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## A 'CHARTER OF LIBERTIES': IS REFUSING THE 'RIGHT TO DIE' A FAILURE TO MAINTAIN THE SPIRIT OF MAGNA CARTA?

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### 1. INTRODUCTION

Magna Carta emerged from a struggle between one ruthless leader (the King of England) and a group of equally ruthless lesser leaders who wanted the king to share his power with them. Ordinary people played no part in this struggle and their interests were not protected by Magna Carta. However, the spirit of Magna Carta was that government should not be arbitrary, but should be subject to rational law; and that freedom should be maximised (subject to principles such as the need to avoid harm to others and the need to raise taxes for the common good). This is the essence of a modern secular liberal democracy.

It may not be obvious what any of this has to do with the idea of a 'right to die'. However, making government subject to rational law and protecting individual freedom protects the less powerful in society – people who have insufficient money or influence to buy their freedoms. People who are suffering incurable illness or disability are among the most powerless people in modern society, for even money and influence is not guaranteed to help alleviate suffering.

In a modern liberal secular democracy the State has no right to tell us how to run our lives (subject to the principles already mentioned). Who could dispute that choosing the time and manner of one's own death is part of running one's own life? No-one should tell people who are ill or disabled that they should die. But equally, no one should prevent them from dying if and when they wish to do so

This was partially accepted in the UK when suicide was legalised (Suicide Act 1961 s 1), and was acknowledged, in *Haas v Switzerland* (2011) 53 E.H.R.R. 33, to be an element of the 'right to respect for private life' in the ECHR Art 8. But assisting suicide remains a crime in the UK and most other European countries - as is voluntary euthanasia (killing someone at that individual's request) and mercy killing (defined here as killing someone in what the perpetrator believes to be that individual's best interests).

The aim of this paper is to explore how the the legal regulation of assisted dying in England and Wales works, and to propose a different form of regulation that would be more likely to achieve its aims. Applicable to many jurisdictions, this is an increasingly important issue. For medical science cures, treats and manages diseases and injuries that used usually to be fatal. So people are living longer, but increasingly with illnesses, disabilities or deteriorating mental capacity that make their lives so

intolerable that the joy of living becomes outweighed by pain, suffering and indignity. And this trend will increase. The demand from some of these people to be allowed to seek help in securing a release from this suffering will increase. At least nine jurisdictions now allow some forms of assisted dying. But in many other jurisdictions there are rigid laws that criminalise those whose sole aim is to carry out the wishes of their loved ones.

If we accept that we should be able to kill ourselves, it follows logically that – all other things being equal – we should be able to be killed, or helped to die, by others at our request. Otherwise we are not being allowed to choose the time and manner of our own deaths. However, all other things are not equal. Complete legalisation of assisted dying (AD) – by which I mean voluntary euthanasia (VE) and assisting suicide (AS) but not mercy killing – would run the risk of exposing vulnerable people to pressure to die from people seeking to benefit from their deaths. We therefore need a regulatory system that allows those who wish to die to do so, while ensuring that, as far as possible, those whose dying is assisted are *only* those who wish this to happen. This is broadly the position of both the ECtHR and the UK courts (although not UK legislation) regarding AS but not VE.

## 2. ETHICO-POLITICAL PRINCIPLES AND THE AIMS OF LEGAL REGULATION

There are 3 broad positions of principle on this issue:

### a) *The sanctity of human life*

Proposition 1: Killing and helping to kill is fundamentally wrong, so AD should be criminal in all circumstances. The aim of legal regulation should be to preserve the sanctity of human life. This trumps individual autonomy.

Proposition 2: Allowing AD would ‘send a message’ that suicide is fine. It would facilitate the placing of pressure on vulnerable people to die before they are ready, doing demonstrable harm to them. Thus autonomy would be compromised by allowing AD anyway.

### b) *The preservation of individual autonomy*

Proposition 1: Suicide is not immoral and it harms only the dead person. It is therefore rightly legal. Thus killing that individual, or assisting their death, at their request is also moral and so should also be legal in all circumstances. The aim of legal regulation should be to preserve individual autonomy. This trumps the sanctity of human life.

Proposition 2: Preventing AD does demonstrable harm (i) to those who wish to die by preventing or obstructing their deaths; (ii) driving AD underground, facilitating the placing of pressure on vulnerable people to die before they are ready, undermining the sanctity of human life anyway.

