

**THE HUMAN RIGHTS IMPLICATIONS OF THE BLANKET BAN
ON ASSISTED SUICIDE IN ENGLAND AND WALES: A CRITICAL
EXAMINATION OF THE COMPATIBILITY OF THE SUICIDE ACT
1961 WITH THE EUROPEAN CONVENTION ON HUMAN
RIGHTS**



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PREFACE

This dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration except as declared in this Preface and specified in the text.

It is not substantially the same as any that I have submitted, or, is being concurrently submitted for a degree or diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text. I further state that no substantial part of my dissertation has already been submitted, or, is being concurrently submitted for any such degree, diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in this Preface and specified in the text

It does not exceed the prescribed word limit for the relevant Degree Committee.

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ABSTRACT

The compatibility of the blanket ban on assisted suicide in England and Wales with the European Convention on Human Rights ('ECHR') has been considered on a number of occasions by both the domestic courts and the European Court of Human Rights ('ECtHR'). Following the ECtHR's decision regarding Diane Pretty's application, challenges to the compatibility of the Suicide Act 1961 with the ECHR have, in the main, centred on the right to choose the manner and timing of one's death as protected by Article 8 of the ECHR. Through doctrinal and comparative analysis, this thesis critically examines the compatibility of the ban with Article 8 of the ECHR. This analysis reveals that the ban is incompatible with Article 8 of the ECHR. This thesis also examines the compatibility of the ban with the right to life (Article 2) and the right to freedom from torture or inhuman or degrading treatment (Article 3). Recent case law from the United Kingdom Supreme Court, together with evidence of the impact of the ban on individuals, reveals that the ban violates the right to life of some individuals who are forced to take their lives prematurely before their physical condition deteriorates to such an extent that they can no longer suicide without assistance. Further, in criminalising assistance, the State subjects some individuals to inhuman or degrading treatment in violation of the negative obligation in Article 3 and, in failing to protect against the materialisation of that harm, the State fails to comply with its positive obligation to protect under Article 3. This thesis concludes with an examination of whether the ban is discriminatory in violation of Article 14, read in conjunction with any or all of Articles 2, 3 and/or 8. The ban has a disproportionately adverse effect on individuals who, as a result of their medical condition, are physically incapable of suiciding in the same way that individuals without physical disabilities can. Further, having distilled a definition of 'suicide' for the purpose of the Suicide Act 1961, it is apparent that the ban only applies to some cases of suicide and that distinction is based on the individual's medical condition and/or disability, which is a prohibited ground of discrimination under Article 14 of the ECHR. The findings that the ban violates Articles 2, 3 and 8 alone, and taken together with Article 14 of the ECHR, fundamentally alter the narrative surrounding the validity of the Suicide Act 1961 and have profound implications for subsequent challenges to the ban and to the formulation of, and debate surrounding, amendments to the Suicide Act 1961.

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INTRODUCTION

1. Background

I know that I am dying, but I am far from depressed ... I intend to get every bit of happiness I can wring from what is left of my life so long as it remains a life of quality; but I do not want to live a life without quality. There will come a point when I will know that enough is enough. I cannot say precisely when that time will be ... I just know that, globally, there will be some point in time when I will be able to say – “this is it, this is the point where life is just not worthwhile.” When that time comes, I want to be able to call my family together, tell them of my decision, say a dignified good-bye and obtain final closure – for me and for them.

My present quality of life is impaired by the fact that I am unable to say for certain that I will have the right to ask for physician-assisted dying when that “enough is enough” moment arrives. I live in apprehension that my death will be slow, difficult, unpleasant, painful, undignified and inconsistent with the values and principles I have tried to live by...¹

This statement by Ms Taylor – who had a terminal neurodegenerative condition – about the impact of Canada’s analogous ban on assisted suicide encapsulates the reality of hundreds, if not thousands, of individuals residing in England and Wales who have a life-threatening or life-limiting medical condition that will leave them with little, or no, quality of life and which may result in a prolonged, painful and/or undignified death. As Ms Taylor’s account demonstrates, it is impossible to overstate the magnitude of the harm that prohibiting assisted dying causes individuals living with life-threatening and life-limiting conditions who would die with assistance were it lawful. Laws such as the Suicide Act 1961, which criminalises assisting and encouraging suicide in England and Wales,² forces such individuals to ‘choose’ between equally unsatisfactory options. They can:

¹ Statement of Ms Taylor, extracted in the decision of the Canadian Supreme Court in *Carter v Canada (Attorney General)* [2015] 1 SCR 331 [12].

² The key provision is section 2, which provides:

- (1) A person (‘D’) commits an offence if—
 - (a) D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and
 - (b) D’s act was intended to encourage or assist suicide or an attempt at suicide.
- (1A) The person referred to in subsection (1)(a) need not be a specific person (or class of persons) known to, or identified by, D.
- (1B) D may commit an offence under this section whether or not a suicide, or an attempt at suicide, occurs.

- Take their lives prematurely, before their physical condition deteriorates to a point at which they can no longer suicide³ without assistance;
- Travel to a permissive jurisdiction, if they have the financial means to do so, to die with assistance, either alone or accompanied by loved ones who face the risk of prosecution under the Suicide Act 1961 upon their return;
- Seek assistance in England and Wales, thereby exposing those providing such assistance and any persons present at the time of their suicide, to the risk of prosecution under the Suicide Act 1961;
- Do nothing and face a potentially prolonged, painful and/or undignified death.

Plainly, none of these options is acceptable for the person who would die with assistance in the country in which they and their loved ones reside, were it lawful. Each carries a multitude of risks beyond prosecution, including the potential for catastrophic injury as a result of an unsuccessful attempt to suicide. There is also the psychological harm that each of those ‘options’ poses not only to the individual but also to their loved ones. And, it is not a small section of society who are so affected. In 2018, the leading cause of death in England and Wales was dementia and Alzheimer’s disease (12.8 per cent of registered deaths), with ischaemic heart diseases and malignant cancers accounting for a significant percentage of deaths in both males and females. Further, estimates suggest that two people out of 100,000 will develop motor neurone disease and a third die within a year of diagnosis, while more than half die within two years.⁴

Of course, not all individuals with cancer, ischaemic heart disease, or a degenerative neurological condition would access assistance in dying if it were lawful. However, data from permissive jurisdictions reveals that the overwhelming majority of individuals who access assistance in dying have cancer and a significant number of patients have degenerative neurological conditions. Rates of assisted dying relative to total death rates in permissive jurisdictions vary from 0.39 per cent in Oregon to 4 per cent in the Netherlands (which have been selected as representative of the most restrictive and the broadest assisted dying systems). While one must be cautious when extrapolating data from

³ Throughout this thesis, ‘suicide’ is used both as a verb and a noun. The phrase ‘commit suicide’ and the like has intentionally been avoided as the concept of ‘committing’ implies criminality and derives from the time when suicide was a criminal offence.

⁴ College of Nurses, ‘Motor Neurone Disease: Statistics’ <<http://mnd.rcnlearning.org.uk/what-is-motor-neurone-disease/statistics/>> accessed 30 July 2019; Office for National Statistics, ‘Deaths registered in England and Wales: 2019’ <<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2018#leading-causes-of-death>> accessed 11 August 2019.

jurisdictions that are legally, politically and demographically different, that data suggests that anywhere from 2112 to 21,664 individuals could access assisted dying were it legal in England and Wales.⁵ Often, it is the potential that thousands of people could access assistance in dying which is cited as a reason *against* permitting assisted dying in England and Wales. That interpretation of the data not only assumes that assisted dying is, *per se*, bad – and, in a secular society that respects the autonomy and self-determination of capacitous individuals to refuse life-sustaining treatment, such a presumption is invalid – it also ignores the reality that at least some, if not the majority, of those individuals are forced to endure the harm outlined by Ms Taylor because they are not able to access lawfully assistance in dying.

It is also notable that the blanket ban does not stop people from dying with assistance. Over 400 individuals have travelled from England and Wales to Switzerland to die with assistance at Dignitas clinics, and that is only counting the data from one of the organisations that provides such assistance in one of the permissive jurisdictions.⁶ There is also evidence that hundreds of people have died with assistance in England and Wales. Given the alternatives confronting individuals with terminal or life-limiting conditions, it is hardly surprising that they would seek to die with assistance notwithstanding the ban. The ban on assisted suicide in England and Wales thus adversely impacts a considerable number of people and exposes them to harm the likes of which few of us could comprehend, while also failing to prevent individuals from accessing assistance both at home and in permissive jurisdictions overseas.

Given the magnitude of this harm, it is imperative that the justifications proffered for maintaining the ban are valid. While there is a wealth of academic discourse on the moral, ethical and philosophical justifications for and against assisted dying, the *legal* analysis is comparatively slight, especially in terms of the human rights implications of the ban. This is so despite the fact that the domestic courts and the European Court of Human Rights (‘ECtHR’) have considered the English ban in the context of the European Convention on Human Rights (‘ECHR’) on several occasions, most notably in *Pretty, Purdy, Nicklinson*

⁵ There were 541,589 deaths in England and Wales in 2018 (the latest figures available). ‘Deaths registered in England and Wales: 2018’ (n 4).

⁶ The latest figures reveal that 457 British members of Dignitas had been accompanied to a clinic in Switzerland where they subsequently die by suicide with assistance. Dignitas, ‘Accompanied suicide of members of Dignitas, by year and by country of residence’ (1998-2019) <<http://dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2019.pdf>> accessed 17 July 2019.

and *Conway*.⁷ While *Pretty* is especially notable as it was the first case in which the ECtHR held that Article 8 of the ECHR, which protects the right to private life, encompasses a right to avoid an undignified death (or, put another way, a right to choose the manner and timing of one's death), the Court held that the ban was compatible with the Article 8 rights of Ms Pretty who faced a deterioration akin to that described by Ms Taylor. According to the ECtHR, the *blanket* ban on assisted suicide was necessary to protect individuals vulnerable to undue pressure from dying with assistance as a result of such pressure. Both the House of Lords and the ECtHR rejected the other bases upon which Ms Pretty challenged the ban, including, *inter alia*, the right to life (Article 2, ECHR), freedom from torture or inhuman or degrading treatment (Article 3) and the right to enjoy one's rights free from discrimination (Article 14). In the subsequent decision of *Purdy*, the House of Lords focused on the lack of an offence-specific policy guiding decisions to prosecute under s 2 of the Suicide Act 1961. In *Nicklinson*, a majority of the Supreme Court determined – for varying reasons – that it was not possible to consider whether the ban was compatible with Article 8 of the ECHR. However, two members of the bench – Lady Hale and Lord Kerr – did proceed to examine the ban's compatibility and determined that it violated Article 8 as a *blanket* prohibition on assisted suicide was a disproportionate interference with Mr Nicklinson's and Mr Lamb's right to choose the manner and timing of their death.

Notwithstanding the fact that the only two justices of the Supreme Court who have considered the ban's compatibility with Article 8 of the ECHR found that the ban violated the right to choose the manner and timing of one's death, the most recent challenge to the ban's compatibility with the ECHR was rejected by both the High Court and the Court of Appeal, with the Supreme Court rejecting the application for leave to appeal.⁸ While Lady Hale and Lord Kerr were in the minority in *Nicklinson* in terms of examining the ban's compatibility, they were the only justices to do so. It would be reasonable to assume, then, that subsequent, *lower*, courts considering the ban's compatibility with Article 8 of the ECHR would at the least have regard to their reasoning. Yet, neither the High Court nor

⁷ *Pretty v Director of Public Prosecutions and Secretary for the Home Department* [2001] UKHL 61, [2002] 1 AC 800; *Pretty v United Kingdom* (2002) 35 EHHR 1; R (*On the application of Purdy*) v Director of Public Prosecutions [2009] UKHL 45, [2010] 1 AC 345; R (*On the application of Nicklinson*) v Ministry of Justice [2014] UKSC 38, [2015] AC 657; *Nicklinson v United Kingdom* (2015) 61 EHRR SE7; R (*On the application of Conway*) v Secretary of State for Justice [2018] 2 WLR 322, [2017] EWHC 2447 (Admin); R (*On the application of Conway*) v Secretary of State for Justice [2018] 3 WLR 925, [2018] EWCA Civ 1431.

⁸ R (*on the application of Conway*) v Secretary of State for Justice (Supreme Court of the United Kingdom, 27 November 2018) <<https://www.supremecourt.uk/docs/r-on-the-application-of-conway-v-secretary-of-state-for-justice-court-order.pdf>> accessed 6 June 2019.

the Court of Appeal in *Conway* made any meaningful reference to the reasons of either Lady Hale or Lord Kerr, and one is left to wonder how a ban which was previously found to be incompatible by those justices of the Supreme Court who considered the question is now compatible notwithstanding the fact that no amendments have been made to the ban. This inconsistency is not only problematic from a jurisprudential point of view, it also has calamitous consequences for individuals like Noel Conway who are forced to confront the deterioration and ‘choices’ described by Ms Taylor. Indeed, Tony Nicklinson was forced to bring about his death by refusing food and hydration and Omid T, who was also challenging the ban’s compatibility with the ECHR, was forced to take his life prematurely, travelling to Switzerland to obtain assistance in dying while he was still physically capable of doing so.

Given the severity of these consequences, the reasons provided by the courts for determining that the ban *is* compatible with the ECHR must be carefully scrutinised and their legal validity confirmed. Yet, limited attention has been directed to this task in the scholarly literature. Rather than examine the validity of the courts’ substantive reasons concerning Article 8, the academic analysis has focused predominantly on the validity of the Supreme Court’s deference to Parliament.⁹ Further, following the ECtHR’s decision in *Pretty*, and in the absence of any meaningful critique of that Court’s treatment of the Article 2 and Article 3 claims, it seems to have been accepted as a given that the ban does not engage, let alone violate, either the right to life or the right to freedom from torture or inhuman or degrading treatment. This narrow focus has not only affected the way in which subsequent cases have been argued, it has also impacted upon Parliamentary debate concerning potential amendments to the Suicide Act 1961 to lessen the prohibition. There is, then, a glaring lacuna in the literature surrounding the validity of the blanket ban on assisted suicide in England and Wales from a human rights perspective. The purpose of this thesis is to fill that lacuna, a task which has significant implications for the judicial review proceedings challenging the ban that have been foreshadowed¹⁰ and any proposed

⁹ See, for instance, Ross Beaton, ‘R.(Nicklinson): The boundaries of proportionality review and the end of life’ (2014) 19 *Judicial Review* 135; Nataly Papadopoulou, ‘From *Pretty* to *Nicklinson*: changing judicial attitudes to assisted dying’ (2017) 3 *European Human Rights Law Review* 298; Steve Foster, ‘Still no right to die: a study in the constitutional limitations of the UK judiciary’ (2017) 22 *Coventry Law Journal* 57; Clark Hobson, ‘Is it now institutionally appropriate for the courts to consider whether the assisted dying ban is human rights compatible? *Conway v Secretary of State for Justice*’ (2018) 26 *Medical Law Review* 514; Steve Foster, ‘Human rights, judicial activism or deference and the case of assisted suicide’ (2019) 24 *Coventry Law Journal* 69.

¹⁰ Katie Gibbons, ‘Father’s plea to die legally and with dignity’ *The Times* (London, 2 July 2019) 14; ‘Paul Lamb to bring new legal case for the right to die’ (Leigh Day, 7 May 2019) <<https://www.leighday.co.uk/News/2019/May-2019/Paul-Lamb-to-bring-new-legal-case-for-the-right-to>> accessed 15 July 2019.

amendments to the Suicide Act 1961, which seem more likely following the general debate recently held in the House of Commons on the functioning of the Suicide Act 1961.¹¹

2. Research focus

Following *Pretty*, it is accepted that Article 8 of the ECHR incorporates a *qualified* right to choose the manner and timing of one's death and the blanket ban on assisted suicide in s 2 of the Suicide Act 1961 interferes with that right. Both the ECtHR in *Pretty* and the domestic courts in *Conway* held that that interference was necessary in order to protect individuals vulnerable to undue pressure. The domestic courts in *Conway* further held that the ban was necessary to protect the sanctity of life and the doctor/patient relationship. The decisions of Lady Hale and Lord Kerr in *Nicklinson* cast significant doubt on the conclusions of the High Court and Court of Appeal in *Conway* and necessitate a close inspection of the reasons given by the courts for reaching the opposing outcome. Further, no attention has been given to the validity of the ECtHR's rejection in *Pretty* of the applicability of Articles 2 and 3. The purpose of this thesis is to address these shortcomings in the jurisprudence and academic literature by critically examining the compatibility of the blanket ban on assisted suicide in England and Wales with the ECHR. More specifically, the research focus of this thesis is Article 2 (right to life), Article 3 (freedom from torture or inhuman or degrading treatment) and Article 8 (right to private life) of the ECHR and whether the ban violates any or all of those rights in the case of individuals like Noel Conway, Omid T and Diane Pretty. In answering these questions, various research methodologies will be employed including, in particular, doctrinal and comparative legal analysis.

The objective of this research is to determine whether the blanket ban on assisted suicide in England and Wales:

1. Engages the right to life (Article 2, ECHR) and, if so, whether Article 2 is violated;
2. Engages the right to freedom from torture or inhuman or degrading treatment (Article 3, ECHR) and, if so, whether the ban violates Article 3;
3. Violates the right to choose the manner and timing of one's death (Article 8, ECHR).

¹¹ HC Deb 4 July 2019, vol 662, cols 1412-51 <<https://hansard.parliament.uk/commons/2019-07-04/debates/EFD57ADB-AE18-4D6B-9DA8-CCDDF99D1D0A/AssistedDying>> accessed 30 July 2019.

Having considered the compatibility of the blanket ban on assisted suicide with the substantive rights in Articles 2, 3 and 8, this thesis also examines whether the ban is discriminatory insofar as it has a disproportionately prejudicial impact upon individuals as a result of their medical condition/physical disability in violation of Article 14 read in conjunction with any or all of Articles 2, 3 and/or 8 ECHR. This thesis also considers whether the ban discriminates between analogous cases on the basis of a person's disability/medical condition in violation of Article 14, taken together with Article 8 of the ECHR. Central to this analysis is a determination of the meaning of 'suicide' as that term is employed in the Suicide Act 1961. Through doctrinal and comparative research methodologies, a legal definition of 'suicide' will be distilled. This, in turn, will reveal whether the Suicide Act 1961 discriminates against a specific form of suicide based on a person's medical condition/disability in violation of Article 14 of the ECHR, read in conjunction with Article 8. A further objective should thus be added to the above list:

4. Whether the ban is discriminatory in violation of Article 14 of the ECHR, read in conjunction with Articles 2, 3 and/or 8.

3. Value of this research

The practical effect of the prohibition on assisted suicide has been discussed above. It forces some individuals to take their lives prematurely, before their physical condition deteriorates to the point at which they can no longer suicide without assistance. Others are compelled to obtain assistance unlawfully with the worry that those assisting will be prosecuted or to travel to a permissive jurisdiction to die alone or, if loved ones accompany them, with the concern that they will be prosecuted. Others still face a potentially protracted, painful and undignified death. All too frequently, the debates in Parliament, before the courts and in the academic literature concerning the ban's legitimacy fail to fully appreciate the very real and potentially catastrophic impact the ban has on a significant number of individuals. To that end, the deterioration and side-effects of treatment confronting Lecretia Seales – a woman with a terminal brain tumour who unsuccessfully challenged New Zealand's analogous ban on assisted suicide – is as harrowing as it is illuminating:

First, the administration of steroids to reduce the effect of intracranial oedema has a number of very undesirable side effects. One side effect is a massive weight gain. Ms Seales has already begun to suffer this side effect. Steroids can also impair a

patient's sleep, induce mood and behavioural changes and predispose patients to stomach ulcers and bleeding.

Second, stopping or reducing steroids is likely to cause Ms Seales to suffer severe headaches until she dies. Professor Ashby has explained these headaches “tend to be difficult to control by morphine or other pain killers”.

Third, in any event, a point will be reached when steroids will cease to be effective. This in turn is likely to increase intracranial pressure for Ms Seales, which in turn is likely to lead to a condition known as “coning”. This occurs when the brain “herniates”, or presses down the spinal canal, and puts pressure on the brain stem, causing the nervous system functions that control respiration and cardiac function to shut down. At this point Ms Seales is likely to be administered “palliative sedation”.

Fourth, palliative sedation can involve the administration of sedatives, benzodiazepines, anti-psychotics and/or occasionally barbiturates to maintain the comfort and dignity of the patient. At this point Ms Seales will not be able to interact with her husband and family.¹²

It is difficult to comprehend what competing interests could be sufficiently weighty as to justify forcing a person to endure such a deterioration. Yet, in determining that the *blanket* ban is proportionate, that is the conclusion reached by the ECtHR in *Pretty* and the High Court and Court of Appeal in *Conway*. For so long as the ban remains in force in its current iteration, individuals like Noel Conway, Omid T, Diane Pretty and hundreds, if not thousands more, continue to face the agonising dilemma outlined above.

The research and analysis undertaken in this thesis has the potential to fundamentally alter the discourse surrounding the Suicide Act 1961 and its compatibility with the ECHR. This thesis not only critically examines the validity of the conclusion reached by the domestic courts in *Conway* and the ECtHR in *Pretty* that the blanket ban is compatible with Article 8 of the ECHR, it also expands the inquiry to include previously foreclosed avenues of analysis, in particular the right to life (Article 2), the right to freedom from torture or inhuman or degrading treatment (Article 3) and the right to enjoy those substantive rights free from discrimination (Article 14). The research that will be conducted in respect of each of those rights is novel; no court has considered the potential that the English ban

¹² *Seales v Attorney-General* [2015] NZHC 1239 [41].

violates the State's positive obligation to protect life (under Article 2) or that the State, in criminalising assistance, is subjecting individuals to treatment which violates Article 3. The same applies to the analysis undertaken in respect of Article 14, the legal definition of 'suicide' as that term is used in the Suicide Act 1961 having never been considered by the courts or in the academic literature. Not only will such research be directly relevant to the applicability of Article 14 of the ECHR, it will also have significant implications for medical law more generally, in particular the legitimacy of the law's differential treatment of end-of-life practices, especially the withdrawal/refusal of life-sustaining treatment *vis-à-vis* assisted suicide and euthanasia.

