasia: Right to Die with Dignity' (2014) 3(4) Journal of Family Medicine and Primary Care 478

Campbell L, 'Current Debates About Legislating for Assisted Dying: Ethical Concerns' (2018) 24(1) Medico – Legal Journal of Ireland 20

Dyer C, 'DNACPR Notices: Campaigner for Patient's Right to be Consulted Says Government Has Misunderstood her Demands' (2020) 369 British Medical Journal <https://www.proquest.com/docview/2441287916?pq-origsite=primo&accountid=12118> accessed 6 April 2022

Lee CHJ, Duck IM and Sibley CG, 'Demographic and Psychological Correlates of New Zealanders' Support for Euthanasia' (2017) 130 The New Zealand Medical Journal 9

Papadopoulou N, 'From Pretty to Niklinson: Changing Judicial Attitudes to Assisted Dying' (2017) 3 European Human Rights Law Review 6

Pearce L, 'DNACPR Notices: What the Guidance Says' (2021) 36(6) Nursing Standard 55

Other

Assisted Dying Bill HL (UK Parliament, 19 January 2015) <https://bills.parliament.uk/bills/1381> accessed 20 March 2021

Moore S, *The Decriminalisation of Suicide* (PhD Thesis, London School of Economics and Political Science 2000)

UK Parliament, 'The Right to Die and Assisted Suicide' <https://www.parliament.uk/business/publications/research/key-issues-parliament-2015/social-change/debating-assisted-suicide/> accessed 28 March 2021