### c) *Creating conditions that facilitate choice (that is as free as possible)*

Neither the principle of sanctity of life nor that of autonomy should be allowed to trump the pragmatic considerations contained in proposition 2 of both positions of principle. The aim of legal regulation should be to facilitate AD to the extent that it gives effect to the genuine wishes of those who wish to die, to protect those who do not, and to treat suicidal desires (and their causes) as a public health issue.

We shall see that the legal regulation of AD in England and Wales currently purports to adopt the ethical position and aims in (c) in relation to AS, and in (a) in relation to VE.

### 3. ASSISTED SUICIDE: LAW AND POLICY

Prosecution of people against whom there is sufficient evidence is not automatic in the UK. It has to be ‘in the public interest’ (Sanders, Young and Burton, 2010, Ch 7). The Code for Crown Prosecutors sets out broad ‘public interest’ criteria. The result is that some types of offence and offender are nearly always prosecuted, while others are not. It was not evident that prosecution was unlikely for AS until statistics began to be published a few years ago, although in fact it was rare.

In the leading case (*R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45) Mrs Purdy suffered from MS and foresaw that the time would come when she would want to end her life. Not knowing if she would wish, or be able, to do this without assistance by that time, she initially sought an assurance from the Crown Prosecution Service (CPS) and the Chief Prosecutor (DPP) that her husband would not be prosecuted if he assisted in her suicide. The DPP refused to give that assurance. She then argued that, as it was impossible to predict how the DPP would exercise discretion in AS cases, a specific policy was needed (The CPS only began publishing, on its website, reasons for not prosecuting notable cases following the High Court hearing in *Purdy* in 2008. The *Daniel James* case (discussed by A Mullock, “Prosecutors making (Bad) Law?” (Med LR (2009) 17: 290) was the first. Also see Even then, predicting what would happen in a particular case was difficult, since the particular reasons for not prosecuting in the *James* case could not be discerned from the Code). The court agreed: since Mrs Purdy’s Art 8 right to privacy was violated by the Suicide Act, only the exercise of discretion to not prosecute in appropriate cases could ensure that Art 8 (2) (violation of 8 (1) is permissible only when it is “necessary ... in the interests of ... public safety ... for the protection of health or morals”) is satisfied. But to ensure consistent interpretation of what are ‘appropriate cases’, and to help Mrs Purdy and people in her type of position predict what the DPP would do, published guidelines were needed (This conclusion has been challenged on the grounds that there is no obligation to help people predict when the law will not be enforced against them; and that since the consistency of the DPP’s decision-making had not been challenged, there was no problem to remedy: K. Greasley, ‘*R (Purdy) v DPP and the case for wilful blindness*’ (2010) Ox J LS 30: 301. This fails to recognise that consistent practice cannot be judged abstractly; it has to be evaluated according to a clear set of standards, which is what the House of Lord ordered the DPP to formulate and publish).

Interim guidelines, broadly collating the criteria used for making decisions up to that point in time, were rapidly produced and made subject to a public consultation exercise. In 2010 the final guidelines were published [http://www.cps.gov.uk/publications/prosecution/assisted\\_suicide\\_policy.html](http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html). Updated October 2014. Last visited, 21st October 2014). The main elements of the guidance identify prosecution as more likely when:

- ❖ the victim was under 18 years of age;
- ❖ the victim had not reached, or was not capable of reaching, a voluntary, clear, settled and informed decision to commit suicide and/or was subject to pressure from D or others;
- ❖ the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
- ❖ the victim did not seek the assistance of the suspect personally or on his or her own initiative;
- ❖ the suspect was not wholly motivated by compassion
- ❖ the suspect had a history of violence or abuse against the victim;
- ❖ the victim was physically able to undertake the act that constituted the assistance him or herself;
- ❖ the suspect was unknown to the victim and assisted the victim providing specific information via, for example, a website or publication;

- ❖ the suspect assisted more than one victim who were not known to each other;
- ❖ the suspect was acting in his or her capacity as eg a medical doctor, nurse, other healthcare professional, a professional carer (note that the position is different for eg a doctor who acts as a friend and has no duty of care to the victim);
- ❖ the actions of the suspect were of substantial assistance;
- ❖ the suspect had not sought to dissuade the victim and/or did not act reluctantly.

We should note that whether illness/incapacity is terminal or not is irrelevant, and that the guidelines do not apply to voluntary euthanasia (VE). This is the result:

*Assisted suicide cases referred to CPS by police (1/4/2009 to 25/4/2015)*

([http://www.cps.gov.uk/publications/prosecution/assisted\\_suicide\\_policy.html](http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html). Updated October 2014. Last visited, 21<sup>st</sup> October 2014).