4. Structure

While the focus of this thesis is assisted suicide and, to a lesser extent, euthanasia, it is impossible to consider such practices in isolation. Rather, it is necessary to locate both practices within the existing end-of-life system in England and Wales and to examine how English law treats other end-of-life practices, in particular the withdrawal/refusal of life-sustaining treatment. The status of those latter practices in English law is directly relevant to the question of whether the *blanket* ban on assisted suicide is necessary for the purposes of Article 8 of the ECHR (Chapter Four) and the differential treatment of various end-of-life practices is also pertinent to a determination of whether the Suicide Act 1961 unlawfully discriminates between forms of suicide, which is considered in Chapter Six. Chapter One thus introduces various end-of-life practices and the law regulating same in England and Wales. Having established the legal position in England and Wales, the nature of the various permissive assisted dying regimes is also discussed, providing a foundation for the comparative analysis undertaken in subsequent chapters, in particular Chapter Five. Chapters Two, Three and Four each address the first three research objectives outlined above. Chapter Two considers the compatibility of the Suicide Act 1961 with the right to life in Article 2 of the ECHR. Central to this analysis, which is conducted by way of doctrinal methodology, is a determination of whether the ban engages the right to life, a proposition resoundingly rejected by both the House of Lords and the ECtHR in *Pretty*. However, Ms *Pretty* argued that the right to life incorporated the inverse: the right not to live. No court has considered whether the ban on assisted suicide violates the general positive obligation to *protect* life which is an accepted aspect of a state's obligations under Article 2. Given the evidence that the ban compels some people to take their lives

prematurely, it is argued that the State's positive obligation to protect is engaged and, indeed, violated by the blanket ban on assisted suicide.

Continuing with a doctrinal methodology, Chapter Three examines the compatibility of the Suicide Act 1961 with the right to freedom from torture or inhuman or degrading treatment (Article 3, ECHR). Ms Pretty was also unsuccessful in arguing that the ban violated Article 3 before both the House of Lords and the ECtHR, with the courts rejecting the contention that the State could be said to have subjected Ms Pretty to any 'treatment'. Having regard to the recent Supreme Court decision concerning the ban on abortion in Northern Ireland and its compatibility with Article 3, in particular, the reasons of President Hale and Lord Kerr, Chapter Three considers the possibility that the ban, in criminalising assistance, does in fact constitute treatment such as to engage Article 3 of the ECHR. That, however, is not the end of the Article 3 examination; for a violation to arise, there must be treatment which reaches the minimum level of severity. Whether the ban constitutes treatment which reaches that threshold for some individuals in England and Wales is considered through comparative analysis, with particular reliance placed on the Canadian case of *Carter*,¹³ together with anecdotal evidence drawn from domestic and ECtHR jurisprudence and secondary sources. Whether the ban violates the positive obligation to protect individuals from ill-treatment reaching the Article 3 threshold is also considered.

Chapter Four concerns the ban's compatibility with Article 8 of the ECHR. As it is accepted that Article 8 includes the right to choose the manner and timing of one's death, and the ban interferes with that right, the central focus of this chapter is whether the ban is necessary in a democratic society. Through doctrinal and comparative analysis of domestic and international case law, this chapter examines the nature and scope of the proportionality assessment developed in domestic jurisprudence and applies that test to the ban. Each of the three justifications given for the ban by the High Court in *Conway* are considered, with particular regard being had to the legal status – and regulation – of other end-of-life practices, in particular the withdrawal/refusal of life-sustaining treatment. While the doctrinal analysis undertaken in this chapter suggests that there is no requirement for a person challenging the compatibility of the ban to prove that an alternative to the blanket ban would function appropriately and meet the concerns raised by the State, Chapter Five examines the efficacy of permissive schemes, having regard to

¹³ *Carter v Canada (Attorney General)* 2012 BCSC 886 and *Carter* (Supreme Court) (n 1).

the data available from those jurisdictions, to determine whether a less restrictive ban would meet the three aims proffered for the ban.

Having considered the ban's compatibility with the substantive rights to life (Article 2), freedom from torture or inhuman or degrading treatment (Article 3) and private life (Article 8), the final substantive chapter, Chapter Six, explores the potentially discriminatory effect of the ban. Central to this examination is the distillation of the meaning of 'suicide' as that term is used in the Suicide Act 1961. That definition is developed through doctrinal analysis of coronial jurisprudence and criminal case law, and reveals that other end-of-life practices, in particular the withdrawal/refusal of life-sustaining treatment, may constitute suicide for the purposes of the Suicide Act 1961. That being the case, the question arises as to whether the Suicide Act 1961 discriminates between individuals on the basis of their medical condition and/or physical disability, which is a prohibited ground of discrimination under Article 14 of the ECHR.

The principles of autonomy and dignity are central to the analysis undertaken in Chapters Two to Six. This is unsurprising given that those principles underpin the ECHR and, together with self-determination, guide decisions made in end-of-life situations in England and Wales. It is notable that while those principles enable capacitous individuals to make decisions concerning their medical treatment even when the inevitable outcome is their death (for instance, the refusal of life-sustaining treatment), those same principles, while equally applicable, are not afforded the same degree of respect when a capacitous individual decides to die by suicide with assistance. The analysis undertaken in Chapters Two to Six involves an assessment of the validity of the weight attributed by the State to the autonomy, self-determination and dignity of individuals like Diane Pretty, Noel Conway and Omid T. In determining whether the ban is compatible with Articles 2, 3 and 8 of the ECHR, this thesis provides a more comprehensive analysis of the legitimacy of the weight attributed to competing interests by the State than has previously been undertaken either by the courts or in the academic literature.

CHAPTER ONE

THE LEGAL STATUS OF END-OF-LIFE PRACTICES IN ENGLAND AND WALES: A COMPARATIVE EXAMINATION

1. Introduction

This chapter introduces, and defines, key terms and outlines the legal status of end-of-life practices in England and Wales, which is then contextualised within the broader international setting, in particular permissive jurisdictions. Several issues that are central to the analysis undertaken in subsequent chapters are also considered including, in particular, the differential treatment of assisted suicide and euthanasia *vis-à-vis* the withdrawal/refusal of life-sustaining treatment in English law. The role of, and implications for, human rights in the regulation of end-of-life practices is also examined with a view to introducing the normative framework employed in subsequent chapters.

2. Terminology

A multitude of phrases are employed in judicial, legislative and academic writing to describe various aspects of ‘assisted dying’ and ‘end of life choices’ including, for instance, ‘assisted suicide’, ‘euthanasia’, ‘voluntary euthanasia’, ‘involuntary euthanasia’, ‘passive euthanasia’ and ‘palliative sedation’. Perhaps unsurprisingly given the controversial nature of the topic, there is no single, undisputed, definition of any of the relevant terms.¹⁴ Where, however, reference is made to the following terms, the attendant definitions can be taken to apply unless stated otherwise:

- Euthanasia: the phrase (first appearing in contemporary writings in the 17th century)¹⁵ derives from the Greek *eu* meaning good and *thanatos* meaning death. It refers to a third party deliberately ending another person’s life.¹⁶ Some definitions

¹⁴ ‘The way we classify actions is indicative of the way we think about them’ (Tom Beauchamp and Arnold Davidson, ‘The Definition of Euthanasia’ (1979) 4 *The Journal of Medicine and Philosophy* 294, 294). Similarly, Margaret Sommerville has observed ‘[e]ven with an overriding aim of neutrality and precision, it can be difficult to define, accurately and clearly, which interventions or non-interventions constitute euthanasia and which do not. But a definition is necessary’ (Margaret Sommerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide* (2nd edn, McGill-Queen’s University Press 2014), 25).

¹⁵ [Francis] Bacon was the first in history since the Roman historian Suetonius (c. 70-140AD) in *The Life of Caesars* to use the term “euthanasia.” Both Bacon and Suetonius employed the word in its etymological meaning, that is, to signify an easy death through the mitigation of pain rather than a death hastened by a physician through the administration of poison’ (Ian Dowbiggin, *A Concise History of Euthanasia: Life, Death, God, and Medicine* (Rowman and Littlefield Publishers 2007), 23).

¹⁶ See, for instance, Emily Jackson and John Keown, *Debating Euthanasia* (Hart Publishing 2012), 2.

include reference to an intention to relieve suffering,¹⁷ though this is by no means a unanimously accepted aspect of euthanasia. Unless specified otherwise, ‘euthanasia’ refers to a third party doing an act with the intention of ending another’s life.

- Voluntary euthanasia (sometimes referred to as voluntary active euthanasia): is ‘a deliberate act intended to terminate a person’s life at his or her own explicit request.’¹⁸ This phrase is employed to distinguish situations in which a competent patient actively requests euthanasia, from situations in which they do not (i.e. involuntary and/or passive euthanasia).¹⁹
- Involuntary euthanasia: euthanasia is involuntary when ‘the person killed is capable of consenting to her own death, but does not do so, either because she is not asked, or because she is asked and chooses to go on living’.²⁰
- Non-voluntary euthanasia: involves ending another person’s life when that person lacks the capacity to consent to, or refuse, it and has made no prior decision in this respect.²¹
- Passive euthanasia: covers circumstances in which death follows the withdrawal/refusal of life-sustaining treatment.²²

¹⁷ See, for instance, Benjamin White and Lindy Willmott, ‘How Should Australia Regulate Voluntary Euthanasia and Assisted Suicide?’ (2012) 20 *Journal of Law and Medicine* 410, 411. See, also, Penney Lewis, *Assisted Dying and Legal Change* (OUP 2007), 4. Julian Savulescu defines euthanasia as ‘X intentionally kills Y for Y’s benefit’ (Julian Savulescu, ‘Autonomy, Interests, Justice and Active Medical Euthanasia’ in Michael Cholbi and Jukka Varelius (eds), *New Directions in the Ethics of Assisted Suicide and Euthanasia* (Springer 2015), 41).

¹⁸ Anja Terkamo-Moisio, ‘The Traditional Model Does Not Explain Attitudes Toward Euthanasia: A Web-Based Survey of the General Public in Finland’ (2016) 75 *OMEGA – Journal of Death and Dying* 266, 267. See, also, Pekka Louhiala, Heta Enkovaara, Hannu Halila, Heikki Pälve and Jukka Vänskä, ‘Finnish physicians’ attitudes towards active euthanasia have become more positive over the last 10 years’ (2015) 41 *Journal of Medical Ethics* 41, 353: ‘a measure taken with the definite intention to end life at the patient’s explicit request due to refractory suffering’.

¹⁹ See, for instance, White and Willmott (n 17), 411; Jackson (n 16) 2; Keown (n 16) 87 citing Select Committee on Medical Ethics, (HL 1993-94, 21-I) [20]-[26]; Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill (HL 2004-5, 86I-II), Vol I, 14 <<http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8602.htm>> accessed 30 July 2019; Commission on Assisted Dying, *The Current Legal Status of Assisted Dying in Inadequate and Incoherent* (Demos 2011) 37; Lewis (n 17), 5; Savulescu defines active euthanasia as ‘X performs an action which itself results in Y’s death’ and voluntary euthanasia as ‘Y requested death himself’ (Savulescu (n 17), 41).

²⁰ Lewis (n 17) 5 citing Peter Singer, *Practical Ethics* (2nd edn, Cambridge University Press 1993) 175. See, also, Jackson (n 16) 2; White and Willmott (n 17), 411; Andrew Dunnett, *Euthanasia: The Heart of the Matter* (Hodder & Stoughton 1999) 5; Commission on Assisted Dying (n 19) 37; Savulescu (n 17), 41.

²¹ See, for instance, Lewis (n 17), 5. According to Savulescu, euthanasia is non-voluntary when ‘Y is incapable of expressing a preference’, Savulescu (n 17), 41.

²² As Jackson identified: “‘treatment withdrawal’ is a less value-laden term’ and is, thus, used more frequently than ‘passive euthanasia’ Jackson (n 16), 2. Savulescu defines passive euthanasia as ‘X allows Y to die. X withholds life-saving treatment or withdraws life-saving treatment’ (Savulescu (n 17), 41). See, also, in this respect Lewis (n 17), 5; White and Willmott (n 17), 411.

- Assisted suicide: what constitutes ‘suicide’ is by no means settled and Chapter Six considers the meaning of the term for the purposes of the Suicide Act 1961. In the meantime, it is sufficient to note that the phrase ‘assisted suicide’ is generally employed to describe situations in which a competent person takes their own life (i.e. they do the final act necessary to bring about their death) having received assistance in doing so, typically through the provision of the means necessary to end their life.²³
- Terminal/palliative sedation: the administering of sedatives with the intention of ‘reducing the level of consciousness of a terminally ill patient’²⁴ to relieve refractory symptoms.²⁵

3. End-of-life practices in England and Wales

3.1 Assisting and encouraging suicide

The Suicide Act 1961 decriminalised suicide but criminalised ‘complicity in another’s suicide’ (s 2). In its current iteration, the Act criminalises acts ‘capable of encouraging or assisting the suicide or attempted suicide of another person’ (s 2(1)(a)). The *mens rea* of the offence is an intention to encourage or assist another’s suicide or attempted suicide (s 2(1)(b)). Notably, pursuant to ss 2(1A) and 2(1B), the person who is assisted or encouraged ‘need not be a specific person (or class of persons) known to, or identified, by the defendant’ and an offence will occur regardless of whether ‘a suicide, or an attempt at suicide, occurs.’

A number of Bills proposing amendments to the Suicide Act 1961 have been debated by both houses of Parliament. Those Bills have variously proposed amendments permitting:

- A defence for persons who provide assistance and are ‘motivated by a reasonable and compassionate concern for another’s welfare’;²⁶

²³ See, for instance, White and Willmott (n 17), 411; Jackson (n 16), 2; Lewis (n 17), 5; Commission on Assisted Dying (n 19), 37; Savulescu (n 17), 41.

²⁴ Paulina Taboada, ‘Sedation at the End of Life. Clinical Realities, Trends and Current Debate’, in Paulina Taboada (ed.) *Sedation at the End-of-life: An Interdisciplinary Approach* (Springer 2015), 5.

²⁵ ‘Refractory symptoms’ are ‘symptoms that cannot be adequately controlled despite aggressive efforts to identify a tolerable therapy that does not compromise consciousness’ (Kay De Vries and Marek Plaskota, ‘Ethical dilemmas faced by hospice nurses when administering palliative sedation to patients with terminal cancer’ (2016) 15 *Palliative & Supportive Care* 148, 148). See, also, Marian Verkek, ‘Towards responsive knowing in matters of life and death’ in Christoph Rehmann-Sutter, Heike Gudat, and Kathrin Ohnsorge (eds), *The Patient’s Wish to Die: Research, Ethics, and Palliative Care* (OUP 2015), 140.

²⁶ Suicide Act 1961 (Amendment) [HL] Bill, HL Deb 11 December 1985, vol 469, cols 288-318, 309 <<https://api.parliament.uk/historic-hansard/lords/1985/dec/11/suicide-act-1961-amendment-bill-hl>> accessed 30 July 2019.

- Assistance for individuals suffering unbearably as a result of a terminal illness;²⁷
- Assistance for individuals with a terminal illness and a life-expectancy of 6 months or less.²⁸

Each attempt to amend the Suicide Act 1961 to provide for some form of assisted dying has been unsuccessful and the blanket prohibition remains intact; assisting and encouraging suicide is criminal. Similarly, several challenges to the compatibility of the blanket ban with the ECHR have failed.²⁹ There are, however, other end-of-life practices which are lawful in England and Wales.

3.2 Palliative sedation and passive euthanasia

In England and Wales a capacitous patient has ‘an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered’.³⁰ ‘This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.’³¹ In December 2015, the Court of Protection reaffirmed the right of a 50-year-old woman with capacity to refuse life-saving dialysis on the basis that such a life ran contrary to her erstwhile ‘emphasis on money, material possessions and “living the high life”’.³² Central to the absolute right of capacitous individuals to refuse life-sustaining treatment are the principles of autonomy and self-determination.³³ While the principle of the sanctity of life carries significant weight, it is not absolute; it can and does give way to other principles including a patient’s autonomy and self-determination.³⁴ Further, the United Kingdom (‘UK’) Supreme Court has recently confirmed that where doctors and family members are agreed, life-sustaining treatment that is not in the patient’s best interests can be withdrawn from incapacitous patients

²⁷ Assisted Dying for the Terminally Ill HL Bill (2003-04) <<https://publications.parliament.uk/pa/ld200304/ldbills/017/04017.iii.html>> accessed 30 July 2019.

²⁸ Assisted Dying HL Bill (2014-15) <<https://services.parliament.uk/bills/2014-15/assisteddying.html>> accessed 30 May 2019; Assisted Dying HC Bill (No 2) (2015-16) <<https://services.parliament.uk/bills/2015-16/assisteddyingno2.html>> accessed 30 July 2019; Assisted Dying HL Bill (2016-17) <https://publications.parliament.uk/pa/bills/lbill/2016-2017/0042/lbill_2016-20170042_en_2.htm#1g1> accessed 30 July 2019.

²⁹ *Pretty* (n 7), *Nicklinson* (n 7) and *Conway* (n 7).

³⁰ *Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782, [1993] Fam 95, 102 (Lord Donaldson).

³¹ *ibid.* See, also, *Airedale NHS Trust v Bland* [1993] AC 789, 859, [1993] UKHL 17 (Lady Hale): ‘It is not lawful to treat a patient who has capacity and refuses that treatment.’

³² *Kings College Hospital NHS Foundation Trust v C & Anor* [2015] EWCOP 80 [8], [2015] 11 WLUK 797.

³³ See, for instance, *Re B(Consent to treatment) v An NHS Hospital Trust* [2002] EWHC 429 (Fam), [2002] 2 All ER 449 [16]ff; *Bland* (n 31), 864.

³⁴ See, for instance, *Bland* (n 31) 859, 864

without a declaration from the courts.³⁵ In such cases, the patient's dignity – as evidenced in the assessment of their best interests – assumes particular significance.

In addition to the right to refuse life-sustaining treatment, palliative sedation is an accepted part of end-of-life care in England and Wales.³⁶ The law has developed to accommodate practices that would otherwise constitute murder (relying on oblique intention);³⁷ the doctrine of double effect 'allows death to be knowingly caused as a side-effect [of proper pain relief of refractory symptoms] and so draws a distinction between the intention underlying an action on the one hand and the consequences that are foreseen but are not intended on the other.'³⁸

Thus, while a doctor cannot assist a patient to die when they are *not* receiving life-sustaining treatment, they can assist a patient who *is* receiving such treatment. Indeed, they are mandated to if the patient is capacitous and refuses or withdraws consent to such treatment or, if they are incapacitous, and the treatment is no longer in the patient's best interests. The disparate treatment of end-of-life practices in English law will be considered in greater detail in the ensuing chapters.

4. Assisted suicide and euthanasia: a global perspective³⁹

4.1 Legally permissive jurisdictions

Assisted suicide and/or voluntary active euthanasia is currently permitted (meaning there is legislation or case law which *expressly* provides that assisted suicide and/or voluntary active euthanasia is lawful, as opposed to there being no express prohibition of the practices)⁴⁰ in the following jurisdictions:

- Belgium;⁴¹

³⁵ *An NHS Trust v Y* [2018] 3 WLR 751, [2018] UKSC 46.

³⁶ See, for instance, National Institute for Health and Care Excellence, 'Guideline NG31: Care of dying adults in the last days of life' (December 2015) <<https://www.nice.org.uk/guidance/ng31/chapter/Recommendations>> accessed 30 July 2019.

³⁷ *Nicklinson* (n 7) [255] (Lord Sumption). Similarly, Ognall J opined, in *R v Cox* (1992) 12 BMLR 38 (41) that: 'There can be no doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death. What can never be lawful is the use of drugs with the primary purpose of hastening the moment of death.'

³⁸ *Briggs v Briggs* [2016] [2017] 4 WLR 37, [2017] EWCOP 53 [88]. See, also, *Nicklinson* (n 7) [18] (Lord Neuberger).

³⁹ While every attempt has been made to source the relevant primary material, language restrictions necessitate reliance on secondary sources in some instances.

⁴⁰ As is the situation in, for instance, Scotland: *Gordon Ross v Lord Advocate* [2016] CSIH 12, 2016 SC 502.

⁴¹ 28 May 2002 Act on Euthanasia, B.S. 22 June 2002. For a translation of the legislation: <<http://www.ethical-perspectives.be/viewpic.php?LAN=E&TABLE=EP&ID=59>> accessed 30 July 2019.

- Canada (federally⁴² and in Quebec⁴³);
- Colombia;⁴⁴
- Luxembourg;⁴⁵
- Switzerland;⁴⁶
- The Netherlands;⁴⁷
- The following US States:
 - California;⁴⁸
 - Colorado;⁴⁹
 - Hawai'i;⁵⁰
 - Maine;⁵¹
 - Montana;⁵²
 - New Jersey;⁵³
 - Oregon;⁵⁴
 - Vermont;⁵⁵
 - Washington State;⁵⁶
 - Washington D.C.⁵⁷

⁴² Criminal Code (RSC 1985, c.C-46) s 241.

⁴³ Act Respecting End-of-Life Care (Bill-52, 2014).

⁴⁴ Constitutional Claim Decision C-239/97 (20 May 1997). Summary: <<http://english.corteconstitucional.gov.co/sentences/C-239-1997.pdf>> accessed 30 July 2019. Legislation giving effect to that decision is Resolution 1216 (2015), Official Gazette No 49.489 (21 April 2015) <http://www.icbf.gov.co/cargues/avance/docs/resolucion_minsaludps_1216_2015.htm> accessed 30 July 2019.