Not proceeded with	95
Completed prosecution (and conviction) (Kevin Howe)	1
Charged and/or on-going prosecution	8
Referred onwards for prosecution for other offence(s)	6
TOTAL	110

The most recent case is *Nicklinson* ([2014] UKSC 38). Although this concerned a man with ‘locked-in’ syndrome, which meant he could not commit suicide even with assistance (and so he really sought immunity for loved ones who, at his request, would commit VE) most of the discussion concerned AS. Some of the judges in this case envisaged issuing a declaration that UK law on AS is incompatible with the ECHR if there no move to at least partial decriminalisation were to be made. For they considered the link between the criminalisation of AS and what is “necessary ... in the interests of ... public safety ... for the protection of health or morals” (Art 8 (2)) is too tenuous.

We know from the fact that AS is rarely prosecuted that the guidelines pointing against prosecution are given great weight in practice. People are not prosecuted when they are judged (by police and CPS) to help other people who genuinely wish to die to do so. They discourage people from helping other people to die when they have something to gain from the death. But whether they succeed in achieving the aims of position (c) is another matter. They discourage ‘victims’ from seeking assistance from types of perpetrator or in particular situations as follows:

*Perpetrators with a specialist ability to facilitate suicide*

This policy restricts the expert advice and help victims can get on the least painful or distressing ways to die. The policy is “designed to ensure that assistance in suicide remains an amateur activity carried out by inexperienced individuals without the assistance of professionals.” (Lewis, 2011). The result is botched attempts, deaths that are more painful and distressing than they need to be, and more cases where the assister ends up being the actual killer and hence more likely to be prosecuted. For example, a terminally ill man, William Stanton, recently survived a suicide pact in which his wife, who was healthy but did not want to live without him, died (<http://www.dailymail.co.uk/news/article-1304427/>). There are many cases where, as a result of inadequate knowledge, people make unsuccessful suicide attempt after (Keating and Bridgeman, 2012).

A tragic example of the general problem of restricting advice from professionals is the only prosecution for AS carried out between the publication of the guidelines and the decision in *Nicklinson*. The perpetrator provided petrol and a lighter to a vulnerable man known to have suicidal intent, and who subsequently suffered severe burns as a result. ([http://www.cps.gov.uk/news/latest\\_news/kevin\\_howe\\_convicted\\_of\\_assisted\\_attempted\\_suicide/](http://www.cps.gov.uk/news/latest_news/kevin_howe_convicted_of_assisted_attempted_suicide/)). Defenders of the Policy may see this case as vindication of its restrictive policy, enabling prosecution of the irresponsible perpetrator. In reality it serves to condemn that policy, for if the victim had been able to secure better advice and assistance he is unlikely to have suffered so horrifically.

*Perpetrators whose assistance was no greater than that which the victim could do*

An example is Loder's case, in which three people were arrested. It was decided there was insufficient evidence against one, and that it was not in public interest to prosecute the other two. One had only contributed to the deceased's 'preparations' while the other had only had two phone conversations with her

([http://www.cps.gov.uk/news/latest\\_news/cps\\_statement\\_on\\_decision\\_in\\_relation\\_to\\_doctor\\_elisabeth\\_wilson/](http://www.cps.gov.uk/news/latest_news/cps_statement_on_decision_in_relation_to_doctor_elisabeth_wilson/)).

But this principle compounds the principle that specialist help is penalised. One result is that many UK citizens travel to Switzerland to die at Dignitas, where death is assisted by expert help. They are generally assisted in their travels by friends and/or family who are never prosecuted (Rogers, 2010). For the effort and anguish involved for the person who wants to die in travelling abroad and going through that process is evidence that they really want to do this and will have convinced the 'suspects' that this is no mere whim. On the other hand many people in this situation *need* assistance to travel to Switzerland. This would, if the policy is interpreted consistently, make prosecution likely. In addition, according to the official policy, anyone organising a Dignitas-type process in the UK, or who gives organised advice on suicide via websites, organisations etc will be probably prosecuted. Very ill or disabled people would be more likely to travel unassisted to such a place in the UK than outside the UK, but it is hard to understand why it is preferable for people to travel abroad to die than to do so in the UK, unless the objective is simply to make it more difficult, which is hard to reconcile with any of the principles that might form the ethical basis of law and policy.