⁴⁵ Law of 16 March 2009 on Euthanasia and Assisted Suicide (Mémorial A-No. 46, 16 March 2009) <<http://www.legilux.public.lu/leg/a/archives/2009/0046/a046.pdf#page=7>> accessed 30 July 2019

⁴⁶ Swiss Criminal Code, SR 311.0 (1937, amended 2015) art 115. 'Assisting suicide is legal in Switzerland if it is offered without selfish motive to a person with decision-making capacity. There are no direct legal rules about physician involvement and most assisted suicides are provided by lay right-to-die associations' (Samia A. Hurst and Alex Mauron, 'Assisted Suicide in Switzerland: Clarifying Liberties and Claims' (2017) 31 Bioethics 199).

⁴⁷ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002.

⁴⁸ End of Life Option Act (2016).

⁴⁹ Colorado End-of-Life Options Act (2016).

⁵⁰ Our Care, Our Choice Act (2018).

⁵¹ Death with Dignity Act (LD 1313) (2019).

⁵² In 2009, the Supreme Court of Montana held that the consent of a terminally ill adult with capacity could shield physicians from 'homicide liability' in the context of assisted suicide: *Baxter and Ors v State of Montana & Anor* (2009 MT 444). The source of the right is The Rights of the Terminally Ill Act (Title 9, Chapter 50 of the Montana Code Annotated) which applies to 'qualified patients' who are defined as '18 years of age or older' with terminal conditions and whose death is anticipated 'within a relatively short time' (Title 50, Chapter 9, Part 2 of the Montana Code Annotated, 50-9-102(13), 50-9-102(16) and 50-9-204.

⁵³ Aid in Dying for the Terminally Ill Act (2019).

⁵⁴ Death with Dying Act (1997).

⁵⁵ An Act Relating to Patient Choice and Control at End of Life (2013).

⁵⁶ Death with Dignity Act (RCW 70.245) (2009).

⁵⁷ Death with Dignity Act 2016 (Law 21-182) (2017).

- The Australian State of Victoria,⁵⁸
- The Australian State of Western Australia.⁵⁹

Table 1 provides a comparative overview of the situation in each of the jurisdictions just outlined.

⁵⁸ Voluntary Assisted Dying Act 2017.

⁵⁹ Voluntary Assisted Dying Act 2019.

TABLE 1: List of jurisdictions in which AS and/or VAE are legally permitted

| Jurisdiction | Assisted Suicide? (PAS or General) ⁶⁰ | Voluntary Active Euthanasia? | Source (legislation, case law or other?) | 'Adults' (i.e. 18 years or older) only? | Terminal conditions only? | Subject to a 'suffering' criteria? | Death within a specified period? | Advanced directives authorising euthanasia permitted? |
|------------------|--|------------------------------|--|---|---------------------------|---|---|---|
| Belgium | PAS ⁶¹ | Yes | Euthanasia: 28 May 2002 Act on Euthanasia, (B.S. 22 June 2002) PAS: guidance from the Federal Control and Evaluation Commission | No | No | Constant and unbearable physical suffering that cannot be alleviated | No | Yes |
| California | PAS | No | End of Life Option Act (2016) | Yes | Yes | No | Within 6 months | No |
| Canada – federal | PAS | Yes | Criminal Code, (RSC 1985, c.C-46) as amended by Bill C-14 (2015) | Yes | Yes | Enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they | Their natural death has become reasonably foreseeable | No |

| | | | | | | | | |
|-----------------|----|-----|--|------------------|-----|--|------------------------------------|-------------------|
| | | | | | | consider acceptable | | |
| Canada – Quebec | No | Yes | Act Respecting End-of-Life Care (Bill-52, 2014) | Yes | Yes | Constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable | At the end of life | No |
| Colombia | No | Yes | Judgment C-239/1997 followed by Resolution 1216 (2015), Official Gazette No 49.489 | No ⁶² | Yes | Severe pain and suffering that cannot be relieved | Near or short term fatal prognosis | Yes ⁶³ |

⁶⁰ 'PAS': physician-assisted suicide; 'general': suicide assisted by persons other than physicians.

⁶¹ Carter (2012) (n 13) [508]. Herman Nys, 'A discussion of the legal rules on euthanasia in Belgium briefly compared with the rules in Luxembourg and the Netherlands' in David Albert Jones, Chris Gastmans and Calum MacKellar (eds) *Euthanasia and Assisted Suicide: Lessons from Belgium* (Cambridge University Press 2017), 10.

⁶² Young people over 14 do not need parental authorization, children between 12 and 14 years of age compulsorily require the consent of their parents, and boys and girls between 6 and 12 years old must demonstrate a "neurocognitive development and exceptional psychological that allows them to make a free, voluntary, informed and unequivocal decision in the medical field and their concept of death reaches the expected level for a child over 12 years old" L Lopez Benavides, 'The right to die with dignity in Colombia' (2018) 6 *Forensic Research and Criminology International Journal* 426, 428. See, also, decision of the Colombian Constitutional Court in Judgment T-544/2017 [37]-[38].

⁶³ Resolution 1216 (2015), art 15(3), discussed at length by the Colombian Constitutional Court in Judgment T-721/17 [6.1.6]ff.

| | | | | | | | | |
|------------|-----|-----|--|-----|------------------|---|-----------------|-----|
| Colorado | PAS | No | Colorado End-of-Life Options Act (2016) | Yes | Yes | No | Within 6 months | No |
| Hawai'i | PAS | No | Our Care Our Choice Act (2018) | Yes | Yes | No | Within 6 months | No |
| Luxembourg | PAS | Yes | Law of 16 March 2009 on Euthanasia and Assisted Suicide (Mémorial A-No. 46, 16 March 2009) | Yes | No ⁶⁴ | Constant and unbearable physical or mental suffering without hope of recovery | No | Yes |

⁶⁴ The Luxembourgian Act refers to a 'medicale sans issue' which can loosely be translated as a 'dead end' medical situation, which does not necessarily mean terminal. The lack of a life-expectancy criteria supports this interpretation as do a number of academic writings on the Luxembourgian Act. See, for instance, Nicole Steck, Matthias Egger, Maud Maessen, Thomas Reisch and Marcel Zwahlen, 'Euthanasia and Assisted Suicide in Selected European Countries and US States: A Systematic Literature Review' (2013) 51 *Medical Care* 938; Monica Verhofstadt, Lieve Thienpont and Gjalte-Jorn Ygram Peters, 'When unbearable suffering incites psychiatric patients to request euthanasia: a qualitative study' (2017) 211 *The British Journal of Psychiatry* 238; Ezekiel Emanuel, Bregje Onwuteaka-Philipsen, John Urwin and Joachim Cohen, 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada and Europe' (2016) 316 *JAMA* 79, 80. Given Luxembourg followed Belgium and the Netherlands in permitting assisted dying, neither of which required that the individual be terminally ill, it would be most curious if Luxembourg were to introduce such a restriction in the absence of very clear wording to that effect. That, coupled with the lack of a life-expectancy requirement, and considering there is a suffering requirement (which, if the system was limited to the terminally ill would, arguably, be unnecessary (as is the case in the permissive US states)), tends to favour an interpretation of the Luxembourgian legislation which is not confined to the terminally ill.

| | | | | | | | | |
|------------|-----|----|--|-----|-----|----|----------------------------------|------------------|
| Maine | PAS | No | Death with Dignity Act (LD 1313) (2019) | Yes | Yes | No | Within 6 months | No |
| Montana | PAS | No | Baxter and Ors v State of Montana & Anor (2009 MT 444) (Montana Supreme Court) | Yes | Yes | No | Within a 'relatively short time' | No ⁶⁵ |
| New Jersey | PAS | No | Aid in Dying for the Terminally Ill Act (NJ A1504) (2019) | Yes | Yes | No | Within 6 months | No |
| Oregon | PAS | No | Death with Dying Act (1997) | Yes | Yes | No | Within 6 months | No |

⁶⁵ The Montana Supreme Court based its decision on The Rights of the Terminally Ill Act (Title 9, Chapter 50 of the Montana Code Annotated) which does permit the making of advance directives relating to the withdrawal of life-sustaining treatment. While it would seem, then, that an individual could make an advance directive concerning assisted suicide, the patient must be capable of doing the act that brings about their death (i.e. suicide). On this basis, it would be unlikely that a patient who is incapacitous (and, thus, dependent upon an advance directive) could suicide.

| | | | | | | | | |
|----------------------|----------------------------|---|--|------------------|-----|---|---|-------------------|
| Switzerland | General but <i>not</i> PAS | No | Swiss Criminal Code (S.R. 311.0) (1937) | Not specified | No | No ⁶⁶ | No | Yes |
| The Netherlands | PAS | Yes | Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Stb. 2001, 194). | No ⁶⁷ | No | Unbearable suffering with no prospect of improvement | No | Yes ⁶⁸ |
| Vermont | PAS | No | An Act Relating to Patient Choice and Control at End of Life (2013) | Yes | Yes | No | Within 6 months | No |
| Victoria (Australia) | PAS | Yes (if the patient is physically incapable of suicide) ⁶⁹ | Voluntary Assisted Dying Act 2017 | Yes | Yes | Suffering which cannot be relieved in a manner that the patient | Within 6-12 months depending on the condition | No |

⁶⁶ Per translation of the Federal Court's decision in Haas: 'Where the wish to die is based on an autonomous and all-embracing decision, it is not prohibited to prescribe sodium pentobarbital to a person suffering from a psychiatric illness and, consequently, to assist him or her in committing suicide' (*Haas v Switzerland* (2011) 53 EHRR 33 [16]). 'Terminally ill persons, patients with mental disorders and other severely disabling illnesses have recourse to assisted suicide' Steck et al (n 64) 939 and Table 1.

⁶⁷ Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002, s 2(2)-(4).

⁶⁸ *ibid*, s 2(2).

⁶⁹ Voluntary Assisted Dying Act 2017, Pt 4, Div 2.

| | | | | | | | | |
|---------------------------------------|-----|-----|--|-----|-----|---|---|----|
| | | | | | | considers tolerable | | |
| Washington State | PAS | No | Death with Dignity Act (RCW 70.245) (2009) | Yes | Yes | No | Within 6 months | No |
| Western Australia | PAS | Yes | Voluntary Assisted Dying Act 2019 | Yes | Yes | Suffering which cannot be relieved in a manner that the patient considers tolerable | Within 6-12 months depending on the condition | No |
| District of Columbia (Washington D.C) | PAS | No | Death with Dignity Act of 2016 (L21-0182) | Yes | Yes | No | Within 6 months | No |

4.2 Assisted suicide and rights jurisprudence

The English courts are not unique in their examination of the human rights implications prohibiting assisted suicide; courts in Canada, the US, South Africa, Italy and New Zealand (to name a few) have similarly had cause to examine domestic bans on assisted suicide through the lens of human rights. As the ensuing discussion will demonstrate, there is considerable overlap in the core principles underpinning that jurisprudence. Those principles are directly relevant to the question of the compatibility of s 2 of the Suicide Act 1961 with the ECHR, which is considered in subsequent chapters and the conclusions reached in those chapters draw support from, and build upon, the international jurisprudence canvassed below, in particular the Canadian case of *Carter*.⁷⁰

4.2.1 *England and Wales*

There have been five key human rights challenges to the blanket ban on assisted dying in England and Wales: Diane Pretty (2001), Debby Purdy (2008), Tony Nicklinson, Paul Lamb and ‘Martin’ (2014), Noel Conway (2018), and Omid T (2018).⁷¹ While those cases are considered in detail in the ensuing chapters, the key aspects of the disputes will be considered here, in particular the human rights elements.

Diane Pretty’s landmark litigation was the first to challenge s 2 of the Suicide Act 1961 and it did so via the newly enacted Human Rights Act 1998 (‘HRA 1998’), which incorporated certain of the rights in the ECHR directly into domestic law and, relevantly, conferred power on the courts to declare that legislation was incompatible with the ECHR.⁷² Given the uncharted territory, it is unsurprising that Ms Pretty challenged the ban on a multitude of bases: right to life (Article 2), freedom from torture or inhuman or degrading treatment (Article 3), right to private life (Article 8), freedom of conscience (Article 9), and freedom from discrimination (Article 14). While the domestic courts rejected the entirety of Ms Pretty’s claim, the ECtHR accepted that the ban engaged, and interfered with, her right to private life; Article 8, it was held, includes the right to choose the manner and timing of one’s death or, to put it another way, to avoid an undignified death. In reaching this conclusion, the Court observed that ‘the notion of personal autonomy is an important principle underlying the interpretation of [the] guarantees’ in Article 8.⁷³ The Court also

⁷⁰ *Carter* (Supreme Court) (n 1) and *Carter* (n 13).

⁷¹ The dates reference the latest decision by a domestic court in the proceedings. See, n 7 and n 8. As discussed below – that ‘Martin’ is again seeking to challenge the blanket ban on the basis of its allegedly discriminatory effect.

⁷² Human Rights Act 1998, s 4.

⁷³ *Pretty v United Kingdom* (n 7) [61].

held that the ‘very essence of the Convention is respect for human dignity’.⁷⁴ Despite finding that the ban interfered with Ms Pretty’s right to private life, the ECtHR accepted the State’s claim that the blanket ban on assisted suicide was justified and found no violation of Article 8.

The finding that the blanket ban engaged and interfered with the right to private life paved the way for subsequent human rights challenges, commencing with Debbie Purdy’s judicial review proceedings which centred on the lack of a prosecution policy specific to s 2 of the Suicide Act 1961. Mrs Purdy ‘suffer[ed] from primary progressive multiple sclerosis for which there [was] no known cure’ and wanted to travel to Switzerland to die by suicide with assistance when her suffering became unbearable. Given her condition, she needed her husband’s assistance to get to Switzerland and it was unclear whether such conduct would lead to prosecution under s 2 of the Suicide Act 1961.⁷⁵ No one had been prosecuted for assisting a loved one to travel overseas to die with assistance in a permissive jurisdiction, notwithstanding the fact that such conduct appeared to fall within the ambit of s 2. Mrs Purdy argued that it was unclear what factors the Crown Prosecution Service (‘CPS’) would take into account when deciding whether to prosecute under s 2 of the Suicide Act 1961. The law, it was said, lacked foreseeability and accessibility – both of which are required for an interference with Article 8 to be ‘in accordance with law’ for the purposes of Article 8(2). The House of Lords agreed that the ban could not ‘be “in accordance with the law” unless there [was] greater clarity about the factors which the [Director of Public Prosecutions] and [their] subordinates [would] take into account.’⁷⁶ The House of Lords held that there was ‘an obvious gulf between what section 2(1) says and the way that the subsection [was] being applied in practice in compassionate cases’⁷⁷ and the generic Code governing prosecutions failed to provide sufficient predictability and consistency of decision-making in those cases. The Director was, thus, required to promulgate an ‘offence-specific policy identifying the facts and circumstances which [would be taken] into account in deciding, in a case such as that which Ms Purdy’s case exemplifie[d], whether or not to consent to a prosecution under section 2(1) of the 1961

⁷⁴ *ibid* [65].

⁷⁵ *Purdy* (n 7) [17].

⁷⁶ *ibid* [63].

⁷⁷ *Purdy* (n 7) [54].

Act.⁷⁸ After a consultation period, the CPS published a policy specific to s 2 of the Suicide Act 1961.⁷⁹

The 2014 Supreme Court decision in *Nicklinson* involved two appeals. One – that of Tony Nicklinson and Paul Lamb – concerned a challenge to the compatibility of the blanket ban with Article 8 of the ECHR and the other challenged the lawfulness of the then-recently published s 2-specific CPS policy. The aspect of the judgment concerning Mr Nicklinson and Mr Lamb is considered in detail in Chapter Four. For instant purposes, it is sufficient to note that a majority of the Supreme Court did *not* reach a conclusion as to the ban’s compatibility, while Lady Hale and Lord Kerr did, with both holding that the ban was incompatible with Article 8. Relevantly, there was no dispute that the ban ‘impinges adversely on the personal autonomy of some people with degenerative diseases’.⁸⁰ Indeed, President Neuberger observed that ‘assisting a suicide could be seen ... as promoting the autonomy of the person committing suicide’⁸¹ In addition to the principle of autonomy, several members of the Supreme Court also recognised that human dignity was relevant to an examination of the compatibility of s 2 of the Suicide Act 1961.⁸²

The second of the appeals in *Nicklinson* – that involving ‘Martin’ – concerned how the s 2-specific CPS policy related to carers and health professionals. While the Supreme Court unanimously dismissed this aspect of the appeal, they did so having noted that the representatives of the DPP had clarified the effect of the policy with respect to carers. Following *Nicklinson*, the CPS policy was updated to reflect the characterisation referred to by the Supreme Court.⁸³ The current iteration of the policy sets out 16 public interest factors which tend in favour of prosecution and 6 which tend against:

A prosecution is more likely to be required if:

1. the victim was under 18 years of age;
2. the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;
3. the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;

⁷⁸ *ibid* [56].

⁷⁹ CPS, ‘Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide’ (October 2014) <<https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide>> accessed 30 July 2019.

⁸⁰ *Nicklinson* (n 7) [96].

⁸¹ *ibid* [92]–[97], [186].

⁸² See, for instance, *Nicklinson* (n 7) [311] (Lady Hale).

⁸³ CPS Suicide Policy (n 79) factor 14 in favour of prosecution.

4. the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
5. the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;
6. the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;
7. the suspect pressured the victim to commit suicide;
8. the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;
9. the suspect had a history of violence or abuse against the victim;
10. the victim was physically able to undertake the act that constituted the assistance him or herself;
11. the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication;
12. the suspect gave encouragement or assistance to more than one victim who were not known to each other;
13. the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;
14. the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, **and the victim was in his or her care;**
15. the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;
16. the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

A prosecution is less likely to be required if:

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

2. the suspect was wholly motivated by compassion;
3. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
4. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
5. the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;
6. the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.⁸⁴

Very recently, Noel Conway and Omid T separately challenged the compatibility of the blanket ban with the ECHR. Mr Conway, who has motor neurone disease, argued that the ban was incompatible with his Article 8 right to private life as a less restrictive ban – one which allowed individuals like him with a terminal condition and with a life expectancy of six months or less to be assisted in dying by suicide – better balanced the competing rights. Omid T, who had a life-limiting but not terminal condition, also challenged the compatibility of the ban with Article 8.⁸⁵ Both the High Court⁸⁶ and the Court of Appeal⁸⁷ rejected Mr Conway's claim that a less restrictive ban was available and permission to appeal to the Supreme Court was refused.⁸⁸ It is unclear whether Omid T's litigation, which was stayed pending the outcome of Mr Conway's proceedings – will proceed following his assisted death at a Swiss clinic in October 2018.⁸⁹

Pretty, Purdy, Nicklinson, Conway and *T* centred on the rights contained in the ECHR as incorporated into domestic law through the HRA 1998. As it stands, the only right that has been found to be engaged by the ban in s 2 of the Suicide Act 1961 is the right to private life in Article 8. Central to the recognition that the ban interferes with Article 8, was the acknowledgment that the right to choose the manner and timing of one's death or, alternatively, to avoid an undignified death, is intimately connected to the principles of autonomy and dignity, both of which underpin Article 8 of the ECHR. As was observed

⁸⁴ Emphasis in original.

⁸⁵ R (*On the application of T*) v *Ministry of Justice* [2018] 10 WLUK 162, EWHC 2615 (Admin).

⁸⁶ *Conway* (High Court) (n 7).

⁸⁷ *Conway* (Court of Appeal) (n 7).

⁸⁸ *Conway* (Supreme Court) (n 8).

⁸⁹ Bindmans, 'Omid T dies – legal case left unresolved' (5 October 2018) <<https://www.bindmans.com/news/omid-t>> accessed 30 July 2019.

in respect of Noel Conway’s challenge ‘The Article 8 rights engaged are fundamental to the personal and psychological autonomy and integrity of Mr Conway and others suffering from similar terminal conditions.’⁹⁰ As the ensuing discussion and following chapters reveal, the principles of autonomy and dignity have also assumed significance in rights adjudication concerning analogous bans in other jurisdictions.

4.2.2 *International jurisprudence*

Canada’s *Carter* litigation is examined in detail in Chapter Five. The trial judge in *Carter* held that the Canadian ban on assisted suicide violated, *inter alia*, the rights to life, liberty and security of the person in s 7 of the Canadian Charter of Rights and Freedom (‘Canadian Charter’). Central to that conclusion – which was unanimously confirmed by the Canadian Supreme Court – was the finding that the ban failed to adequately balance the autonomy and dignity of individuals who were suffering unbearably as a result of a medical condition with the countervailing interests of society (including protecting vulnerable individuals).⁹¹

In *Glucksberg*⁹² and *Vacco*,⁹³ the Supreme Court of the United States considered whether state bans on assisted suicide were unconstitutional because they violated, respectively, the Due Process and the Equal Protection Clauses in the United States Constitution. While the Due Process Clause ‘protects those fundamental rights and liberties which are, objectively, deeply rooted in this Nation’s history and tradition’,⁹⁴ the Equal Protection Clause ‘embodies a general rule that States must treat like cases alike.’⁹⁵ Central to the claim in *Glucksberg* was the contention that Washington State’s ban on assisted suicide violated the Due Process Clause because the fundamental right to liberty protected by the Clause entailed ‘a right to commit suicide which itself includes a right to assistance in doing so’.⁹⁶ The Supreme Court rejected that argument, finding that the fundamental right to liberty did not include a right to ‘commit suicide’ and the ban on assisted suicide was rationally connected to legitimate government interests including ‘preserving life’ and protecting ‘vulnerable groups from indifference.’⁹⁷ Notably, the right relied upon to challenge the blanket ban – the right to liberty – included protection for matters ‘central to personal

⁹⁰ This statement was made by the Court of Appeal in a separate set of proceedings to that examined in detail in this thesis: *R (On the application of Conway) v Secretary of State for Justice* [2017] EWCA Civ 275 [23].

⁹¹ See, for instance, *Carter* (Supreme Court) (n 1) [2], [62], [64], [66] and [68].

⁹² *Washington v Glucksberg*, 521 U.S. 702 (1997).

⁹³ *Vacco v Quill*, 521 U.S. 793 (1997).

⁹⁴ *Glucksberg* (n 92) 703.

⁹⁵ *Vacco* (n 93) 793.

⁹⁶ *Glucksberg* (n 92) 703.

⁹⁷ *ibid* 703-4.

dignity and autonomy.⁹⁸ As will become apparent in subsequent chapters, it is significant that several members of the Supreme Court (Justices O’Conner, Ginsburg and Breyer) did not rule out the possibility that an alternatively formulated right – the ‘right to die with dignity’ – would fall within the remit of the fundamental liberty right.⁹⁹ However, it was said that since terminally ill patients had access to palliative care, the ban on assisted suicide did not force individuals to endure an undignified death.¹⁰⁰

In *Vacco*, the Supreme Court rejected the claim that the ban on assisted suicide in New York infringed fundamental rights and involved suspect classifications.¹⁰¹ The ban, it was said, did not treat anyone differently from anyone else, nor did it draw any distinctions between persons.¹⁰² The outcome in *Vacco* ought to be contrasted with the finding in *Carter* that the ban on assisted suicide in Canada ‘imposed a disproportionate burden on persons with physical disabilities, as only they are restricted to self-imposed starvation and dehydration in order to take their own lives’ and that distinction was discriminatory and could not be justified.¹⁰³

In *Stransham-Ford*, the South African High Court accepted the applicant’s claim that the – allegedly – blanket ban on assisted suicide conflicted with his constitutional rights to human dignity and bodily and psychological integrity.¹⁰⁴ The trial judge in *Stransham-Ford* cited the reasons of the trial judge in *Carter* with approval and concluded that the dictum, including the ‘great emphasis placed on the concept of dignity and autonomy’, applied to the case at hand.¹⁰⁵ While the South African Supreme Court of Appeal ultimately overturned the trial judge’s conclusion that the ban violated constitutionally protected rights, it did so not on the basis of the judge’s reasoning with respect to the rights at issue. Rather, the appeal was overturned because, *inter alia*, Mr Stransham-Ford’s death before the trial judge delivered judgment extinguished his claim for relief and, further, ‘it [could not] be said that in the current state of [South Africa’s criminal law] [physician assisted suicide was] in all circumstances unlawful.’¹⁰⁶

⁹⁸ Glucksberg (n 92) 744.

⁹⁹ *ibid* 791 (Breyer J).

¹⁰⁰ Glucksberg (n 92) 791-2.

¹⁰¹ *Vacco* (n 93) 793.

¹⁰² *ibid*.

¹⁰³ *Carter* (Supreme Court) (n 1) [29].

¹⁰⁴ *Stransham-Ford v Minister of Justice and Correctional Services and Ors* (Unreported Case No 27401/15, 4-5-2015).

¹⁰⁵ *ibid* [18].

¹⁰⁶ *Minister of Justice and Correctional Services v Estate Stransham-Ford* (531/2015) 2016 ZASCA 197 [54].

The final judgment of comparative note is the New Zealand High Court's decision in *Seales*.¹⁰⁷ The New Zealand High Court rejected the applicant's claim for, *inter alia*, a declaration that the prohibition on assisted suicide was inconsistent with her right not to be deprived of life and the right not to be subject to cruel, degrading or disproportionately severe treatment.¹⁰⁸ Notwithstanding the lack of success of Ms Seales's application, it is notable that two of the principles that the Court found to be engaged in the case were 'respect for human dignity' and 'respect for individual autonomy'.¹⁰⁹

4.3 Assisted suicide *vis-à-vis* other end-of-life practices

As the preceding analysis reveals, principles of autonomy and dignity are central to an examination of the human rights implications of the criminalisation of assisted suicide. How those principles are applied, however, and the weight given to competing principles such as the sanctity of life, varies considerably between jurisdictions with some courts finding that domestic bans on assisted suicide violate human rights, and others rejecting that contention. In contrast, those same principles, especially autonomy, together with self-determination, are consistently prioritised over competing values, including the sanctity of life, in cases of refusal or withdrawal of life-sustaining treatment. There are many jurisdictions in which a capacitous patient's right to refuse life-saving treatment or to seek withdrawal of such treatment is afforded absolute respect while assisted dying is strictly prohibited including, as discussed above, England and Wales.¹¹⁰ While sanctity of life considerations assume significance in such cases, a more holistic assessment of the patient's best interests is undertaken which includes a consideration of the patient's quality of life (i.e. dignity) and their previously expressed wishes (i.e. autonomy and self-determination). It is also important to note the nature of the inquiry in cases involving incapacitous patients:

[T]he focus is on whether it is in the patient's best interests to give the treatment, rather than on whether it is in his best interests to withhold or withdraw it. If the treatment is not in [their] best interests, the court [or other individuals charged with making assessments] will not be able to give its consent on [their] behalf and it will follow that it will be lawful to withhold or withdraw it. Indeed, it will follow that it will not be lawful to give it. It also follows that (provided of course that they

¹⁰⁷ *Seales* (n 12).

¹⁰⁸ *ibid* [10].

¹⁰⁹ *Seales* (n 12) [62].

¹¹⁰ See also, for instance, Australia (all states bar Victoria and Western Australia), New Zealand, France and South Africa (though, note the comments about the legal status of assisted suicide above).

have acted reasonably and without negligence) the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw it.¹¹¹

Thus, where a patient is capacitous, their decision to cease/refuse life-sustaining treatment *must* be respected, no matter that death will undoubtedly follow and regardless of their reasons for so deciding (provided such reasons do not reflect undue influence). In the case of incapacitous patients, where ongoing treatment is not in their best interests, it is lawful for life-sustaining treatment to be ceased (or not administered), even when death is the unavoidable consequence. These approaches are founded on the well-established common law principles of autonomy and self-determination, which reflect the ECHR's emphasis on dignity and bodily integrity. Where, however, a patient is suffering from a terminal or life-limiting illness or is otherwise in 'intolerable pain' but they are not receiving life-sustaining treatment the withdrawal or refusal of which would lead to their death, they are precluded in England and Wales from obtaining assistance in bringing about their death due to the blanket ban on assisted suicide in s 2(1) of the Suicide Act. This is so even though the issues of autonomy, self-determination and dignity just outlined apply equally to these individuals.

The differential treatment of assisted suicide *vis-à-vis* other end-of-life practices, notwithstanding the commonality of the principles underpinning those practices, is considered in greater detail in subsequent chapters, in particular Chapters Four and Six. For now, it is sufficient to note the consistency in the principles applied by courts in various jurisdictions when examining the rights implications of bans on assisted suicide. That consistency lends support to the structure of the analysis undertaken in the following chapters, in particular, the focus on Articles 2 (right to life), 3 (freedom from torture and inhuman or degrading treatment) and 8 (right to private life) of the ECHR, given the centrality of the principles of autonomy and dignity to those rights.

5. Conclusion

This chapter introduced the legal treatment of end-of-life practices both in England and Wales and in permissive jurisdictions overseas. The differential treatment of assisted suicide and voluntary active euthanasia *vis-à-vis* other end-of-life practices was considered, together with the human rights principles underpinning the regulation of those practices.

¹¹¹ *Aintree University Hospital NHS Foundation Trust v James* [2014] AC 591, [2013] UKSC 67.

Central to all assisted dying practices, from assisted suicide to withdrawal of life-sustaining treatment, are autonomy, dignity and self-determination. Notwithstanding that commonality, English law accords significantly different weight to those principles (and to competing principles, especially the sanctity of life) depending on the practice. Thus, the autonomy and self-determination of a capacitous patient is given pre-eminence over other principles, including the sanctity of life, in cases of withdrawal/refusal of life-sustaining treatment but those same principles give way to other interests, including the sanctity of life, when it comes to assisted suicide and euthanasia. This is so even if both patients are capacitous and suffering intolerably as a result of a medical condition which is terminal. This distinction – and its legal validity in the context of the ECHR – is considered in greater detail in the following chapters.

CHAPTER TWO

PROTECTING LIFE AND ASSISTING DEATH: IS *NOT* ALLOWING ASSISTED DYING A VIOLATION OF THE RIGHT TO LIFE?

1. Introduction

Article 2 protects the right to life; it prohibits the arbitrary taking of life by the State or its agents.¹¹² In determining whether the blanket ban on assisted suicide is compatible with Article 2, the first question is whether the ban engages the right to life. That is, does the ban interfere with a person's right to life? It was argued on behalf of Ms Pretty that the right to life encompassed the right not to live, and by denying her the opportunity to die by suicide with assistance, the State was violating her right *not* to live. In rejecting that contention, both the House of Lords and the ECtHR reiterated that Article 2 *protects* life and, unlike other articles in the ECHR, cannot be said to protect the inverse (i.e. a right *not* to live). While that may seem determinative of the question of the ban's compatibility with Article 2 (leaving aside for a moment the fact that the ECHR is a 'living instrument ... to be interpreted in present-day conditions'¹¹³), there is evidence that the ban forces some people to take their lives sooner than they otherwise would have if they were able to lawfully obtain assistance in dying by suicide at a later time. This chapter will examine in greater detail that evidence and whether it is sufficient to support the contention that the ban violates the right to life of individuals who feel compelled to take their lives prematurely as a result the ban.

2. Does the blanket ban engage the right to life?

The trial judge in *Carter* accepted the anecdotal evidence that the Canadian ban compelled some people to take their lives sooner than they otherwise would if assisted suicide were permitted:

[T]he prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be

¹¹² This 'dual aspect' is not unique to Article 2. See, for instance, J-F Akandji-Kombe, 'Positive obligations under the European Convention on Human Rights: A guide to implementation of the European Convention on Human Rights', Human Rights Handbooks (No.7) (Council of Europe 2007) 5-6, 8 and 21. See, also, *Giuliani and Gaggio v Italy* (2011) 52 EHRR 3 [204]ff.

¹¹³ See, for instance, *Schalk and Kopf v Austria* (2011) 53 EHRR 20 [57]; *EB v France* (2008) 47 EHRR 21 [92]; *Goodwin v United Kingdom* (2002) 35 EHRR 18 [74]–[75].

incapable of doing so when they reached the point where suffering was intolerable. On that basis, she found that the right to life was engaged.¹¹⁴

The Canadian Supreme Court endorsed that finding, holding that the ban ‘may cause those affected to take their own lives sooner than they would were they able to obtain a physician’s assistance in dying.’¹¹⁵ Consistent with the Canadian jurisprudence, the trial judge in the New Zealand case of *Seales* accepted the submission made by Ms Seales that the analogous ban in New Zealand engaged her right to life since it ‘may have the effect of forcing [her] to take her own life prematurely, for fear that she will be incapable of doing so when her condition deteriorates further.’¹¹⁶ These findings are not unique to the Canadian and New Zealand contexts; as then-President Neuberger observed in *Nicklinson*:

The argument based on the value of human life is not one which can only be raised by the Secretary of State. 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). Section 2 therefore not merely impinges adversely on the personal autonomy of some people with degenerative diseases, but actually, albeit indirectly, may serve to cut short their lives.¹¹⁷

In 2018, 6,507 individuals died by suicide.¹¹⁸ Given the above findings of Lord Neuberger in *Nicklinson*, the Canadian courts in *Carter* and the New Zealand High Court in *Seales*, it is likely that a percentage of those 6500 individuals were ‘forced [as a result of the ban on assisted suicide] 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’.¹¹⁹ Data disclosed by the Directors of Public Health in 2014 in response to a freedom of information request by Dignity in Dying, revealed that 7 per cent of suicides in England involve people who

¹¹⁴ As described in *Carter* (Supreme Court) (n 1) [57]. See, also, *Carter* (n 13) [1325].

¹¹⁵ *Carter* (Supreme Court) (n 1) [90]. See, also, [57]-[58]: ‘The evidence of premature death was not challenged before this Court. It is therefore established that the prohibition deprives some individuals of life.’ And, *Ocalan v Turkey* (2005) 18 BHRC 293 [202].

¹¹⁶ *Seales* (n 12) [166].

¹¹⁷ *Nicklinson* (n 7) [96].

¹¹⁸ Office for National Statistics, ‘Suicides in the UK: 2018 registrations’ (3 September 2019) <<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations>> accessed 6 February 2020.

¹¹⁹ *Nicklinson* (n 7) [96].

are terminally ill.¹²⁰ Assuming, in the absence of evidence to the contrary, that that percentage has remained relatively stable, that means that approximately 455 people who died by suicide in 2018 had a terminal illness. The lack of a central database of coronial conclusions, coupled with the fact that many suicide conclusions are not narrative (and therefore do not typically disclose the individual's antecedents), makes it difficult (if not impossible) to ascertain how many of those individuals felt compelled to take their lives sooner than they otherwise would have chosen to if they could have obtained assistance at a later date. However, the anecdotal evidence strongly suggests that at least some of those 400 individuals and, indeed, other individuals who, while not terminally ill, may nevertheless be experiencing life-limiting conditions (such as Omid T¹²¹), took their lives sooner than they otherwise would have as a result of the ban.

This is consistent with evidence from the State Coroner given to the Victorian Standing Committee on Legal and Social Issues which was considering the introduction of assisted suicide in Victoria (Australia). That evidence revealed that terminally ill individuals were dying by suicide in that jurisdiction:

These are people who are suffering from irreversible physical terminal decline or disease, and they are taking their lives in desperate, determined and violent ways. They are the category of suicides we want to talk to you today about.

...

I will say that there were at least 197 suicide deaths in those four years [between 2009 and 2012] where the deceased was suffering an irreversible deterioration in their physical health. When you break them down, about 80 per cent involved physical illness and in about 20 per cent, if you like, the aetiology of the deterioration is physical injury.¹²²

This evidence is consistent with that noted by Lord Neuberger in *Nicklinson*: '[t]here is reliable statistical and anecdotal evidence which indicates that, in recent years, hundreds of

¹²⁰ Dignity in Dying, 'The true cost: How the UK outsources death to Dignitas' 40 <https://cdn.dignityindying.org.uk/wp-content/uploads/DiD_True_Cost_report_FINAL_WEB.pdf> accessed 30 July 2019.

¹²¹ *Omid T* (n 85).

¹²² Standing Committee on Legal and Social Issues, Inquiry into end-of-life issues (7 October 2015) 3, 5 <https://www.parliament.vic.gov.au/images/stories/committees/SCLSI/ELC_Transcripts/SCLSI_-_Coroners_Court_-_FINAL_-_End-of-life_choices_7_October_2015.pdf> accessed 30 July 2019.

people suffering from terminal or chronic conditions, whose lives are often painful and/or undignified, committed suicide annually’.¹²³

In addition to the above data, there is first-hand evidence from individuals affected by the blanket ban in England and Wales, and analogous bans overseas, confirming that such bans do indeed cut short the lives of some individuals. The trial judge in *Carter* quoted one of the plaintiffs in those proceedings who described the impact of the (then-analogous) ban in the following way:

The current state of the law deprives me of the freedom to choose how and when I would end my life. The current law may cause me to initiate a premature termination of my life simply because if I wait until I am ready to do so, I may be unable to do so, in any humane fashion, without asking my loved ones to put themselves at legal risk.¹²⁴

A 2017 report prepared by Dignity in Dying based on, *inter alia*, interviews with individuals who were terminally ill as well as those whose loved ones had accessed assistance in dying by suicide in permissive jurisdictions overseas, contains multiple statements confirming that the ban in England and Wales ‘serve[s] to cut short [the] lives’¹²⁵ of some individuals:

- The best way I could describe that feeling is if you leave it too late, you’re trapped. I want to reach a stage where I say, ‘look, this isn’t an enjoyment any more.’ But there’s no way I’m going to end up trapped.
- I feel so strongly about that. If it was available in this country, I could get a few more months with quality of life. Now, you’ve got to end your life early. It’s not practical to say, ‘Oh, let’s go have an extended holiday in Switzerland and then when I come to the end...’ Because you can’t. I want my children with me and they can’t uproot their lives for me for weeks on end.
- They should allow assisted dying here because to go to Switzerland, I would have to travel while I’m still well enough. I’d be ending my life before I should have to.
- It’s going to be a hard decision. It’s going to be hard to say, ‘Right, I’ve got to go now. I’ve got to say it’d be nice to stay longer, but if I stay any longer I could end up not able to make it.’ If it comes to a choice between the two, I’d rather go

¹²³ *Nicklinson* (n 7) [14].

¹²⁴ *Carter* (n 13) [1145].

¹²⁵ *Nicklinson* (n 7) [96] (Lord Neuberger).

early than take the risk of leaving it too late. If I could do it here, well, that'd be marvellous. I'd be able to stay longer.

- The timing is really difficult. If we'd left it very much longer, Bob would have been in too much pain to travel, and I think he knew that, which is why he pushed it forward a bit, because he didn't have choice.¹²⁶

This evidence plainly demonstrates that the ban 'not merely impinges adversely on the personal autonomy of some people with degenerative diseases, but actually, albeit indirectly, may serve to cut short their lives.'¹²⁷ Indeed, Omid T who had multiple systems atrophy and whose death was not imminent, decided to travel to Switzerland in late 2018 while he was still able to do so in order to die with assistance. He did so after a failed attempt to take his life in 2015.¹²⁸ In those circumstances, the ban can be said to engage the right to life of such individuals. That, however, does not conclude an examination of the compatibility of s 2 of the Suicide Act 1961 with Article 2 of the ECHR. Having determined that the right to life is engaged, the question remains whether that engagement constitutes a violation of the State's obligation to protect life under Article 2 of the ECHR. Put plainly, does the fact that the ban forces some people to take their lives prematurely constitute a violation of Article 2 of the ECHR?

3. Does the blanket ban violate the State's positive obligation to protect life?

In the seminal decision of *Oneriyildiz v Turkey*¹²⁹ the Grand Chamber of the ECtHR was clear that 'Article 2 lays down a positive obligation on States to take appropriate steps to safeguard the lives of those within their jurisdiction' and 'this obligation must be construed as applying in the context of any activity, whether public or not'.¹³⁰ The ECtHR further held that the positive obligation 'entails above all a primary duty on the state to put in place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life.'¹³¹

Lady Hale further clarified the nature of the obligations imposed by Article 2 in the Supreme Court decision of *Rabone* holding that there are 'three distinct obligations upon the state', the third of which 'is a positive obligation to protect life. As a general rule, that

¹²⁶ Dignity in Dying, 'The true cost' (n 120) 38-39.

¹²⁷ *Nicklinson* (n 7) [96].

¹²⁸ *Bindmans* (n 89).

¹²⁹ *Oneriyildiz v Turkey* (2005) 41 EHRR 20.

¹³⁰ *ibid* [71].

¹³¹ *Oneriyildiz* (n 129) [89].

positive obligation is fulfilled by having in place laws and a legal system which deter threats to life from any quarter and punishes the perpetrators or compensates the victims if deterrence fails' and 'in certain circumstances ... [i]t entails an obligation to take positive steps to prevent a real and immediate risk to the life of a particular individual from materialising'.¹³²

There is a strong argument that, in forcing individuals such as Omid T to take their lives sooner than they would otherwise choose to, the blanket ban contravenes this positive obligation to protect life. More specifically, the Suicide Act 1961, not only fails to 'deter threats to life' but also itself poses a threat to the life of certain individuals. Any claim that the ban is nonetheless justified as it is 'necessary' fails for a number of reasons. First, the reference to 'absolutely necessary' in Article 2(2) does not invoke the same analysis that 'necessary in a democratic society' does in, for instance, Article 8.¹³³ Rather, 'absolutely necessary' qualifies the permitted use of force set out in Article 2(2).¹³⁴ It asks whether a state's use of force was 'absolutely necessary' for one of the reasons set out in Article 2(2). Neither the text of Article 2(1), nor the subsequent case law, permits a proportionality assessment when determining whether the State has violated its positive obligation to protect life.

Second, even if a proportionality assessment were permitted, the ban would be disproportionate for the reasons canvassed in Chapter Four with respect to Article 8. When considering the proportionality of the impugned measure, it is necessary to examine, *inter alia*, what the ban actually achieves and whether a lesser measure would unacceptably compromise the aims pursued by the measure. Addressing the latter point first, the aims of the ban are said to be protecting individuals vulnerable to undue pressure, promoting the 'sanctity of life' and protecting the doctor/patient relationship. Each of those 'aims' suffer from the weaknesses discussed at length in Chapter Four. But more pressing is the fact that, while the ban is, *de jure*, blanket insofar as it does not permit of any exceptions, the *de facto* reality is very different. The way in which the CPS exercises its prosecutorial discretion demonstrates that there is, in fact, an acceptance of certain forms of assisted

¹³² *Rabone v Pennine National Health Service Trust* [2012] 2 AC 72, [2012] UKSC 2 [92]-[93] (Lady Hale).

¹³³ This can be contrasted with, for instance, the position under New Zealand's Bill of Rights which provides with respect to the right to life that 'No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice' (Article 8). The reference to 'principles of fundamental justice' invites an examination of proportionality when considering whether an interference is justified. This accounts in large part for the different approach taken by the trial judge in *Seales* when examining whether the ban was compatible with the right to life (*Seales* (n 12)).

¹³⁴ See, for instance, *Armani da Silva v United Kingdom* (2016) 63 EHRR 12 [243].

suicide. As, the sentencing judgment in *Desai*¹³⁵ (discussed at length in Chapter Four) makes clear, benevolent assistance rendered to a terminally or chronically ill (or, indeed, an elderly) loved one to die by suicide is unlikely to lead to prosecution – though that seems to hold true only for assistance that falls short of euthanasia (contrast *Desai* with *Gazeley*¹³⁶). Arguably, then, there *is* a lesser measure which does not unacceptably compromise the objective, given the position taken by the CPS and the judiciary with respect to prosecutions under s 2 of the Suicide Act 1961. But, again, there is nothing in the jurisprudence concerning Article 2 to suggest that an interference with an individual’s right to life can be justified on the basis of proportionality.