To privilege AS abroad over AS in the UK, is both arbitrary and cruel. The suffering of people who wish to die, and that of their friends and family, is compounded by requiring travel to a foreign country away from the comfort of one's home and loved ones (S. Ost, "The De-medicalisation of Assisted Dying: Is a Less Medicalised Model the Way Forward?" *Med L Rev* 18(4) (2010), 497-540). Moreover the travel will often be literally painful and difficult, and available only to those who can afford it.

*Perpetrators who are honest enough to admit that they endorsed the victims' wishes*

Coupled with the emphasis given to the reluctant suspect and determined victim, we have here a set of random value judgements about culpability that have nothing to do with any of the ethical principles identified earlier. If the suspect is reluctant to help the 'victim' s/he would presumably consider the act irrational (if it were rational why would s/he be reluctant to help a loved one?). But if it is considered irrational, surely this would be a bad reason for helping, as treatment or persuasion should be encouraged to enable the victim to see sense. The Guidelines focus on the motive of the perpetrator ('compassion'). This is inevitable when considering whether to prosecute. But it gives only partial protection to the victim. If we wish to give effect to principle (c) the policy should focus on whether the victim freely chose to die.

Further, as Neuberger indicates in *Nicklinson*, if we want to be sure that someone who says they want to die really wish to do so, it is better to investigate what pressures and psychological problems they may be suffering before they die (when they can be asked) than afterwards (when those speaking for

them may be the very people putting them under this pressure). Thus while the prosecution policy could be tweaked to give better effect to principle (c), only a pre-suicide policy can give it full effect.

#### 4. VOLUNTARY EUTHANASIA: LAW AND POLICY

We have seen that the CPS refuses to articulate a policy for VE. The DPP could have included this within the AS policy, but chose not to do so. He has not publicly stated why. The court in *Purdy* required AS guidelines, which he produced, but did not suggest that VE guidelines would be inappropriate. We might categorise people who seek VE as follows:

- a) those who are physically incapable of taking the final step
- b) those who try and fail to take the final step themselves
- c) those who do not wish to take the final step themselves

The purpose of this might be to construct a policy allowing VE for (a) but not (c). But no-one is incapable of taking the final step. Tony Nicklinson, who could do nothing for himself, might have been regarded as within group (a). He sought a ruling that he could be killed when he wished. But eventually, frustrated and distressed by lack of success in the courts, he starved himself to death. So even people who can do nothing for themselves can take the final step. But, condemning them to this is to condemn them to one of the most inhumane deaths one can imagine.

#### 5. DIFFERENT LAWS AND POLICIES FOR ASSISTED DYING: REDUCING AND ESCALATING HARM

We have seen that, although the ‘sanctity of human life’ and ‘individual autonomy’ positions comprise positions of principle that share no common ground, they do share empirical concerns to avoid or reduce harm. It is to this shared concern that we now turn, some of which has already been touched on, but which needs more systematic analysis.

##### 1) *The doctrine of ‘double effect’*

Adherents to the ‘sanctity of life’ doctrine who oppose all AD, such as Keown (2002), generally attempt to mitigate the harshness of their position by endorsing the doctrine of ‘double effect’. This doctrine, which emerged from catholic theology, was made part of English law in *Adams* ([1957] Crim LR 773) and endorsed in *Airedale NHS Trust v Bland* ([1993] 2 WLR 316). It provides that doctors who administer such large doses of sedation-inducing or pain-relieving drugs that life would be shortened, are not guilty of homicide if their primary objective is to relieve suffering. This is true even if they know that it will shorten life.

While ‘double effect’ allows health care professionals to facilitate AD it also facilitates non-voluntary euthanasia by health care professionals. Some will be mercy-killers, while others will be bounty-hunters or pathological killers. What are we to make of Howard Martin GP, who admitted hastening the death of dozens of his patients, some – but not all – at their request. Only rarely are such cases investigated by the police and even more rarely prosecuted. Martin was tried for murder. But he was acquitted, and then struck off (<http://www.theguardian.com/society/2010/jun/19/howard-martin-doctor-euthanasia>). The prosecution only happened because of its extreme facts, and the acquittal will have done nothing to encourage future prosecutions or deter medical killing without consent.

##### 2) *Forcing or persuading people to die when not ready*

A permissive AD policy could make vulnerable people – particularly those who feel a burden to friends and relatives - susceptible to pressure from those people to end their lives. Further, a permissive policy could create a climate that takes the stigma from active life-ending that is offensive per se to adherents of position (a) ('sanctity of human life'), but which also increases susceptibility to pressure. This concern should also be shared by anyone adhering to b) or c), for ending life due to pressure is intrinsically bad and also compromises autonomy. However, there is always the risk of pressure from friends and relatives, whatever the law and policy. The present policy is especially risky. For it gives more leeway to friends and relatives who assist suicide than to health care professionals acting in a professional capacity. We are rightly concerned about people with a vested interest encouraging the weak and vulnerable to end their life, so a rational policy would not allow them to engage in AD. If requests for AD were vetted and acted upon only by professionals of some kind, the risks would be greatly reduced.