In sum, the blanket ban on assisted suicide forces some individuals to take their lives prematurely, lest their condition deteriorate such that they are no longer capable of dying by suicide without assistance. In maintaining the blanket ban in the face of proposed amendments seeking to permit some forms of assisted suicide,¹³⁷ the State has failed to comply with its general positive obligation to protect the right to life of everyone in its jurisdiction: ‘the regulatory framework [is] defective’¹³⁸ and the ban is, thus, incompatible with Article 2 of the ECHR. It would be premature, however, to conclude an examination of Article 2 without considering whether the ban also violates the State’s operational obligation to protect.

4. Does the blanket ban violate the State’s operational obligation under Article 2?

The ‘operational obligation’ to protect arises when there is a ‘real and immediate risk to the life of a particular individual’.¹³⁹ For a state to be found to have violated its operational duty to protect:

[I]t must be established that the authorities *knew, or ought to have known at the time*, of the *existence of a real and immediate risk to life of identified individuals* ... and that they

¹³⁵ *R v Desai*, Sentencing Remarks of Justice Green (Guildford Crown Court, 17 November 2017) <<https://www.judiciary.gov.uk/wp-content/uploads/2017/12/r-v-desai-green-j-sentencing-remarks-20171201.pdf>> accessed 30 July 2019

¹³⁶ *R v Gazeley* (Crown Court Hereford 19 June 2015) <<https://www.judiciary.uk/wp-content/uploads/2015/10/r-v-gazeley-2.pdf>> accessed 30 July 2019

¹³⁷ See n 19

¹³⁸ *Oneryildiz* (n 129) [109]

¹³⁹ *Rabone* (n 132) [93]

failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.¹⁴⁰

Cases in which the State has been found to have violated its operational duty to protect include situations in which: prison authorities failed to protect prisoners from self-harm¹⁴¹ and from violence perpetrated by other inmates;¹⁴² medical professionals failed to protect individuals from self-harming,¹⁴³ including in circumstances where the patient was not detained under the Mental Health Act 1983;¹⁴⁴ military personnel have failed to implement policies regarding the provision of iridium satellite phones to military police patrol units.¹⁴⁵

In each of those cases, the courts (either domestic or the ECtHR) were satisfied that there was a ‘real and immediate risk’ to an identified individual(s)¹⁴⁶ and the relevant authorities knew or ought to have known of that risk but failed to take reasonable steps to protect against it. The threshold is high.¹⁴⁷ The burden of proof is beyond reasonable doubt, although where a person dies while within the State’s control or custody, ‘the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation.’¹⁴⁸ The meanings attributed to ‘real’ and ‘immediate’ account in large measure for the high threshold; ‘real’ means objectively well-founded, while ‘immediate’ connotes present and continuing, not remote, fanciful or negligible.¹⁴⁹ Given that threshold, it is unsurprising that there are numerous cases in which individuals in the custody of the State have died by suicide and no violation of Article 2 has been found, either because the authorities did not know and could not have known of the risk, or the steps taken to ameliorate the risk were reasonable.¹⁵⁰ Likewise, no violation of Article 2 was found in *Van*

¹⁴⁰ *Tagayeva v Russia* App no 26562/07 (ECtHR, 13 April 2017) [482] (emphasis added).

¹⁴¹ *Renolde v France* (2009) 48 EHRR 42.

¹⁴² See, for instance, *Edwards v United Kingdom* (2002) 35 EHRR 19.

¹⁴³ See, for instance, *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681, [2009] UKHL 74 and *Reynolds v United Kingdom* (2012) 55 EHRR 35.

¹⁴⁴ See, for instance, *Rabone* (n 132).

¹⁴⁵ *R (Long) v Secretary of State for Defence* [2015] 1 WLR 5006, [2015] EWCA Civ 770.

¹⁴⁶ Recent ECtHR jurisprudence suggests that where the threat emanates from an identified individual (for instance, a violent offender released on parole), the operational duty to protect will arise even if there is no identified victim (see, for instance, *Choreftakis v Greece* App no 46846/08 (ECtHR, 17 January 2012) and *Mastromatteo v Italy* (2002) ECHR 694). Such case law is, however, limited to situations in which the State is taken to be aware of the risk posed by an identified individual.

¹⁴⁷ See, for instance, *Van Colle v Chief Constable of the Hertfordshire Police* [2009] 1 AC 225, 234 [2008] UKHL 50.

¹⁴⁸ *Fanzjyeva v Russia* (2018) 67 EHRR 33 [49].

¹⁴⁹ Paul Matthews (ed), *Jervis on Coroners* (13th edn, Sweet & Maxwell 2014) Ch 21, [21-16]. See, also, *Rabone* (n 132) [39]-[40]; *Savage* (n 143) [41]; *Re W’s Application* [2004] NIQB 67 [13], [17]; *Re Officer L* [2007] 1 WLR 2135, [2007] UKHL 36 [20]; *Mitchell v Glasgow City Council* [2009] 1 AC 874, [2009] UKHL 11 [31].

¹⁵⁰ See, for instance, *Keenan v United Kingdom* (2001) 33 EHRR 38; *Orange v West Yorkshire Police* [2002] QB 347, [2001] EWCA Civ 611.

Colle despite police being alerted to the fact that, prior to his death, the deceased had received death threats. Nor was a violation found in *Osman* despite the family reporting their harassment to police prior to the named individual murdering one family member and seriously wounding another.¹⁵¹ In both *Van Colle* and *Osman* the courts (domestic and ECtHR) considered that there was insufficient evidence to demonstrate that there was a ‘real and immediate’ risk to life.

Given the relatively narrow scope of the operational duty and the high threshold applicants must meet, the claim that the blanket ban invokes this obligation because some individuals may be forced to take their lives sooner than they otherwise would is unlikely to gain traction before the courts. In any event, relying on the operational duty to allege an Article 2 violation is inimical to the objective of such individuals – namely, being lawfully provided with assistance in dying by suicide at a later date. Even if an individual were able to demonstrate that the duty arose (which, for the following reasons is unlikely), a reasonable response by authorities to ameliorate the risk of self-harm would be to take steps to prevent the individual from taking their own life which is plainly antithetical to the individual’s objective of avoiding a situation in which they cannot take their own life without assistance. Leaving aside these fundamental issues, there are several reasons why individuals who find themselves in a situation akin to that confronted by Omid T, Ms Taylor and Ms Seales are unlikely to meet the high threshold required to establish an operational duty under Article 2.

The main hurdle confronting such individuals is the fact that, unless they make themselves known to authorities, they fail to meet the ‘identified individual’ requirement. Even if they do make themselves known to police or other authorities, as cases such as *Osman* and *Van Colle* demonstrate, statements of potential future behaviour are unlikely to meet the high threshold required to engage the operational duty. Unless such individuals are able to demonstrate that there is an objectively well-founded risk that they will bring about their death by suicide and that that risk is present and continuing, the operational duty will not arise. That is not to say that it is impossible to conceive of such a situation. *Mammadov v Azerbaijan* concerned a complaint by the applicant that police had violated their operational duty under Article 2 in circumstances where the applicant’s wife self-immolated while being evicted from their accommodation by police.¹⁵² The majority ECtHR observed that:

¹⁵¹ *Osman v United Kingdom* (2000) 29 EHRR 245 and *Van Colle* (n 147).

¹⁵² *Mammadov v Azerbaijan* (2014) 58 EHRR 18.

[I]n a situation where an individual threatens to take his or her own life in plain view of state agents and, moreover, where this threat is an emotional reaction directly induced by the state agents' actions or demands, the latter should treat this threat with the utmost seriousness as constituting an imminent risk to that individual's life, regardless of how unexpected that threat might have been. In the Court's opinion, in such a situation as in the present case, if the state agents become aware of such a threat a sufficient time in advance, a positive obligation arises under art.2 requiring them to prevent this threat from materialising, by any means which are reasonable and feasible in the circumstances.¹⁵³

While the majority ultimately found no violation due to conflicting evidence, the minority considered that the police had violated their operational duty as a result of their failure to take steps to 'defuse the situation by verbally persuading' the woman not to self-immolate and by failing to 'intervene and prevent her from igniting' the kerosene she had poured over herself.¹⁵⁴ *Mammadov* demonstrates that, while it is not inconceivable that the blanket ban could give rise to an operational duty to protect, even if an individual who was forced to take their life prematurely was able to demonstrate a 'real and immediate risk' of their suicide, the authorities would likely be found to have taken the reasonable steps required of them if they can demonstrate that they did all that was reasonably possible to prevent the individual from taking their own life *at that time*. Permitting such individuals to die by suicide with assistance at a later date – leaving aside the fact that the Director of Public Prosecutions ('DPP') does not have such a power, let alone the police¹⁵⁵ – is unlikely to be considered 'reasonably necessary' for the purposes of complying with the operational duty under Article 2.

For those reasons, any claim that the blanket ban violates the operational duty to protect specific individuals is unlikely to succeed before the courts as it is doubtful that an individual who feels compelled to take their life before their condition deteriorates would be able to meet the high threshold imposed by the requirement that the risk of their suicide be 'real and immediate'. Even if they could meet that threshold, the authorities would likely be found to have complied with their operational duty by taking steps to dissuade the individual from taking their life *at that time* or, if the circumstances required it, actively preventing them from taking such steps. There is nothing in the case law to support the

¹⁵³ *ibid* [115].

¹⁵⁴ *Mammadov* (n 152) [OI-8]-[OI-9].

¹⁵⁵ *Purdy* (n 7).

contention that a reasonable response of the authorities would be to authorise the provision of assistance at a later date – again, leaving aside the fact that no such power exists.

5. Summary

The blanket ban on assisted suicide forces some individuals to take their lives sooner than they otherwise would if they could access assistance in dying at a later time. Like Omid T, many of these individuals have medical conditions that will, ultimately, leave them incapable of taking their lives without assistance. In order to avoid that eventuality and a potentially prolonged, painful and/or undignified death, such individuals take their lives when they are still physically capable of doing so or they travel to a permissive jurisdiction while they are still able to do travel. In compelling such individuals to take their lives prematurely, the ban violates the State's general positive obligation to protect individuals. More specifically, in maintaining the blanket ban on assisted suicide in the Suicide Act 1961, the State has failed to establish 'a legal system which deters threats to life from any quarter'.¹⁵⁶

6. Rectifying the incompatibility

Having established that the ban, insofar as it forces some individuals to take their lives sooner than they would otherwise choose to, violates the State's general positive obligation to protect, the next issue is what the State must do to rectify that incompatibility. The answer to that inquiry lies in the nature of the incompatibility between the ban and Article 2 of the ECHR. The ban is incompatible with the right to life of those individuals who feel compelled to take their lives prematurely lest they deteriorate to the point at which they can no longer take their own life without assistance. To rectify that incompatibility, the State can take two approaches to amending the legislation. That said, the State could choose to do nothing to rectify the incompatibility; a declaration of incompatibility does not affect the legal validity of the impugned legislation and Parliament can determine not to address the incompatibility.¹⁵⁷

The first method of addressing the incompatibility would be to repeal the ban, at least insofar as it applies to individuals who have terminal and degenerative conditions. This is not the same as permitting assisted suicide. Rather, it simply removes the criminal

¹⁵⁶ *Rabone* (n 132) [92]-[93] (Lady Hale).

¹⁵⁷ See, for instance, *Nicklinson* (n 7) [343] (Lord Kerr).

sanctions imposed on those who assist certain individuals to die by suicide. A similar system exists in Switzerland where providing assistance for benevolent reasons is not illegal, though there is no regulatory system governing the provision of assistance and doctors are not permitted to provide assistance.¹⁵⁸ But such an approach does not address the fact that some individuals suffer from conditions which will preclude them from being able to take the final step(s) necessary to bring about their death (for instance, swallowing the lethal dose which has been provided to them (i.e. the act of assistance)). Individuals like Noel Conway who have motor neurone disease face a deterioration to the point where they will receive artificial nutrition and hydration ('ANH') and will be ventilated. The only way for such individuals to bring about their death (aside from withdrawal of the ANH and/or ventilation) is if another person directly administers a lethal dose of medication, for instance through a PEG tube. An act which in England and Wales would constitute murder. Thus, in order for such individuals to be relieved of the pressure to take their lives before deteriorating to that state, the State would need to not only repeal the ban on assisted suicide, but also amend English law to accommodate such acts, for instance through the insertion of an exception to murder in the Offences Against the Person Act.

The second option available to the State is to amend or repeal the ban and simultaneously introduce a system of assisted dying according to which assistance (both to suicide and euthanasia) may be rendered by specific persons to individuals who meet specific eligibility criteria. This is the scheme adopted in a number of permissive jurisdictions including, most recently, Western Australia and Canada, though many confine the permitted assistance to suicide only (see, for instance, each of the permissive jurisdictions in the US). In those jurisdictions, people who by reason of physical incapacity cannot do the final act leading to their death (for instance, swallowing a lethal dose of medication) cannot lawfully access assistance in dying. A system that does not accommodate assisted dying for such individuals (i.e. euthanasia) will continue to violate Article 2 of the ECHR since it will continue to force such individuals to take their lives prematurely while they are still physically capable of dying by suicide.

Which option the State selects (provided it selects an option, as opposed to electing to do nothing) will, at least insofar as the ECtHR is concerned, likely fall within its margin of appreciation provided it removes the pressure to take one's life prematurely and does not interfere with the ECHR rights of other individuals. That said, the margin of appreciation

¹⁵⁸ Swiss Criminal Code (S.R. 311.0), art 115. See, also, *Haas* (n 64).

does not displace the supervisory function of the ECtHR and if the system introduced by the State fails to address the incompatibility, it will continue to violate Article 2 of the ECHR and the margin of appreciation will not immunise the State from a finding to that effect by the ECtHR.¹⁵⁹

7. Conclusion

Both the House of Lords and the ECtHR resoundingly rejected Diane Pretty's argument that the blanket ban on assisted suicide violated her right to life (Article 2, ECHR). However, that argument was based on the contention that, as with other substantive rights in the ECHR (such as Article 11), the right to life incorporated the inverse: the right not to live. There is an alternative argument with respect to Article 2 which has a much firmer foundation in the broader ECHR jurisprudence concerning the right to life. Namely, that the blanket ban violates the State's general positive obligation to protect life. There is copious evidence that the ban forces individuals who are facing a painful and undignified death over which they will have no control, to take their lives before they deteriorate to a point at which they can no longer do so. That is, they suicide prematurely. Such individuals do so by travelling to permissive jurisdictions if they are physically capable of doing so and have the financial resources necessary or by taking their lives by means that are in no way guaranteed to succeed and which can be extremely traumatic for them and their loved ones. This clearly reveals that 'the regulatory framework [is] defective'¹⁶⁰ and the ban is, thus, incompatible with Article 2 of the ECHR. The State can rectify this incompatibility by repealing the ban which would decriminalise assisted suicide but would not address the group of individuals who, as a result of physical incapacity, cannot take their own lives and, thus, require more extensive assistance: that is, euthanasia. While the ban does not deal with euthanasia, the same arguments with respect to s 2 of the Suicide Act 1961 similarly apply to the offence of murder: by not permitting euthanasia for some individuals, English law forces them to take their lives prematurely in violation of the general duty to protect under Article 2 of the ECHR. The State would, then, also have to introduce an exception to the offence of murder to rectify that incompatibility. The other avenue available to the State would be to introduce a system of assisted dying which expressly permits assisted suicide and euthanasia in specific circumstances such as to avoid the current situation in which individuals are taking their lives prematurely. This alternative

¹⁵⁹ See, for instance, *Fernandez Martinez v Spain* (2015) 60 EHRR 3 [125].

¹⁶⁰ *Oneriyildiz* (n 129) [109].

would better protect potentially vulnerable individuals and would ensure transparency and accountability of those involved in assisting another's death.

CHAPTER THREE

FREEDOM FROM TORTURE OR INHUMAN OR DEGRADING TREATMENT: DOES THE PROHIBITION ON ASSISTED SUICIDE CONSTITUTE ILL-TREATMENT?

1. Introduction

In addition to her Article 2 challenge, Diane Pretty alleged that the refusal to provide her husband with immunity from prosecution for assisting her to suicide violated Article 3 of the ECHR. Article 3 provides that '[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment.' The prohibition is absolute; ill-treatment that constitutes torture or is inhuman or degrading cannot be justified by reference to its purpose or to competing societal values. Diane Pretty's Article 3 challenge failed before both the House of Lords and the ECtHR, both of which rejected any contention that the State had subjected Ms Pretty to 'treatment' such as to engage Article 3 of the ECHR. The decisions of the House of Lords and the ECtHR in *Pretty* seemingly foreclosed any further argument that the ban on assisted suicide was incompatible with Article 3. However, subsequent jurisprudence concerning the nature and content of Article 3 provides scope for the argument that the ban on assisted suicide in England and Wales does, in fact, constitute 'treatment' for the purposes of Article 3 and, in the specific circumstances of individual cases such as Noel Conway and Omid T, that treatment reaches the minimum level of severity such as to violate Article 3 of the ECHR.

2. Is Article 3 engaged?

As with other negative rights in the ECHR, the ECtHR has interpreted Article 3 to include positive obligations as well. Such obligations derive from Article 1 of the ECHR which, when taken together with Article 3, 'imposes on States positive obligations to ensure that individuals within their jurisdiction are protected against all forms of ill-treatment prohibited under Article 3, including where such treatment is administered by private individuals.'¹⁶¹ While it is not overly clear whether Ms Pretty's case with respect to Article 3 was run on the basis of the State's negative obligation not to subject her to ill-treatment or on the basis of the State's positive obligation to protect her from such treatment,¹⁶² neither line of argument had success before the House of Lords. In respect of the negative obligation in Article 3, Lord Bingham held that:

¹⁶¹ *Chernega v Ukraine* App no 74768/10 (ECtHR, 5 April 2011) [150].

¹⁶² Contrast the reasons of Lord Bingham, Lord Steyn and Lord Hope in *Pretty* (n 7) [11(3)], [60] and [89].

There is ... nothing in Article 3 which bears on an individual's right to live or to choose not to live. That is not its sphere of application ... Moreover, the absolute and unqualified prohibition on a member State inflicting the proscribed treatment requires that 'treatment' should not be given an unrestricted or extravagant meaning. It cannot, in my opinion, be plausibly suggested that the Director or any other agent of the United Kingdom is inflicting the proscribed treatment on Mrs Pretty, whose suffering derives from her cruel disease.¹⁶³

Lord Bingham also determined that the ban did not engage the State's positive obligation to protect since there was 'no positive obligation to ensure that a competent, terminally ill, person who wishes but is unable to take his or her own life should be entitled to seek the assistance of another without that other being exposed to the risk of prosecution.'¹⁶⁴ Further, while the negative prohibition is absolute, the positive obligations under Article 3 are not; a 'fair balance ... has to be struck between the general interest of the community and the interests of the individual', and that balance had been fairly struck by the criminal prohibition on assisted suicide.¹⁶⁵ Lord Hope aptly summarised the nature of Ms Pretty's Article 3 claim and the reasons for its rejection, holding that:

It is clear that [the Director] is not directly responsible for the disease or for its consequences. Nothing has been identified that he has done and should be restrained from doing in order to remove or alleviate these consequences. I would conclude that we are not dealing here with a case with an act which is expressly prohibited. The argument is that the article applies positively, as it requires the Director to do something to avoid the incompatibility. This raises the question whether the Director's refusal to give the undertaking is incompatible with article 3 because it is disproportionate.

...

It was a proportionate response for Parliament to conclude that that interest could only be met by a complete prohibition on assisted suicide. I would also hold that ... the Director's decision ... cannot be said to be unfair or arbitrary or to have impaired her Convention right more than is reasonably necessary. It was not disproportionate to the object of section 2(1).¹⁶⁶

¹⁶³ *Pretty* (n 7) [13].

¹⁶⁴ *ibid* [15].

¹⁶⁵ *Pretty* (n 7) [90]–[97]. Similarly, Lord Steyn was of the view that 'the present case does not involve any positive action ... nor is there any risk of a failure to treat [Ms Pretty] properly' ([60]).

¹⁶⁶ *Pretty* (n 7) [92] and [97].

By the time the matter reached the ECtHR, the argument under Article 3 was based solely on the positive obligation to protect. In rejecting Ms Pretty's application, Strasbourg confirmed the House of Lords' findings:

The suffering which flows from natural occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible...

In the present case, it is beyond dispute that the respondent State has not, itself, inflicted any ill-treatment on the applicant....

The applicant has claimed rather that the refusal of the DPP to give an undertaking not to prosecute her husband if he assisted her to commit suicide and the criminal-law prohibition on assisted suicide¹⁶⁷ disclose inhuman and degrading treatment for which the State is responsible as it will thereby be failing to protect her from the suffering which awaits her as her illness reaches its ultimate stages...

[T]he positive obligation on the part of the State which is relied on in the present case would not involve the removal or mitigation of harm by, for instance, preventing any ill-treatment by public bodies or private individuals or providing improved conditions or care. It would require that the State sanction actions intended to terminate life, an obligation that cannot be derived from Article 3 of the Convention.¹⁶⁸

Thus, per the ECtHR, while suffering which flows from an illness *may* constitute treatment contrary to Article 3, for the State to be liable for such treatment the applicant must be able to point to conduct on the part of the State which has exacerbated, or runs the risk of exacerbating, the individual's suffering. While the decision of the ECtHR in *Pretty* is ostensibly determinative of the question of whether the ban in s 2 of the Suicide Act 1961 is compatible with Article 3, the ECHR is a 'living instrument' and a 'dynamic and flexible

¹⁶⁷ Insofar as this reference to the ban on assisted suicide suggests that it was argued that the ban itself constituted treatment, two points need to be made. First, that was not the argument with respect to Article 3 run before the House of Lords (see, in that respect, the summary of Lord Bingham in *Pretty* (n 7) [11]). And, secondly, insofar as an argument was made before the ECtHR that the ban itself constituted treatment (which the ECtHR judgment strongly points against (*Pretty v United Kingdom* (n 7) [53]), it was made in the context of the State's positive obligation to protect from ill-treatment as distinct from a claim that the ban itself constituted treatment which violated the State's negative obligation to protect. The following discussion will illuminate the significance of this distinction.