It must be accepted that any permissive AD policy might encourage or pressure some people to seek to end their life when, in other circumstances, they would not. In some cases encouragement can be positive, providing release from suffering, but in some cases encouragement (and, in all cases, pressure) will be negative. But there is no evidence that negative encouragement or pressure is greater in jurisdictions with permissive policies than in those with restrictive policies Commission *ON ASSISTED DYING*, 2011). Further, people have the right to demand that life-saving equipment be switched off (*B* [2002] EWHC 429 (Fam)). As Hale points out in *Nicklinson*, these people are no less vulnerable to pressure from uncaring or unscrupulous relatives than those who seek active help in dying.

Nonetheless, position (c) requires that law and policy seek to maximise the positive cases and minimise the negative ones. Logically, this would be by having trusted people talk to those seeking AD to ascertain whether they are acting under pressure from those they do not wish to 'burden', or the pressure of whatever it is from which they are suffering. And, in the latter case, whether there are other ways of eliminating or reducing that suffering that do not require AD. If this is accepted, the law should look at AD cases in advance of the decision being taken, not afterwards. It would not only be a more accurate way of identifying whether people act as autonomously as is possible, but might even reduce the number of deaths. It is certainly not likely to increase them.

Current law and policy allowing AS but not VE creates a different kind of pressure to end life prematurely. People suffering many forms of degenerative disease know that they will wish to die at some point before their life ends 'naturally'. They will seek to die when life becomes, on balance, worse than death. But many in this position fear that they will not be able to kill themselves - even with assistance - by that time, that they will not be able to communicate their wishes clearly, or that they will not be able to ensure their wishes are carried out. They therefore feel under pressure to take their lives prematurely, while they can do so and/or communicate and enforce their wishes. As Neuberger said in *Nicklinson* "The evidence shows that, in the light of the current state of the law, some people with a progressive degenerative disease feel themselves forced to end their lives before they would wish to do so, rather than waiting until they are incapable of committing suicide when they need assistance (which would be their preferred option)." (para 96). If we allowed VE this problem would be alleviated and some people would choose to die later than they do now, and would do so as contentedly as their circumstances allow.

### **3) Inhumane life and death**

We have seen that current law and policy aims to prevent VE, to discourage AS, and to limit the amount of help and expertise that is made available to those who nonetheless seek AS. Persuading or requiring people to stay alive when they wish to die deliberately constrains autonomy. But the more tangible harm is that those suffering conditions such as disability, great pain, and degenerative illness are forced to endure increasingly tortured lives. As Neuberger said in *Nicklinson*, sufferers live a life that is "undignified, distressing and intolerable." There are many of them: hundreds of people living in enormous pain and/or distress (Commission on Assisted Dying, 2011)..

We have also seen that attempts to kill are often botched, causing distress and sometimes physical harm. Some people try several times before they are successful, others eventually ask someone to administer VE and risk prosecution, while yet others suffer interminably. As Magnusson (2002, p 202) says in relation to the ‘underground’ practices producing partial, botched and failed attempts at taking life: ‘reliable knowledge about compassionate killing comes at a high price.’

We have seen that the response of some people to the prohibition of VE is self-starvation. This is the only practical and lawful way for people in the desperate situation of Nicklinson, for example, to end their lives. Similarly, the difficulties facing HCPs in assisting suicide lead some people to die far more painfully (eg through overdoses of paracetamol) than they would if medical AS were allowed. Many people are forced to take the Dignitas route. But dying people generally want their loved ones with them in their final hours, and that desire is usually reciprocated. It is impractical for more than a very few loved ones to accompany someone to Dignitas. Along with the many other disadvantages of going to Switzerland, this makes Dignitas a distressing ‘last resort’ even for most of those who can afford it.

‘Double effect’ can be similarly distressing, as “... it will only be possible to ensure that her loved ones are at her side when she dies if the doctor admits that which the doctrine of double effect forbids, namely that she is killing her patient rather than merely attempting to relieve her pain.” (Jackson, 2004, p 436).

Current law and policy does little to reduce deaths among those who contemplate such difficult choices, and nor would a more prohibitive approach. A more permissive approach to VE and medical AS would reduce suffering, probably without increasing death.

If any of these actions – starvation, exile to Dignitas, the agony of an overdose, the dismay and pain following failed suicide attempts, clandestine killing on the pretext of ‘double effect’ - were forced on one person by another it would be criminal and/or a violation of Art 3 of the ECHR- the prohibition of ‘inhuman or degrading treatment’. Yet that is what current law and policy does to countless numbers of people who are already suffering beyond endurance. Indeed, it hard to imagine who endured the worse suffering: Nicklinson who starved himself to death or Martin – one of the other applicants in *Nicklinson* – who attempted self-starvation but failed.

Those who oppose permissive AD law and policy on ‘sanctity of human life’ grounds dispute this argument that approach (a) leads to suffering. Palliative care, continuous deep sedation (CDS) and the doctrine of ‘double effect’ are said to enable those who wish to die to do so without suffering. But

- ❖ whether even the best palliative care can eliminate all intense pain is disputed, and the best care is frequently not available anyway
- ❖ many cases do not turn, primarily, on significant pain
- ❖ many cases do not involve terminal illness, which is the only situation where ‘double effect’ or CDS are applicable, and not all doctors are willing to give the massive life-ending overdoses required for the former
- ❖ ‘double effect’ (and, for the same reasons, CDS) are, as we have seen, hugely problematic in themselves

#### **4) *The ‘dark figure’ of euthanasia***

Some fear that the more permissive the AD policy – particularly one allowing VE - the greater the risk of involuntary euthanasia. Others argue that, just as regulating AS in advance is likely to reduce AS based on pressure from others, so regulating VE in advance is likely to reduce involuntary euthanasia.

‘Sanctity of life’ proponents rarely take into account the risk of involuntary AD under current law and policy and under less permissive regimes. In 1999 it was estimated that up to 100,000 patients a year



are quietly helped to die in the UK (Tur, 2002). The UK is not unusual. In an Australian survey of 683 surgeons, over one-third (247) stated that, when administering drugs to alleviate suffering, they administered more than necessary for this purpose but with the intention of hastening death. Moreover, it may be that the main difference between the 247 and the rest is their self-evaluation of their mental state (Douglas, 2001). Magnusson (2002, p 40) also estimates that “a significant proportion of the medical profession has participated, illegally, in assisted death” in Australia. Similarly the 1996 BBC Scotland survey on medical AS showed that 12% of health care professionals personally knew another professional who had assisted suicide, while 4% said they did this themselves. (Daruwala, 2003). When Keown (2002, ch 6) concluded that there is little evidence of unlawful assisted dying in the UK at the hands of health professionals this underplayed this data, and also ignores the risk posed by families/friends.

Clearly the risks are particularly high in systems like that of the UK where the doctrine of ‘double effect’ allows doctors to – in effect – engage in mercy killing in certain circumstances. As Ost (2005, p 359) points out, we can only be sanguine about this (and adherents to position (a) like Keown (2002) actually advocate doctors ending life on this basis) if we can rely on doctors telling the truth about their primary aim. But this reliance is surely misplaced, as how many would tell the truth if their primary aim was to hasten death?

What about the ‘dark figure’ in more permissive regimes? A survey of 3,000 Australian doctors found non-voluntary euthanasia to be five times more common in Australia, where euthanasia is illegal, than it is in the Netherlands. Further, Australian doctors were far less likely than their Dutch counterparts to discuss the decision to hasten a patient's death with the patient herself, or to seek her consent (Kuhse et al, 1997). There is evidence from many non-permissive jurisdictions of significant levels of non-voluntary euthanasia in medical settings. Evaluations suggest that criminalising VE is less effective in controlling this than policies like that of the Netherlands (Jackson, 2004).

If there is a danger of a permissive AD regime creating a climate of active life-ending, there is an equally high risk of a restrictive AD regime creating a climate of deception concerning the procuring and administering of drugs, the drugs paper trail, and post-mortem paperwork (Magnusson, 2002). In such a climate, not only is AD tolerated among many HCPs, but wrong-doing is far less likely to be discovered than in jurisdictions where AD is allowed in regulated circumstances. This, again, undermines Keown's sanguine attitude. So even in the Netherlands, there is deception: AD by relatives is not permitted, but many doctors are aware of it, occasionally facilitate it, and often report such deaths as ‘natural’. The deception is not primarily a product of Netherlands' permissiveness, but of the ban on relative-assisted dying (Ost and Mullock, 2011). In the UK this is exacerbated by the cover for euthanasia provided by ‘double effect’.