¹⁶⁸ *Pretty* (n 7) [54]-[55].

approach [must be taken] to ... [its] interpretation'.¹⁶⁹ Bearing that in mind, a closer reading of both the House of Lords' reasons and that of the ECtHR in *Pretty* in light of the recent decision of the Supreme Court in *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland) ('Northern Ireland Abortion Case')*¹⁷⁰ reveals that the issue is far more nuanced than the earlier decisions suggest, and, for the reasons that follow, there is scope for a claim that the blanket ban is, in fact, incompatible with Article 3 of the ECHR.

As with any Convention right, the first hurdle confronting an applicant claiming a violation is to demonstrate that the challenged measure, here the blanket ban on assisted suicide, engages the impugned right. In the Article 3 context, that requires proof first, that the measure complained of constitutes 'treatment' so as to engage the State's negative obligation or, alternatively, that the State has failed to protect a specified individual(s) from ill-treatment.

2. Does the blanket ban constitute 'treatment' under Article 3?

The House of Lords in *Pretty* was unequivocal in its finding that the suffering of Ms Pretty stemmed from her terminal illness *and* there was no conduct on the part of the State that could be said to constitute 'treatment' which either caused or exacerbated that suffering. Further, there was, according to both the House of Lords and the ECtHR, no harm which the State could be said to be obliged to mitigate or protect Ms Pretty from. In sum, the refusal of the DPP to grant Ms Pretty's husband immunity did not invoke either the State's negative or positive obligations under Article 3 of the ECHR. Those findings were, however, specific to the argument made on behalf of Ms Pretty that the violation of Article 3 emanated from the refusal of the DPP to grant immunity to her husband. Neither the House of Lords nor the ECtHR considered the possibility that the criminalisation of assisted suicide *itself* constitutes 'treatment' contrary to Article 3 or whether the ban exacerbates the suffering of individuals with terminal or life-limiting conditions such as to be incompatible in those cases with Article 3 of the ECHR. The decisions of the House of Lords and the ECtHR do not, then, address the argument that the blanket ban on assisted suicide, insofar as it criminalises assistance, violates the State's *negative obligation* not to inflict treatment contrary to Article 3 of the ECHR and/or constitutes a failure to

¹⁶⁹ *ibid* [53].

¹⁷⁰ *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland)* [2019] 1 All ER 173, [2018] UKSC 27.

comply with the *positive obligation* to protect against such treatment. In both instances, contrary to the argument advanced in the *Pretty* litigation, the impugned treatment is said to emanate *directly from the State*.

Before moving on to consider this argument in greater detail, it is first necessary to examine how the courts have characterised ‘treatment’ for the purposes of Article 3. In a statement that reflects the reasons of the rest of the Court, Lord Bingham in *Pretty* held that:

Article 3 is ... complementary to Article 2. As Article 2 requires states to respect and safeguard the lives of individuals within their jurisdiction, so Article 3 obliges them to respect the physical and human integrity of such individuals. There is in my opinion nothing in Article 3 which bears on an individual’s right to live or to choose not to live. That is not its sphere of application...¹⁷¹

Lord Bingham’s emphasis on the sanctity of life in Article 2 overlooks the fact that, as discussed in Chapter One, the right to life does not prevent capacitous patients from refusing life-sustaining treatment even when the inevitable consequence is death. Likewise, it does not preclude doctors, together with an incapacitous patient’s family, ceasing life-sustaining treatment on the basis that it is no longer in the patient’s best interests. Article 2 can and does give way to other considerations including an assessment of the quality of the individual’s life.¹⁷² Thus, although Article 2 ‘requires the State to take appropriate steps to safeguard the lives of those within its jurisdiction’,¹⁷³ it does not prevent the functioning of a medical system in which principles of autonomy, dignity and self-determination (frequently couched in terms of the Article 8 right to private life¹⁷⁴) regularly trump sanctity of life concerns as is the case in England and Wales. Further, the House of Lords’ decision in *Pretty* must be considered in light of the fact that the ECtHR went on to find that Article 8 enshrines a right to choose the manner and timing of one’s death. Article 3 must, then, be read in conjunction with *both* Articles 2 and 8 which, when read together, provide a framework in which the sanctity of life provides a starting point, but does not preclude the exercise of an individual’s autonomy, dignity and self-determination in choosing the manner and timing of their death.¹⁷⁵ Another aspect of Lord Bingham’s reasons extracted

¹⁷¹ *Pretty* (n 7) [13]. See, also, *ibid* [60] (Lord Hope).

¹⁷² See, in this respect, the Grand Chamber in *Lambert*: ‘The Court considers that ... in a case such as the present one reference should be made, in examining a possible violation of Article 2, to Article 8 of the Convention and to the right to respect for private life and the notion of personal autonomy which it encompasses.’ *Lambert v France* (2015) ECHR 545 [142].

¹⁷³ *ibid* at [140].

¹⁷⁴ *Lambert* (n 172) [98] citing *Haas* (n 64) [51] and *Koch v Germany* (2013) 56 EHRR 6 [52].

¹⁷⁵ See, for instance, *Briggs* (n 38) and *James* (n 111).

above must also be considered. His Lordship held that there is nothing in Article 3 that ‘bears on an individual’s right to live or not to live.’ But, for individuals like Noel Conway, accessing assisted suicide is not a question of living/not living. It is a matter of putting an end to suffering. And that is precisely the remit of Article 3 of the ECHR. This reasoning is illuminated by end-of-life cases involving incapacitous patients. In such cases, a decision by doctors along with the patient’s family to cease life-sustaining treatment is not a decision that it is better for the patient to die. It is not a question of living/not living. Rather, it is a question of whether the current treatment and its ongoing administration is in the patient’s best interests. It is, then, an Article 8 question of quality of life, which is influenced by Article 2 considerations, in particular the sanctity of life. Likewise, a decision by an individual like Noel Conway to access assistance in dying is not a question of living/not living but, rather, of suffering/not suffering and that is patently an Article 3 question influenced by both Articles 2 and 8. Indeed, as Lord Bingham himself acknowledged, Article 3 ‘obliges [states] to respect the physical and human integrity of ... individuals’ living within their jurisdiction and suffering – whether physical or psychological – has profound implications for a person’s ‘physical and human integrity’.¹⁷⁶

Lord Bingham went on to consider whether the matter of *D v United Kingdom*¹⁷⁷ offered any support for Ms Pretty’s argument. In that case, the applicant had sought asylum upon arriving at Heathrow airport and was refused. He was subsequently found to be in possession of illegal drugs and was convicted and sentenced to imprisonment. During his imprisonment, he received treatment for HIV. Upon his release, the State sought to deport the applicant to St Kitts. The applicant successfully challenged the deportation order on the basis that his return would subject him to ill-treatment contrary to Article 3 as he would not receive the standard of care he had received in the UK and would likely suffer terribly as his condition deteriorated. Consistent with its erstwhile extradition/deportation jurisprudence,¹⁷⁸ the ECtHR held that there was a real risk that the applicant would suffer treatment contrary to Article 3 upon his return to St Kitts. That finding was made even though neither the UK nor the authorities in St Kitts would be actively treating the applicant in a manner that was inconsistent with Article 3. Rather, it was accepted that the

¹⁷⁶ *Pretty* (n 7) [13].

¹⁷⁷ *D v United Kingdom* (1997) 24 EHRR 423.

¹⁷⁸ See, for instance, *Soering v United Kingdom* (1989) 11 EHRR 439 and *Chahal v United Kingdom* (1997) 23 EHRR 413.

applicant would not receive the same standard of treatment which he had received in the UK and that would cause a ‘severe increase in his suffering and shortening of his life.’¹⁷⁹

D v United Kingdom appears to provide support for Ms Pretty’s claims insofar as it demonstrates that a state may be liable for ill-treatment stemming from suffering that arises as a result of an individual’s medical condition and is not directly caused by, but is nevertheless exacerbated by, the State. However, Lord Bingham rejected its application to Ms Pretty’s case given that in *D* the ‘state was proposing to take direct action against the applicant [i.e. the deportation], the inevitable effect of which would be a severe increase in his suffering and a shortening of his life’ and, consequently ‘[t]he proposed deportation could fairly be regarded as treatment’.¹⁸⁰ In contrast, according to Lord Bingham, the Director had not subjected Ms Pretty to any such treatment. In *Soering*, the ECtHR described the origins of an extraditing country’s liability under Article 3 as follows: ‘[i]n so far as any liability under the Convention is or may be incurred, it is responsibility incurred by the extraditing Contracting State by reason of its having taken action which has as a direct consequence the exposure of an individual to proscribed ill-treatment’.¹⁸¹ Lord Bingham was, then, correct that *D* did not assist Ms Pretty, but not for the reasons his Lordship proffered. Deportation and extradition cases do not assist an applicant like Ms Pretty who did not allege any direct ill-treatment by the State, not because there is no ‘treatment’ on the part of the State but precisely because the ban itself constitutes treatment by the State which causes suffering that reaches the minimum level of severity. That is, the State itself is the source of the ill-treatment, as opposed to exposing an individual to ill-treatment occurring elsewhere.

As the ensuing discussion of the *Northern Ireland Abortion Case* reveals, unlike the case run on behalf of Ms Pretty, there is scope for the argument that the ban in s 2 of the Suicide Act 1961 constitutes treatment by the State which causes suffering for some individuals (or, at the least, exacerbates suffering arising from a medical condition) that meets the minimum level of severity in violation of Article 3 of the ECHR. A majority of the Supreme Court in the *Northern Ireland Abortion Case* held that the appellant did not have standing and the appeal was thus dismissed on a procedural basis. Nevertheless, in a unique turn of events, several members of the Bench (including two who determined that the

¹⁷⁹ *Pretty* (n 7) [14].

¹⁸⁰ *D* (n 177) [14].

¹⁸¹ *Pretty* (n 7) [91].

appellant lacked standing) proceeded to examine the substantive arguments, including those made under Article 3.

Lord Kerr – with whom Lord Wilson agreed – held that the ban on abortion in the case of rape, incest or fatal foetal abnormality was, *in general* (that is, without reference to the facts of a given case) incompatible with Article 3.¹⁸² While Lord Mance rejected the appellant’s general claim, his Lordship did not foreclose the possibility that an Article 3 violation may arise in a given case.¹⁸³ Of particular relevance for instant purposes is the acceptance, implicit in that finding, that the prohibition on abortion in those circumstances *might* constitute treatment for the purposes of Article 3. Similarly, while President Hale did not consider it necessary to examine the Article 3 complaint in light of her finding that the ban violated Article 8 of the ECHR, she nonetheless held:

[T]hat the risk of prosecution of the woman, *and of those who help her*, thus forcing her to take that risk if she procures an illegal abortion in Northern Ireland, or to travel to Great Britain if she is able to arrange that, *constitutes ‘treatment’ by the State for [the] purpose [of Article 3]. It is the State which is subjecting her to the agonising dilemma.* I also have little doubt that there will be some women *whose suffering on being denied a lawful abortion* in Northern Ireland, in the three situations under discussion here, *will reach the threshold of severity required to label the treatment ‘inhuman or degrading.’*¹⁸⁴

President Hale’s observations in respect of Article 3 are consistent with those of Lord Kerr whose reasons deal most comprehensively with the Article 3 case. In rejecting the argument made on behalf of the State that those prohibited from accessing abortions in the cases of rape, incest and/or fatal foetal abnormality ‘had not been “treated” at all by the state’, his Lordship said:

At present, a girl or woman who obtains an abortion in circumstances other than those narrowly prescribed [by the relevant legislation] commits a criminal offence and is liable to prosecution. That constitutes ill-treatment in so far as imposing that sanction on women amounts to a breach of article 3. *Likewise, requiring a woman to carry to term a foetus who is doomed to die, or a foetus who is the consequence of rape or incest, when the impact on the mother is inhuman and degrading is, in every sense, treatment to which*

¹⁸² *Northern Ireland Abortion Case* (n 170) [235]–[237].

¹⁸³ *ibid* [91], [95] and [100].

¹⁸⁴ *Northern Ireland Abortion Case* (n 170) [33] (emphasis added).

the woman is subjected by the state. It is, moreover, treatment which because of its inhumanity or degrading effect, is in violation of article 3.

*Moreover, the threat of prosecution of a doctor whose assistance in the termination of a pregnancy is sought has a direct impact on a girl's or woman's experience of pregnancy where, for instance, she has been told that the foetus she is carrying has a fatal foetal abnormality...*¹⁸⁵

The reasons of President Hale and Lords Kerr and Wilson – and, to a lesser extent, Lord Mance – support the contention that the blanket ban on assisted suicide, insofar as it criminalises the provision of, and thus precludes individuals from lawfully accessing, assistance in dying by suicide constitutes ‘treatment’ on the part of the State for the purposes of Article 3. Applying President Hale’s reasons, it is the blanket prohibition on assisted suicide which subjects the individual to an ‘agonising dilemma’, not their illness. As a result of the blanket ban, an individual is forced to decide whether to take their lives sooner than they otherwise would, to nonetheless seek assistance and potentially expose others to the risk of prosecution, to travel overseas and live their last moments in a foreign country without family or loved ones (or, if the latter have attended, with the concern that they may be prosecuted under s 2), or they must endure a death over which they have no control and which may be prolonged, painful, undignified or otherwise cause significant psychological distress. Of course, each of those potential risks are, to varying extents, speculative. As the data from the CPS considered in Chapter Four reveals, it is unlikely that a person will be prosecuted for assisting another to travel overseas for the purposes of dying with assistance in a permissive jurisdiction. Likewise, a person’s death may be neither painful nor psychologically distressing. But it is precisely the speculative nature of these eventualities which creates the ‘dilemma’ referred to in the context of abortion by President Hale and, thus, renders the ban in s 2 of the Suicide Act 1961 ‘treatment’ for the purposes of Article 3.

Insofar as the reply is that the State has not caused the individual’s condition, two interrelated points must be made. First, in the same way that the State is not responsible for the pregnancy of the woman concerned, but is nonetheless responsible for the subsequent experience of the woman caused by the ban on abortion, so too is the State not responsible for the condition which drives an individual to seek assistance in dying by suicide but it is nevertheless responsible for the individual’s subsequent experience caused by an express legislative provision and this constitutes treatment for the purposes of Article

¹⁸⁵ *ibid* [231]-[232] (emphasis added)

3. Second, at the very least, the blanket ban on assisted suicide – a measure of the State – exacerbates the suffering some individuals experience as a result of their medical condition and thus constitutes treatment for which the State is responsible for the purposes of Article 3.

Arguably, the reasoning of President Hale and Lord Kerr and Lord Wilson in the *Northern Ireland Abortion Case* has greater force in the assisted dying context given that, in the case of abortion, the interests of the mother are pitted against those of the unborn foetus, and the enduring question of when life commences – and the margin of appreciation afforded by Strasbourg to States in making that assessment – leaves doubt as to whether, in the case of abortion, there are two rights in opposition (i.e. the alleged right to life of the unborn foetus versus the right to reproductive autonomy of the mother protected by Article 8, and her right not to be subjected to ill-treatment contrary to Article 3 of the ECHR). In contrast, in the case of assisted suicide, the interests which are said to be in ‘competition’ with and, indeed, trump a person’s Article 8 right to choose the manner and timing of their death and their Article 3 right to freedom from torture or inhuman or degrading treatment are said to be those of an unspecified group of individuals, namely those ‘vulnerable’ to undue influence, and society’s general interest in protecting the doctor/patient relationship and the ‘sanctity of life’.¹⁸⁶ The tenuousness of such ‘rights’ (if they can be so characterised) *vis-à-vis* the position of the foetus in the Northern Ireland Constitution bolsters the strength of the observations of President Hale and Lord Kerr and Lord Wilson when applied to the assisted dying context. In any event, the prohibition on torture or inhuman or degrading treatment under Article 3 is absolute and cannot be balanced against any other rights.¹⁸⁷

Proceeding on the basis that, in light of the findings of President Hale and Lord Kerr and Lord Wilson in the *Northern Ireland Abortion Case*, the ban *does* constitute ‘treatment’ for which the State bears responsibility under Article 3, the next issue is whether it reaches the minimum level of severity.

¹⁸⁶ See Chapter Four for a more comprehensive assessment of these aims.

¹⁸⁷ See, for instance, *Chahal* (n 178) and *Northern Ireland Abortion Case* (n 170) [32] (Lady Hale).

3. The minimum level of severity

3.1 General principles

‘The right not to be subjected to torture or inhuman or degrading treatment is absolute – it is not to be balanced against any other rights’¹⁸⁸ As Lord Kerr has observed, once the minimum level of severity has been met ‘it does not matter a whit what the person or agency which is responsible for the perpetration of that treatment considers to be the justification for it’.¹⁸⁹

However, as Lord Kerr also recognised, the ‘anterior question’ – whether the treatment has reached the minimum level of severity – ‘does not, in every instance, leave out of account the purpose of the conduct.’¹⁹⁰ As the Grand Chamber held in *Gäfgen*, an assessment of whether the threshold has been reached:

[D]epends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim. Further factors include the purpose for which the treatment was inflicted together with the intention or motivation behind it..¹⁹¹

The fact that such relativity seems directly at odds with the absoluteness of the prohibition has been the subject of extensive academic debate, though such debate does not impact the present inquiry.¹⁹² It is sufficient for instant purposes to note that *once the threshold of severity has been met*, there is *no scope* for exception or justification.¹⁹³ The issue, then, is whether the blanket ban on assisted suicide reaches the relevant threshold.

As noted above, Lord Mance in the *Northern Ireland Abortion Case* did not consider it possible to determine, in general, whether the ban on abortion in the specified circumstances constituted inhuman or degrading treatment. His Lordship was of the view that any finding of a violation of Article 3 would depend on the facts of the given case. Such a position is consistent with the jurisprudence of the ECtHR which, as the extract

¹⁸⁸ *Northern Ireland Abortion Case* (n 170) [32] (President Hale).

¹⁸⁹ *ibid* [215].

¹⁹⁰ *Northern Ireland Abortion Case* (n 170) [216] (Lord Kerr).

¹⁹¹ *Gäfgen v Germany* (2011) 52 EHRR 1 [88].

¹⁹² See, for instance, Natasa Mavronicola ‘Is the prohibition against torture and cruel, inhuman and degrading treatment absolute in international law? A reply to Steven Greer’ (2017) 17 *Human Rights Law Review* 479 vis-à-vis Steven Greer ‘Is the prohibition on torture, cruel, inhuman and degrading treatment really “absolute” in international human rights law?’ (2015) 15 *Human Rights Law Review* 101.

¹⁹³ See, for instance, *Chahal* (n 178), *Soering* (n 178) and *Othman (Abu Qatada) v United Kingdom* (2012) 55 EHRR 1 and, academically, Mavronicola (n 192) and Stephanie Palmer, ‘A wrong turning: Article 3 ECHR and proportionality’ (2006) 65 *Cambridge Law Journal* 438.

from *Gäffen* above reveals, is dependent on ‘all the circumstances of the case’ including, importantly, the characteristics of the individual. As President Hale observed in the *Northern Ireland Abortion Case*, ‘it cannot be said that every woman who is denied an abortion [in the three circumstances under consideration] will suffer so severely that her rights under article 3 have been violated. *It depends upon an intense focus on the facts of the individual case*’.¹⁹⁴

While, ostensibly, Lord Mance’s conclusion seems to be at odds with Lord Kerr’s determination that the prohibition was, in general, incompatible with Article 3, the two seemingly opposing outcomes can be reconciled by the fact that Lord Mance was considering the issue from the point of view of the State’s negative obligation not to inflict treatment contrary to Article 3, while Lord Kerr considered the State’s positive obligation to protect individuals from such treatment. According to Lord Kerr, the ban on abortion posed a *risk* to some girls and women of treatment contrary to Article 3 and that *risk* of acting incompatibly with their Article 3 rights was sufficient to engage the positive obligation of the State to prevent that risk materialising. The blanket prohibition on abortion in the case of rape, incest and/or fatal foetal abnormality, insofar as it posed a risk of constituting inhuman or degrading treatment to some girls and women (who he described as belonging to a ‘highly vulnerable group’¹⁹⁵), thus constituted a violation of the State’s positive obligation to protect against such treatment.¹⁹⁶ President Hale expressed ‘sympathy’ with that conclusion, though determined it unnecessary to explore it further given her findings with respect to Article 8.¹⁹⁷

The reasons of Lord Mance and Lord Kerr reveal that, in the context of the State’s *negative obligation* not to inflict treatment contrary to Article 3, whether the ban on assisting another to suicide reaches the threshold of inhuman and degrading treatment depends on the individual’s circumstances. In contrast, in the context of the State’s positive obligation to protect individuals from such treatment, it may be that the *risk* of some (unspecified) individuals being subjected to such treatment is sufficient to engage the State’s obligation to protect and the failure to permit assistance in certain circumstances constitutes a violation of that positive obligation. Common to both perspectives is an examination of whether being denied assistance *could* constitute treatment that reaches the minimum level of severity contrary to Article 3.

¹⁹⁴ *Northern Ireland Abortion Case* (n 170) [34] (emphasis added).

¹⁹⁵ *Northern Ireland Abortion Case* (n 170) [241].

¹⁹⁶ *ibid* [257]-[262] (Lord Kerr) and [34] (President Hale).

¹⁹⁷ *Northern Ireland Abortion Case* (n 170) at [34] (President Hale).