### 5) *The slippery slope*

This concerns future harm that would be caused by current (and more permissive) law and policy. There are two type of argument usually advanced by ‘sanctity of human life’ proponents such as Keown (2002):

(i) *‘Empirical’*: there are several elements, but Smith concludes that there is no evidence to support any of them (Smith, 2005a). For example, Keown argues that legalising VE will lead to more non-voluntary euthanasia because it is difficult to frame/enforce safeguards to prevent the slide. He draws parallels with abortion, where agreement is often routine with little probing of the reasons for, and pressures to, abort. However, Smith's assessment of the many studies is that the Netherlands does not have higher rates of non-voluntary euthanasia than other countries with which it has been compared (as we have seen, it has lower rates than Australia). The same is true of Oregon. In any event, as Keown's argument relies on parallels with abortion, it would only be valid if AD were regulated as loosely as abortion. As is evident from the Oregon/Netherlands comparison, whether a slope is slippery depends primarily on

how it is constructed. Keown dismisses the idea of non-medical gatekeepers, for example, even tho in *Bland*-type cases this is precisely the arrangement in the UK.

An element added by Keown merits further attention: the risk that AD would move from choice of last resort to an earlier choice. This is, however, only to be regretted if people choosing to die earlier in a new legal environment either do not really want to die or would have enjoyed what remained of their life more than they imagined. These are unknowables that are no more probable than the risk at present that people stay alive longer than they wish and endure more misery than they would have if the law had been different. Nonetheless, law and policy should do all it can to adress the issue.

(ii) *'Logical'*: Keown argues that acceptance of VE logically leads to acceptance of non-voluntary euthanasia, for the former rests on doctors' judgement that someone is better off dead. If they can do that regarding the former, they can do it regarding the latter, as some bio-ethicists argue is appropriate. The evidence that this might be happening particularly in the Netherlands is both contestable and not relevant to an argument of logic, as this is an empirical claim (Smith 2005b). Further, we know from the practice of 'double-effect' – advocated by Keown himself - that non-voluntary euthanasia occurs in all systems to some extent. The argument also seems to assume that the basis of the policy is evaluation by doctors of the value of another's life or the objective suffering of the 'victim'. But if the policy is based on an individual's genuine wish to die, the logical slide is eliminated. Keown acknowledges this, but argues that that, if patient autonomy is the key driver, any attempt to limit VE to the terminally ill will logically expand. This is difficult to argue against, though not impossible as Keown fails to acknowledge that medical judgement and patient autonomy may rationally be made necessary conditions for VE (Lillehammer, 2002). It is, anyway, not necessarily a regrettable slope down which to slide. Tony Nicklinson was not terminally ill, and nor are a significant proportion of sufferers from MS. Whether it follows logically that an assessment that the 'victim' is objectively suffering should be a required element of a VE policy is a more difficult issue. But if it were not, one would eliminate medical appraisal from the system of checks (but substituting another), which would therefore eliminate Keown's worries about medical power.

Both of Keown's slippery slope arguments rest in large part on the fear that legalisation of some forms of physician assisted suicide (PAS) and physician assisted voluntary euthanasia (PAVE) will lead to more death-by-choice. But as long as death is a truly autonomous choice this should be a concern only of supporters of proposition (a). Keown is such, so he is at least consistent. But this is not the position of the law and policy in the UK regarding AS. Nor need it be (nor is it, as far as most supporters of proposition (b) are concerned) a position favouring AD. It is a position that favours patient choice about AD.

Another argument is put by Greasley (2010). If autonomy alone rules, we would allow assisted dying for anyone who seeks it – including, in the example, she gives, teenagers who feel life is not worth living in the absense of their one true love. Greasley argues that the only way of controlling this would be to interpose an objective valuation of that stated belief. In deciding that the teenager is unreasonable but others (people objectively suffering hugely such as Nicklinson) are reasonable we are valuing some lives above those of others. This is the fundamental objection of disability-rights groups who oppose the legalisation of assisted dying, and is not dealt with by Smith's rebuttal of the broader 'logical slippery slope' argument. However, a voluntary, informed and settled expressed wish to die is required. The younger the person (and anyone under 18 would be subject to 'best interests' principles anyway, which would impose objective criteria) and the less objectively rational the wish, the less likely it is to be 'informed and settled'. This would justify more extensive enquiry and a longer period of reflection than would be needed for someone terminally ill or suffering in a way that is objectively intolerable. The issue is not that those lives are of different value but that those people are differentially able to settle on the most important decision of their lives.