3.2 Torture, inhuman or degrading treatment: does the blanket ban reach the minimum threshold?

The Grand Chamber in *Jalloh* summarised the ECtHR's jurisprudence with respect to inhuman and degrading treatment in the following terms:

Treatment has been held by the Court to be 'inhuman' because, *inter alia*, it was premeditated, was applied for hours at a stretch and caused either actual bodily injury or intense physical and mental suffering ... Treatment has been considered 'degrading' when it was such as to arouse in its victims feelings of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance ... or when it was such as to drive the victim to act against his will or conscience ... Furthermore, in considering whether treatment is 'degrading' within the meaning of Article 3, one of the factors which the Court will take into account is the question whether its object was to humiliate and debase the person concerned, although the absence of any such purpose cannot conclusively rule out a finding of a violation of Article 3 ... In order for a punishment or treatment associated with it to be 'inhuman' or 'degrading', the suffering or humiliation involved must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment...¹⁹⁸

As for the distinction between inhuman or degrading treatment on the one hand and torture on the other, the Grand Chamber in *Gäfgen* observed:

[I]t appears that it was the intention that the Convention should ... attach a special stigma to deliberate inhuman treatment causing very serious and cruel suffering ... In addition to the severity of the treatment, there is a purposive element to torture [namely] ... intentional infliction of severe pain or suffering with the aim, *inter alia*, of obtaining information, inflicting punishment or intimidating...¹⁹⁹

There is nothing to suggest that the State enacted s 2 of the Suicide Act 1961 with the intention of inflicting pain or suffering. There is, then, no question of the ban constituting torture for the purposes of Article 3 (though this is not to say that a given individual would not find the dilemma posed by the ban torturous). As for whether it amounts to inhuman

¹⁹⁸ *Jalloh v Germany* (2007) 44 EHRR 32 [68] (citations omitted).

¹⁹⁹ *Gäfgen* (n 191) [90].

or degrading treatment, a preliminary issue that requires examination is what role, if any, the ban's purpose plays in this assessment.

As the earlier extract from *Gäfgen* identifies, in addition to the subjective characteristics of the individual, a further factor that may be relevant to an assessment of the severity of the treatment is 'the purpose for which the treatment was inflicted together with the intention or motivation behind it'.²⁰⁰ Insofar as this suggests that an examination of the treatment's necessity is required, that is plainly wrong. The preceding extracts from the Grand Chamber's decisions in *Jalloh* and *Gäfgen* make clear that, insofar as purpose is relevant, it goes to whether treatment which might not otherwise be inhuman or degrading nonetheless reaches that threshold because the purpose of the treatment was to humiliate or debase the individual. Importantly, there is a long line of ECtHR case law that confirms that the absence of such a purpose is not determinative and does not inexorably lead to a conclusion that the treatment did not meet the minimum level of severity.²⁰¹ Thus, in *Jalloh* there was no suggestion that the forcible administration of emetics to an individual detained by police to extract drugs was inflicted other than for the purpose of procuring evidence of a crime. Nonetheless, the treatment was found to violate Article 3 because it was capable of humiliating and debasing the applicant. Likewise, the decision to detain Ms Price, 'a severely disabled person', 'in conditions where she [was] dangerously cold, risk[ed] developing sores because her bed [was] too hard or unreachable, and [was] unable to go to the toilet or keep clean without the greatest of difficulty, constitute[d] degrading treatment contrary to Article 3 of the Convention' even though the ECtHR was satisfied that there was no intention to humiliate or debase her.²⁰² In contrast, in *Gäfgen*, the mere threat of torture (which may not, absent intention or purpose, have reached the requisite threshold) was intended to humiliate and debase and, thus, constituted ill-treatment contrary to Article 3.

Cases before the ECtHR in which the purpose of the treatment has been relevant tend to have involved acts by State agents directed at individuals with a view to extracting confessions, intelligence or other evidence.²⁰³ According to Lord Kerr, these decisions 'confine[...] the issue of motivation or purpose to a relatively narrow compass': 'an assessment of whether treatment which might otherwise not meet the standard set by

²⁰⁰ *ibid* [88].

²⁰¹ See, for instance, *Gäfgen* (n 191) [108], *Jalloh* (n 198) [68], *Peers v Greece* (2001) 33 EHRR 51 [74].

²⁰² *Price v United Kingdom* (2002) 34 EHRR 53 [30].

²⁰³ See, for instance, *Gäfgen* (n 191), *Aksay v Turkey* (1997) 23 EHRR 553, *Egmez v Cyprus* (2002) 34 EHRR 29.

Article 3 crosses the threshold by reason of that motivation or purpose.²⁰⁴ Such an interpretation must be correct if the prohibition is, as the ECtHR insists, absolute. As the ECtHR has repeatedly reaffirmed, once the minimum level of severity is reached, the reason or motivation behind the conduct cannot convert that behaviour to a condition where it does not meet the Article 3 threshold.²⁰⁵ To find otherwise would be to fundamentally undermine the absolute nature of the prohibition in Article 3.

The purpose of prohibiting access to assisted suicide is, then, irrelevant when determining whether that treatment is contrary to Article 3 of the ECHR. There is no suggestion of intentional infliction of ill-treatment and, as will be canvassed below, the ban has the potential to constitute inhuman and degrading treatment for some individuals such that there is no need to have regard to its purpose in order to transform otherwise Article 3 compliant conduct into inhuman or degrading treatment. But, even if the ban's purpose were relevant, as the analysis of Article 8 in the ensuing chapter makes clear, the validity of the alleged purposes of the ban are debatable. As Chapter Four reveals, the practical impact of the ban – in particular, its failure to prevent individuals from accessing assistance in dying by suicide and the institutional acceptance of such conduct as evidenced by the lack of CPS prosecutions – falls well short of constituting 'provable benefits'. That is all the more so when the individual toll of the ban is examined.

In light of the preceding conclusions that the ban in s 2 of the Suicide Act 1961 may, in fact, constitute 'treatment' for the purposes of Article 3 and that the purpose of that treatment is either irrelevant or, insofar as it is relevant, does not carry any real weight in the instant context, the ban may constitute treatment contrary to Article 3 for some individuals provided the minimum level of severity is reached. Whether the ban reaches that threshold depends on the individual facts of a given case.

3.3. The minimum level of severity – specific cases

As Lady Hale observed in *Nicklinson* 'no-one who has read the appellants' accounts of their lives and their feelings can doubt that they experience the law's insistence that they stay alive for the sake of others as a form of cruelty.'²⁰⁶ Likewise, Lord Sumption acknowledged that the argument made on behalf of the appellants in *Nicklinson* that the ban required

²⁰⁴ *Northern Ireland Abortion Case* (n 170) [217]-[218] (Lord Kerr).

²⁰⁵ See, for instance, *Soering* (n 178), *Chahal* (n 178), *Othman* (n 193).

²⁰⁶ *Nicklinson* (n 7) [314] (Lady Hale).

them to ‘suffer a painful and degrading death’ was ‘a forensic point, but up to a point it is a legitimate one.’²⁰⁷

The trial judgment in *Carter* is also replete with accounts from individuals with terminal or otherwise life-limiting illnesses of the choices – or, to use President Hale’s nomenclature, ‘the agonising dilemma’ – they faced as a result of the analogous ban on assisted suicide in that jurisdiction:

- ‘A physician-assisted death would be compassionate, legal, painless and dignified. The alternatives seem barbaric and cruel. There is also the fear and anxiety associated with taking my own life by other means. I am concerned about having a protracted and painful death should I do nothing, while on the other hand I dread the thought of suicide with the complexities and legal dilemma that will be involved if I have my wife assist me. We both face this reality, that we have only two terrible and imperfect options with a sense of horror and loathing.’
- ‘I simply cannot understand why the law holds that the able-bodied who are terminally ill are allowed to shoot themselves when they have had enough because they are able to hold a gun steady, but because my illness affects my ability to move and control my body, I cannot be allowed compassionate help to allow me to commit an equivalent act using lethal medication. The law obliges me to act now and kill myself – while I am able but while my life is still enjoyable – or to forego altogether the right and ability to legally exercise control over the manner and timing of my death. That is a cruel choice to impose on someone.’²⁰⁸

The following account of Ms LaForest who had Stage IIIC anal cancer provides a harrowing insight into the suffering she was likely to experience and the impact the Canadian ban was going to have on her:

I have been told that I will likely experience a number of alarming side effects [of treatment]. Radiation and chemotherapy will wipe out my red and white blood cells to dangerous levels, leaving me susceptible to infections, moulds and severe fatigue. The radiation may lead to severely burned skin. My doctors have told me to expect burning of my vulva, anus, bowel, vaginal canal and bladder. This cannot be avoided as I am being irradiated right through the pelvis.

²⁰⁷ *ibid* [233] (Lord Sumption).

²⁰⁸ *Carter* (n 13) [1044]–[1048].

If I survive the cancer, I may end up with permanent scarring of my bowel and anus resulting in diarrhea and incontinence. My vulva and vaginal canal will likely shrink and be scarred making intercourse painful in the future. My bladder may be damaged and require, like the vagina, dilators to stretch out badly scarred tissue, and stents to hold open vessels and canals that have collapsed.

I asked my oncologist what would happen if I decided not to have this painful treatment. They told me this was not an option. They described that death by this type of disease is ugly. It is not a way anyone would want to die. It would take time and I would die in agony, regardless of pain medication and therapies that currently exist. They described how my legs would swell to gross proportion as the poisons and toxins built up in my system. And the tumour would continue to grow to explosive proportions blocking off the bowel which will begin to twist and contort under pressure. I would ooze putrescence and mucous, blood and fecal matter out of every orifice. No amount of drugs they assured me would deal with the “break through” pain.

I decided that I would undergo the treatments to try to avoid an awful death, and also because my daughter is just starting university in the fall, and I wanted to make sure that she could take her first steps into adulthood unencumbered by that nightmare. Even if I were to only get another year, I want that time.

Of course, there is the possibility that even despite all my best attempts to beat this disease, I might not be one of the lucky ones. The normal course of incurable anal cancer is that the tumour in the rectal area infects local nodes, which go on to involve the lymphatic system. These nodes enter the bloodstream and are quickly spread to the adrenal glands, then to the liver and lungs, and then if you survive long enough, into the brain. It was easy for me to deduce that if I am not lucky this first time around, I have months, maybe years of medical torture and agony to face before hitting the end of this vicious disease. Now if you were to take my place in this story, can you understand why I might want to skip the last chapter?²⁰⁹

Those accounts find reflection in the case of Noel Conway, who has motor neurone disease and who unsuccessfully challenged the compatibility of s 2 of the Suicide Act 1961

²⁰⁹ *ibid* at [1279].

with the ECHR before the domestic courts. Mr Conway described the progression of his illness and its consequences for him in the following terms:

I do not wish to get to a stage where my quality of life is so limited, in the last six months of life, that I am no longer able to find any enjoyment in it. This disease is a relentless and merciless process of progressive deterioration. At some point, my breathing will stop altogether or I will become so helpless that I will be effectively entombed in my own body. I would not like to live like this. I would find it a totally undignified state for me to live in. I find the prospect of this state for me to live quite unacceptable and I wish to end my life when I feel it is the right moment to do so, in a way that is swift and dignified...²¹⁰

The account of Mr Conway, and the experiences of those individuals extracted from *Carter* above, clearly demonstrate that, for some individuals, the ban on assisted suicide will cause ‘either actual bodily injury or intense physical and mental suffering’ and will ‘arouse ... feelings of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance’.²¹¹ In those circumstances it is strongly arguable, at least insofar as Noel Conway and others with terminal or life-limiting conditions are concerned, that the blanket ban on assisted suicide in England and Wales constitutes inhuman or degrading treatment by the State in violation of its negative obligation not to inflict such treatment.

When the focus is on the specific circumstances of the individual(s) bringing the claim under s 4 of the HRA 1998 – as it should be – it is readily apparent that, in some instances, the ban constitutes inhuman or degrading treatment in violation of Article 3 of the ECHR. When the focus is on the specific case, and not a ‘general claim’ of incompatibility, the interests of others, or society’s interest in protecting the sanctity of life or the doctor/patient relationship, lose all relevance: ‘inhuman or degrading treatment are forbidden. That is the end of it.’²¹²

In sum, then, the blanket ban, insofar as it criminalises the rendering of assistance to another to suicide, constitutes treatment which, in some circumstances, may constitute inhuman or degrading treatment in violation of Article 3 of the ECHR either because the ban itself is causing suffering that reaches the minimum level of severity or because, at the

²¹⁰ *Conway* (Court of Appeal) (n 8) [4].

²¹¹ *Jallob* (n 198) [68]. See, also, *Ilaşcu v Moldova and Russia* (2005) 40 EHRR 46 [424]-[427] and *Valašinas v Lithuania* [2001] WLUK 595 [100]-[101].

²¹² *Northern Ireland Abortion Case* (n 170) [215] (Lord Kerr).

very least, the ban exacerbates the suffering arising from a medical condition. In those cases, the State has breached its negative obligation not to inflict such treatment. That is, not, however the end of the Article 3 examination; it is necessary to consider whether the ban also violates the State's positive obligation to protect individuals from inhuman or degrading treatment.

4. The positive obligation to protect

In the *Northern Ireland Abortion Case*, Lord Kerr considered it undeniable that some girls and women would suffer profound psychological trauma as a result of the ban on abortion in the case of rape, incest and fatal foetal abnormality and '[t]hat circumstance [was] sufficient to give rise to a violation of Article 3 where proper safeguards to mitigate the risk of such trauma are not put in place'.²¹³ His Lordship was of the view that the State's positive duty did not depend on the 'onset of actual suffering'; the State has a positive obligation to 'take adequate measures for [the] care and protection' of those who come within a 'highly vulnerable class' and this positive obligation is 'triggered by the *likelihood* that some individuals in that class will suffer as a result of ill-treatment contrary to Article 3 of the ECHR.²¹⁴ '[T]he risk of women and girls being subject to ill-treatment contrary to article 3 is therefore sufficient to trigger the state's *positive obligations to take measures to prevent that happening*.'²¹⁵ That finding was made in the context of a broader determination that forcing a girl or woman to continue with a pregnancy that arose as a result of rape or incest or when she knows that the foetus she carries will die was 'plainly humiliating' and claims by the respondent State that the fact that such girls and women could travel to England to obtain an abortion did not ameliorate that humiliation but, rather, 'the fact of being required to do so [was] in itself sufficient to expose [girls and women] to the risk of inhuman and degrading treatment'.²¹⁶ As also noted earlier, President Hale expressed 'sympathy' for, but did not expressly endorse, Lord Kerr's conclusion that the risk of inhuman or degrading treatment was sufficient to engage the State's positive obligation to prevent that risk materialising.

Much of what Lord Kerr said with respect to the State's positive obligations in the *Northern Ireland Abortion Case* can be applied to s 2 of the Suicide Act 1961. The preceding examination of Noel Conway's circumstances confirm that the ban on assisted dying

²¹³ *ibid* [236] (Lord Kerr).

²¹⁴ *Northern Ireland Abortion Case* (n 170) [257] (Lord Kerr) (emphasis added).

²¹⁵ *ibid* [237] (Lord Kerr) (emphasis added).

²¹⁶ *Northern Ireland Abortion Case* (n 170) [237]-[238] (Lord Kerr).

constitutes inhuman or degrading treatment for him and others suffering life-limiting or terminal conditions. Such individuals are frequently described as being ‘vulnerable’ and there is no question that individuals like Diane Pretty and Noel Conway, by virtue of their conditions and the lack of control they possess over their deaths, belong to a ‘highly vulnerable group’.²¹⁷ That being the case, and given that the impugned treatment stems from the State through its criminalisation of assistance, the State arguably has a positive obligation to protect individuals belonging to that highly vulnerable group from the materialisation of such ill-treatment. The fact that some individuals could travel to a permissive jurisdiction to access assistance in dying does not ameliorate the risk the ban poses, if anything it exacerbates it since that requires an individual to travel to a foreign country to die alone or, if a loved one attends with them, with the worry that the latter will be prosecuted under s 2 of the Suicide Act 1961. Likewise, the reality that, in the main, such individuals are not prosecuted does not alter the fact that, as *Desai*²¹⁸ makes clear, people who provide benevolent assistance *are* prosecuted and the risk of such prosecution can cause feelings of fear and anguish on the part of the individual seeking assistance such as to constitute ill-treatment contrary to Article 3. Insofar as the justifications for the ban are relevant to the question of the violation of the State’s positive obligation to protect, the analysis in Chapter Four reveals that the *blanket* ban is disproportionate to the aims pursued. Consequently, the reasons given for the violation of the positive obligation to protect in Article 3 do not, in reality, justify the violation.

When one examines what the ban achieves *vis-à-vis* its consequences, its incompatibility with Article 3 is patent. The ban requires that individuals cede control over the manner and timing of their death (an aspect of the right to private life protected by Article 8 of the ECHR) and prevents them from lawfully asserting that autonomy in their country of residence, surrounded by loved ones. ‘They are forbidden to do to their bodies that which they wish to do; they are prevented from arranging their lives in the way that they want; they are denied the chance to shape their future as they desire ... [They must] endure untold suffering and desolation. What is that, if not humiliation and debasement?’²¹⁹ The ban, thus, forces some individuals to endure intense physical and/or psychological suffering, feelings of fear, anguish or otherwise humiliates or debases them and, consequently, constitutes a violation of the State’s negative obligation under Article 3 *in those specific cases*.

²¹⁷ See, for instance, *Pretty v United Kingdom* (n 7) [74].

²¹⁸ *Desai* (n 135).

²¹⁹ *Northern Ireland Abortion Case* (n 170) [261] (Lord Kerr).

Insofar as there is plainly a risk of such treatment arising in respect of some individuals with terminal or life-limiting conditions who, accordingly, belong to a highly vulnerable class of individuals, and the State has failed to prevent that risk from materialising, it constitutes *a general violation* of the State's positive obligation under Article 3.

The issue, then, is what the State must do to rectify that incompatibility.

5. Rectifying the incompatibility

As noted with respect to Article 2, what steps the State must take to rectify the incompatibility depends on the nature of the violation. In the case of Article 2, the State could redress the incompatibility by legalising assistance for some individuals (for instance, incapacitous individuals with a degenerative illness that will leave them unable to die by suicide without assistance and individuals with only a certain period of time left to live), or it could adopt the Swiss model and simply decriminalise benevolent assistance without introducing a regulated system of assistance. While the above analysis has been limited to assessing the compatibility of the Suicide Act 1961 with Article 3, the same reasoning could be applied to euthanasia, though this would require an examination of the common law offence of murder since euthanasia is the intentional taking of a person's life whereas in the case of assisted suicide, the individual does the final act leading to their death. That distinction aside, there is no principled reason why the same conclusion of incompatibility would not be reached in the context of euthanasia. The State criminalises euthanasia through the lack of relevant exceptions to the offence of murder and that, like the Suicide Act 1961, constitutes 'treatment' which forces individuals such as Tony Nicklinson to live in a state of unbearable suffering or to bring about their death through starvation or other distressing means (for instance, refusing treatment in the event of infection). The account of Tony Nicklinson's condition and the manner of his death given by Lord Neuberger in *Nicklinson* provides ample support for the contention that the prohibition on euthanasia constitutes treatment by the State that reaches the minimum level of severity for some individuals.²²⁰

²²⁰ *Nicklinson* (n 7) [3]:

Mr Nicklinson suffered a catastrophic stroke eight or nine years ago, when he was aged 51. As a result, he was completely paralysed, save that he could move his head and his eyes. He was able to communicate, but only laboriously, by blinking to spell out words, letter by letter, initially via a perspex board, and subsequently via an eye blink computer. Despite loving and devoted attention from his family and carers, his evidence was that he had for the past seven years consistently regarded his life as "dull, miserable, demeaning, undignified and intolerable", and had wished to end it.

Notwithstanding the conclusion that the ban on assisted suicide (and, indeed, euthanasia) is incompatible with Article 3, the State can decline to act to remedy the incompatibility.²²¹ Should the State decide to take action, the steps necessary to address the violation are more expansive than those required with respect to the Article 2 violation, primarily because the ban has the potential to affect more individuals from an Article 3 perspective than it does under Article 2 of the ECHR. While the Article 2 incompatibility can be remedied by allowing a specific group of individuals – those whose condition will leave them unable to take their own lives without assistance – to be able to lawfully access assisted suicide and/or euthanasia, the ill-treatment which the criminalisation of assistance causes is not confined to such individuals. As the anecdotal evidence outlined above makes clear, the ban may constitute ill-treatment in cases involving individuals like Tony Nicklinson who are incapable of taking their own lives and it may also constitute ill-treatment for individuals who are currently capable of taking their own lives but do not wish to do so via the risky and potentially barbaric avenues available to them. As the following extract from *Carter* makes clear, criminalising assistance of capacitous individuals who are physically able to take their own lives may constitute ill-treatment because:

A physician-assisted death would be compassionate, legal, painless and dignified. The alternatives seem barbaric and cruel. There is also the fear and anxiety associated with taking my own life by other means. I am concerned about having a protracted and painful death should I do nothing, while on the other hand I dread the thought of suicide with the complexities and legal dilemma that will be involved if I have my wife assist me. We both face this reality, that we have only two terrible and imperfect options with a sense of horror and loathing.²²²

Any system of assisted dying must also accommodate the highly subjective nature of the ‘suffering’ covered by Article 3 of the ECHR. Only allowing assisted dying for individuals with terminal illnesses and a specific life-expectancy (as is the case in the permissive jurisdictions in the US and the Australian States of Victoria and Western Australia) will fail

At the time of the hearing before the Supreme Court, Mr Nicklinson had died following a ‘very difficult and painful course of self-starvation, refusing all nutrition, fluids, and medical treatment [after which] he died of pneumonia’ ([6]).

²²¹ As Lady Hale observed in *Nicklinson* (n 7) [300]:

Parliament is ... free to cure that incompatibility, either by a remedial order under section 10 of the Act or (more probably in a case of this importance and sensitivity) by Act of Parliament, or to do nothing. It may do nothing, either because it does not share our view that the present law is incompatible, or because, as a sovereign Parliament, it considers an incompatible law preferable to any alternative.