The issue of ‘existential’ suffering arises in many jurisdictions. In Switzerland and the Netherlands there are restrictions on assisted dying in such cases, and all the unsuccessful attempts at legislative change have nonetheless been restricted to cases of terminal illness. Ost observes that “a potential danger of loosening the medical criteria for assisted death is that it becomes harder to identify and maintain boundaries” (Ost, 2010, p 526), but the argument of this paper is that boundaries to *what prompts the wish to die* (if that is what Ost is concerned with) are irrelevant. Objective boundaries are politically expedient ways of helping to persuade politicians or sections of public opinion, but that is all. On the other hand, if legal change were to foster a culture of assisted dying (as Huxtable and M Moller (2007), for example, argue) this would, as previously acknowledged, be a concern. On the other hand again, Kay Gilderdale helped her 31 year-old daughter, Lynn, to die (discussed by Ost 2010) when she was neither terminally ill nor as terribly immobilized as Daniel James (whose parents helped him to die before the official guidelines were published, but were not prosecuted) or Tony Nicklinson. Yet her suffering, for nearly 20 years from ME, led her to attempt suicide several times. Edward Downes, aged 85 and suffering from great pain, deafness and blindness, decided to die with his wife, who was terminally ill. He could have continued to live, but did not wish to (*Observer* 19/7/2009). There is no doubt that his wish to die, and that of Lynn Gilderdale, was voluntary, informed and settled.

Greasley’s argument illustrates another problem for those using ‘logical slippery slope’ arguments against legalising assisted dying. They work, if they work at all, both ways. Greasley says that “the law would not regard the assisted dying of a depressed, lovesick teenager as beyond reprimand ... because the teenager, though she might not know it, has everything to live for.” (2010, p 321). But if the reason for objecting to someone helping such a person to die is the objective fact that she has much to live for, it is not the *assistance* that is the problem. It is her deliberate dying that is the problem. If we think that people with objective reasons to live should not be helped to die then we should also think they should not be allowed to take their own lives. This argument against legalising AD is a logical slippery slope leading to the re-criminalisation of suicide. If we resist the logic of this ‘upward’ move we should equally resist the logic of the posited ‘downward’ move.

Jackson sums up the issue well: “Because no system of regulation is either perfect

or entirely without merit, it will always be possible for opponents or supporters of legalised euthanasia to invoke the Dutch system as a model either of depravity, or of effective regulation in action. ... Although the slippery slope argument might superficially appear to be a simple factual claim, capable of objective resolution in the light of the available evidence, it is almost certainly no such thing, and will usually instead be a rhetorical flourish which relies so heavily on its proponent's pre-existing point of view that it is seldom capable of functioning as a freestanding argument.” (2004, p 431).

## 6. CONCLUSION

Jurisdictions that restrict AD out of concern for vulnerable people who might be pressured to end their lives early are right to be concerned. But they should be equally concerned about people ending their lives early because of, or as an unintended consequence of, laws that restrict AD. Moreover, we have seen that there is no rational basis on which to distinguish AS from VE. The best way to protect the vulnerable while giving effect to the wishes of those who seek to die is to allow doctors to help the latter on the basis of clear rational criteria. This pre-authorisation system could be overseen by the courts to ensure that every person who is helped to die really does have a clear, settled and voluntary wish to die. Position (c), however, also requires a modern society to attempt to make life as tolerable as possible for people whose suffering is such that they want to die. Inadequate medical and social services frequently make life worse than it needs to be. If we are truly concerned to reduce AD we should be putting more effort into improving the lives of those who suffer, so that their lives are more valuable to them than their deaths. AD would then be authorised only after they had been offered everything that is reasonably available to make their lives tolerable.

Regulating AD before people die is a far more effective way of protecting the vulnerable than allowing doctors to end life under the cloak of ‘double effect’ and expecting the police to uncover the truth after death. It will reduce the number of people who attempt suicide before they are ready to die, for fear that when they do reach that point they will no longer be able to do the act without help; and will reduce the number of people who try to end their lives and fail, often to try again and again, each time wondering what kind of inhumanity would wish them to suffer serially in these agonising ways.

We could see this as a matter of public health. Or we could see it as as a matter of human rights. Either way, it is a matter of liberty and freedom. If we truly value the spirit of Magna Carta we should not make people like Tony Nicklinson choose between the intolerable alternatives of living a life devoid of pleasure and dignity, or an agonising death by starvation.

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