²²² *Carter* (n 13) [1044].

to protect individuals who have conditions which cause them unbearable suffering but are not terminal or are unlikely to cause their death within a foreseeable period (such as Tony Nicklinson and Omid T). Indeed, even the Canadian requirement that the patient be suffering a ‘grievous and irremediable medical condition’ which, while broad enough to cover ‘illness, disease or disability’ and which incorporates the subjectivity of suffering through the additional requirement that the individual’s condition causes them ‘enduring physical or psychological pain’, nevertheless requires that the individual’s death be ‘reasonably foreseeable’ and would fail to address the incompatibility between s 2 of the Suicide Act 1961 and Article 3 of the ECHR. In fact, litigation is progressing through the provincial courts in Canada challenging the definition of ‘grievous and irremediable medical condition’ on this very basis. In the *Lamb* case it is alleged that the Supreme Court did not confine its findings to individuals with only a certain period left to live and the statutory requirement that a person’s death be ‘reasonably foreseeable’ is incompatible with the Canadian Bill of Rights because it fails to accommodate individuals such as Ms Lamb who has spinal muscular atrophy and Ms Moro who has Parkinson’s disease, whose deaths are not reasonably foreseeable, but whose conditions nevertheless cause them ‘enduring physical or psychological pain’.²²³

In sum, then, if the State determines to rectify the incompatibility and introduces a system of assisted dying, to be compliant with Article 3 of the ECHR it must be available to individuals based on the suffering they are experiencing, as opposed to the terminal nature of their condition and/or the imminence of their death. Indeed, as Lord Neuberger observed in *Nicklinson*, ‘there seems to me to be significantly more justification in assisting people to die if they have the prospect of living for many years a life that they regarded as valueless, miserable and often painful, than if they have only a few months left to live.’²²⁴ Such systems exist in the Benelux jurisdictions. In Belgium, the individual seeking assistance is required to be in ‘persistent and unbearable physical or psychological suffering which cannot be relieved and which stems from a serious and incurable condition caused by accident or disease’.²²⁵ In the Netherlands, the individual must be suffering unbearably with no prospect of improvement.²²⁶ And, in Luxembourg, the individual must ‘be in a medical situation with no way out’ and ‘no prospect of improvement’ and, as a result of

²²³ *Lamb v Canada (Attorney-General)* 2017 BCSC 1802 and 2018 BCCA 266.

²²⁴ *Nicklinson* (n 7) [122].

²²⁵ 28 May 2002 Act on Euthanasia, B.S. 22 June 2002.

²²⁶ Termination of Life on Request and Assisted Suicide (Review Procedures) Act, art 2(1)(b).

this condition, ‘suffer ... physically or psychologically in a constant and unbearable way’.²²⁷ Given the highly subjective nature of ‘unbearable’ suffering, significant debate has attended its scope in the Benelux countries. As Bernheim et al aptly put it:

A main condition for euthanasia in the Benelux laws is ‘unbearable’ suffering. This is actually a slightly unfortunate misnomer. ‘Unbearable’ is an objective notion, while it is the subjective assessment by the patient that matters most. The objective measurement of suffering is still in its infancy ... and no one is in a position to call someone else’s suffering bearable or not... The public, most physicians, and the Control and Evaluation Commission of Euthanasia interpret this term in the euthanasia legislation to mean suffering that is no longer tolerated by the patient.²²⁸

It is left to the medical practitioners involved to determine whether the individual’s suffering has reached the requisite threshold. Safeguards are in place which require the second (and, in some instances, third) opinion of a relevantly qualified individual to confirm the patient’s suffering and the relevant regulatory bodies retain oversight over compliance with the eligibility criteria, including examining a practitioner’s assessment of the patient’s suffering. It is possible to avoid the issue in an objective assessment of suffering by making the ‘threshold’ suffering that is intolerable *to the individual* (which is the standard in, for instance, Canada and Victoria (Australia)).

Of course, as with any system based on human judgement (including the medical system in England and Wales more generally) there is room for error, and opinions will and do differ as to whether a patient’s suffering has met the relevant threshold. But the criterion of ‘suffering’ must be sufficiently subjective to ensure a permissive scheme is, in fact, compatible with Article 3 of the ECHR. As the law surrounding withdrawal of life-sustaining treatment of incapacitous patients makes clear, a system which permits the withdrawal of such treatment in the absence of a patient’s express consent based on assessments of their best interests (which, following the recent UK Supreme Court decision of *Y*, can occur without judicial oversight) can be accommodated within the broader human rights framework.²²⁹ Indeed, the Supreme Court’s decision reveals that a system in which family members and doctors make decisions regarding the ongoing treatment of incapacitous patients – who are, by virtue of their condition, exceedingly

²²⁷ Law of 16 March 2009 on Euthanasia and Assisted Suicide (Mémorial A-No. 46, 16 March 2009), art 2(1).

²²⁸ Jan L Bernheim, Wim Distelmans, Arsène Mullie and Michael A Ashby, ‘Questions and Answers on the Belgian Model of Integral End-of-Life Care: Experiment? Prototype?’ (2014) 11 *Bioethical Inquiry* 507, 518.

²²⁹ *Y* (n 35).

vulnerable – does not pose an unacceptable risk to vulnerable individuals. Arguably, a system in which only capacitous individuals who meet specific eligibility criteria are able to access assistance in dying poses even less of a risk to vulnerable individuals. Certainly, such a system strikes a far better balance between the interests of individuals who, as a result of the ban, experience inhuman or degrading treatment contrary to Article 3 of the ECHR and any other individuals who may be vulnerable to undue influence (which is discussed in detail in Chapter Four).

Drawing the above together, should the State determine to take action to rectify the ban's incompatibility with Article 3 of the ECHR, it will need to introduce a permissive scheme in which individuals who are suffering to an extent which they find is intolerable can access assistance in dying by suicide (the same reasoning would likely lead to the conclusion that the offence of murder is also incompatible with Article 3 insofar as it prohibits euthanasia for individuals like Tony Nicklinson). Any qualification attaching to the individual's condition beyond the unbearableness (or like adjectival qualifier) of their suffering (for instance, that it is terminal or that it will cause the individual's death within a certain period of time) will fail to address the fact that for those individuals who do not meet that criteria, the ban continues to constitute ill-treatment contrary to Article 3 of the ECHR. How the State seeks to protect against errors of judgement will largely be a matter for it, in the exercise of its margin of appreciation. It must be recalled, however, that in the context of Article 3, there is no scope for 'balancing' the rights of others against those individuals subjected to ill-treatment. Having determined that for some individuals the ban will constitute ill-treatment contrary to Article 3 of the ECHR, the State must introduce a system in which those individuals can obtain assistance in dying (or, it can refuse to act, though the ban will remain incompatible with Article 3). Any eligibility criteria and safeguards must not unduly circumscribe access to assistance, otherwise the State runs the risk of introducing a system that falls short of addressing the current incompatibility with Article 3 of the ECHR and further litigation akin to the *Lamb* proceedings currently being heard by the Canadian provincial courts.

6. Conclusion

The decisions of the House of Lords and the ECtHR in the *Pretty* litigation, in particular their rejection of the claim of a violation of Article 3 of the ECHR, had the effect of foreclosing subsequent litigation challenging the compatibility of the blanket ban on assisted suicide with Article 3. None of the subsequent cases challenging the Suicide Act

1961, including Noel Conway's recent litigation, included a challenge on the basis of Article 3. But, the ECHR is a 'living instrument' and the ECtHR has advocated a 'dynamic approach' to interpreting the protections contained therein, including the freedom from torture or inhuman or degrading treatment. Adopting such an approach, through a critical examination of the reasoning of the House of Lords and the ECtHR, in light of subsequent Article 3 jurisprudence, reveals that there is a strong argument that the ban on assisted suicide in England and Wales constitutes 'treatment' *by the State* which is inhuman or degrading for some individuals. More specifically, the decision of the Supreme Court in the *Northern Ireland Abortion Case* and, in particular, the reasons of President Hale, Lord Kerr (with Lord Wilson) and, to a lesser extent, Lord Mance, supports the contention that the State, in criminalising the provision of assistance in dying by suicide, subjects individuals like Noel Conway and Omid T (and, indeed, Diane Pretty) to an agonising dilemma which constitutes treatment such as to engage Article 3 of the ECHR. In such cases, it is the State's criminalisation of assistance which causes the individual's suffering. Certainly, at the very least, the ban on assisted suicide exacerbates the suffering arising from the individual's medical condition and that is sufficient to engage Article 3 of the ECHR.

As for the whether the treatment reaches the minimum level of severity such as to constitute a violation of Article 3, that turns on the facts in a given case. Having regard to the accounts extracted in *Nicklinson, Conway* and in the Canadian case of *Carter*, there is little doubt that denying individuals the right to control the manner and timing of their death causes them 'either actual bodily injury or intense physical and mental suffering' and 'will arouse ... feelings of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance'.²³⁰ The ban thus reaches the minimum level of severity such as to constitute inhuman and degrading treatment for some individuals in England and Wales and thus violates the State's negative obligation not to subject individuals to treatment contrary to Article 3 of the ECHR in those cases. The prohibition on ill-treatment contrary to Article 3 is absolute and, consequently, the reasons for the ban are irrelevant.

The reasoning of Lord Kerr in the *Northern Ireland Abortion Case* raises the possibility of an additional basis upon which a finding that the ban violates Article 3 of the ECHR could be made. Namely, the State's positive obligation to protect. More specifically, Lord Kerr

²³⁰ *Jallob* (n 198) [68].

found that the ban on abortion in Northern Ireland in cases of rape, incest and fatal foetal abnormality posed a risk of ill-treatment contrary to Article 3 for some girls and women and that risk was itself sufficient to engage the State's positive obligation to protect against such harm materialising. Applying Lord Kerr's reasoning to the blanket ban on assisted suicide, it is arguable that the State has failed to protect individuals like Noel Conway and Omid T – who belong to a 'highly vulnerable group' of people – from the harm caused by the ban. As the analysis in Chapter Four reveals, the *blanket* ban is disproportionate to the aims pursued and, consequently, insofar as a violation of the positive obligation to protect can be justified, there is not such justification in respect of the *blanket* ban.

Thus, contrary to the findings of the House of Lords and the ECtHR in *Pretty*, there is a strong argument that the ban on assisted suicide in England and Wales constitutes inhuman or degrading treatment for some individuals, or causes harm which the State has failed to protect against, such as to violate Article 3 of the ECHR. There is no principled reason why the same arguments do not apply to the prohibition on euthanasia, which stems from the common law offence of murder and there is, then, a similarly strong argument that the prohibition on euthanasia violates Article 3 for individuals like Tony Nicklinson who cannot die by suicide.

The State could decide to do nothing about those violations, however, should Parliament decide to remedy the incompatibility, permitting assisted suicide for terminally ill individuals who have a life-expectancy of 6 months or less (as was recommended in the most recent amendments considered by Parliament)²³¹ will not rectify the violation of Article 3. Individuals like Tony Nicklinson who are incapable of doing the final act necessary for taking their life (for instance, swallowing a lethal dose of medication), will be ineligible to access assistance and the prohibition on euthanasia will continue to violate their Article 3 rights. Likewise, for a terminally ill person who could do the final act necessary to die by suicide, they may nevertheless be unable to access assistance in dying by suicide because they have a life expectancy of six months or more. Yet, for those individuals, their suffering may meet the minimum level of severity and the ban on assisted suicide in their case would continue to violate Article 3 of the ECHR. Thus, the State would need to introduce a system of assisted *dying* (i.e. one that permits both assisted suicide and voluntary active euthanasia) which is based on the individual's suffering, as opposed to the nature of their illness and their life expectancy. The Benelux jurisdictions

²³¹ Assisted Dying HL Bill (2016-17) (n 28).

provide potential models, though 'suffering' should be subjectively measured (for instance, by requiring that the individual's suffering is intolerable to them) as opposed to objectively assessed (for instance, 'unbearable').

CHAPTER FOUR

THE RIGHT TO CHOOSE THE MANNER AND TIMING OF ONE'S DEATH: A RE-EXAMINATION OF THE BAN'S PROPORTIONALITY

1. Introduction

This chapter examines the compatibility of the blanket ban with Article 8 of the ECHR. Following the structure of Article 8, the chapter commences with a consideration of the nature of the right to choose the manner and timing of one's death before examining whether the interference which the Suicide Act 1961 poses to that right can be justified under Article 8(2). More specifically, is the ban 'in accordance with law' and 'necessary in a democratic society'? Both of these issues will be considered separately, with the latter assuming the greatest significance. An examination of the compatibility of the ban with Article 8 centres on whether the ban itself is proportionate. Contrary to the erstwhile examination by the domestic and Strasbourg courts, the focus of the proportionality test is not the viability or otherwise of a proposed alternative to the ban; rather, the focus is the ban itself and whether it is proportionate. As this chapter will demonstrate, when examined from that perspective, the blanket ban is not proportionate and is, thus, incompatible with Article 8 of the ECHR. In any event, as the ensuing analysis, together with Chapter Five, reveals, there *is* a less restrictive alternative to the blanket ban.

2. Scope of Article 8(1)

Pursuant to Article 8(1) of the ECHR '[e]veryone has the right to respect for [their] private and family life, [their] home and [their] correspondence.' 'Private life' 'is a broad term not susceptible to exhaustive definition'.²³² It covers the physical and psychological integrity of a person, it can encompass identity (including, for instance, gender identification and sexual orientation), and it also protects the right to personal development (which can be contrasted with the right to develop familial bonds, covered by the right to 'family life').²³³ The broad scope of the protections afforded by the right to private life reflect the principles underpinning Article 8, especially the 'notion of personal autonomy' and self-

²³² *Pretty v United Kingdom* (n 7) [61]. *Pretty* (n 7) [100] (Lord Hope). This is consistent with the domestic jurisprudence concerning the right to refuse life-sustaining treatment:

The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should, in my opinion, be accorded very high priority.

(*Re T* (n 30), 116-17 (President Butler-Sloss) (emphasis added)).

²³³ *Pretty v United Kingdom* (n 7) [61].

determination.²³⁴ The right to private life is, thus, directed at ensuring individuals are given sufficient freedom (subject to *legitimate* restraint) to pursue the life of their choosing. This includes pursuing activities which may be inherently dangerous or which are perceived by others to be morally contentious (there is, for example, a long line of authority concerning the criminalisation of homosexuality).²³⁵ Moreover, as discussed in Chapter One, Article 8 protects the right of capacitous individuals to refuse life-sustaining treatment.²³⁶ Given the breadth of the protections afforded by Article 8 and its emphasis on the individual's autonomy and self-determination, it is unsurprising that the ECtHR has held that the right to 'conduct one's life in the manner of one's choosing' extends to 'exercising [one's] choice to avoid what [one] considers will be an undignified and distressing end to [their] life.'²³⁷ In subsequent decisions, the ECtHR has described this 'right' as being able to 'choose the time and manner of [one's] death'.²³⁸ Plainly, a ban which precludes individuals from exercising that choice by way of assisted suicide constitutes an interference with that right, and this has been confirmed in both the domestic and Strasbourg jurisprudence.²³⁹

The question, then, is whether that interference is justified under Article 8(2) of the ECHR.

3. Justifying an interference: the Article 8(2) requirements

Article 8(2) of the ECHR provides that '[t]here shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society' in one or more of the enumerated legitimate aims. As the ECtHR in *Tysiack* observed '[a]ccording to settled case-law, the notion of necessity implies that the interference corresponds to a pressing social need and in particular that it is proportionate to one of the legitimate aims pursued by the authorities'.²⁴⁰ The courts have dedicated considerable time to clarifying the meaning of 'in accordance with law' and 'necessary in a democratic society'.

²³⁴ *ibid*

²³⁵ Culminating, at least insofar as the United Kingdom is concerned, in the decision of *Dudgeon v United Kingdom* (1982) 4 EHRR 149.

²³⁶ See, for instance, *Purdy* (n 7) [63].

²³⁷ *Pretty v United Kingdom* (n 7) [67]. This was also observed by Lady Hale in *Purdy* (n 7) [61].

²³⁸ See, for instance, *Haas* (n 64) [60].

²³⁹ The HRA 1998 transposed the ECHR into domestic law such that, when dealing with a complaint under the HRA 1998, the focus of the domestic courts is on the proper interpretation and application of domestic rights, as opposed to international rights enshrined in the ECHR (see, for instance, *Re G (Adoption: Unmarried Couple)* [2009] 1 AC 173, [2008] UKHL 38 cited with approval in *Nicklinson* (n 7) [71] (President Neuberger)). See, also, *Pretty v United Kingdom* (n 7) [67] and *Nicklinson* (n 7) [79], [103] and [111] (Lord Neuberger).

²⁴⁰ *Tysiack v Poland* (2007) 45 EHRR 42 [109] (citations omitted).

3.1. 'In accordance with the law'

In the seminal decision of *Sunday Times*, the ECtHR characterised the requirement of being 'in accordance with law' as comprising two elements:

Firstly, the law must be adequately accessible: the citizen must be able to have an indication that is adequate in the circumstances of the legal rules applicable to a given case. Secondly, a norm cannot be regarded as a 'law' unless it is formulated with sufficient precision to enable the citizen to regulate [their] conduct: [they] must be able - if need be with appropriate advice - to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail.²⁴¹

Prosecuting an offence under s 2(1) requires the consent on the DPP.²⁴² This aspect of s 2 and, more specifically, the policy²⁴³ governing the exercise of the prosecutorial discretion, were considered in detail by the House of Lords in the matter of *Purdy*²⁴⁴ and, again, in *Nicklinson* (insofar as the DPP's appeal was concerned).²⁴⁵ At the time *Purdy* was decided there was no specific policy governing the exercise of discretion to prosecute an offence under s 2(1); the decision was made by reference to the generic principles of sufficient evidence and public interest.²⁴⁶ It was this lack of clarity as to the factors that were relevant to the decision to prosecute an offence under s 2 which was at the centre of Debbie Purdy's challenge.

The House of Lords accepted the submission made on behalf of Ms Purdy that 'if the justification for a blanket ban depends upon the flexibility of its operation, it cannot be "in accordance with the law" unless there is greater clarity about the factors which the DPP and his subordinates will take into account in making their decisions.'²⁴⁷ Following the successful appeal in *Purdy*, the CPS developed a policy specific to prosecutions under s 2.²⁴⁸ The policy reiterates that neither list is exhaustive; each case must be considered on its

²⁴¹ *The Sunday Times v United Kingdom* (1979-80) 2 EHRR 245 [49].

²⁴² Suicide Act 1961, s 2(4): no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions.

²⁴³ 'Law' as it appears in Article 8(2) is afforded an expanded meaning, and covers guidelines such as those generated by the DPP (see, for instance, *Purdy* (n 7) and *Nicklinson* (n 7)).

²⁴⁴ *Purdy* (n 7).

²⁴⁵ The policy was also considered in detail in Chapter One.

²⁴⁶ CPS, 'The Code for Crown Prosecutors' (26 October 2018) <<https://www.cps.gov.uk/publication/full-code-test>> accessed 30 July 2019.

²⁴⁷ *Purdy* (n 7) [63].

²⁴⁸ CPS, 'Assisted Suicide' (31 July 2019) <<https://www.cps.gov.uk/publication/assisted-suicide>> accessed 6 February 2020.

own facts and its own merits. This residual discretion may, to a large extent, account for the fact that of the 152 cases classified by police as assisting/encouraging suicide and referred to the CPS for consideration between April 2009 and July 2019, 104 were not proceeded with (i.e. 68 per cent).²⁴⁹ And, of the post-policy cases that have been prosecuted under s 2, only three have been successful. As will be discussed below, the facts of the cases that have been successfully prosecuted vary considerably. In addition to the s 2 prosecutions, a small number of cases in which individuals who have engaged in what might otherwise be characterised as ‘mercy killings’ are prosecuted for other violent offences (for instance, manslaughter²⁵⁰). The statistics made public by the CPS indicate that of the cases referred by police for consideration under s 2, eight have been referred onwards for prosecution for homicide or other serious crime. There is, however, no indication of the rate of successful prosecution of such offences, nor of the number (or nature) of the cases which were classified as homicide or other serious offences from the outset (i.e. not referred on from an initial s 2 referral by police).

In *Nicklinson*, the Supreme Court was faced with, *inter alia*, an appeal by the DPP against a decision of the Court of Appeal (by a 2:1 majority) that the post-*Purdy* policy was insufficiently clear in terms of the impact of the assister being a healthcare professional. More specifically, it was argued that whereas it was sufficiently clear how the DPP would approach a case in which a friend or family member assisted and all the factors tending against prosecution were present, it was far less clear how the DPP would approach the same case in circumstances where the assister was a healthcare professional, especially if the healthcare professional had not had a previous professional relationship with the person being assisted. The majority of the Court of Appeal held that the guidance was insufficiently clear insofar as it did not permit ‘healthcare professionals to foresee to a reasonable degree the consequences of providing assistance’, whereas it was sufficiently clear when it came to relatives and close friends acting out of compassion.²⁵¹

The Supreme Court unanimously upheld the DPP’s appeal (although for varying reasons).²⁵² During the appeal, counsel for the DPP clarified the meaning and intention of

²⁴⁹ A further 29 cases were withdrawn by police, making a total of 87.5 per cent of cases initially classified as assisted suicide by the police either not being pursued by the CPS or the police: *ibid*.

²⁵⁰ As was the case in *Gazeley* (n 136).

²⁵¹ R (*On the application of Nicklinson and Lamb*) v Ministry of Justice; R (*on the application of AM*) v DPP [2014] 2 All ER 32, [2013] EWCA Civ 961 [140].

²⁵² Contrary to the position adopted by the other eight Justices, Lord Kerr considered that the DPP’s appeal should be allowed because, having found that s 2(1) was incompatible with Article 8, that incompatibility could only be addressed by way of a declaration of incompatibility and not by requiring the DPP to prepare (or, indeed, clarify) its policy with respect of prosecutions under s 2 (*Nicklinson* (n 7) [362]-[366] (Lord Kerr)).

the fourteenth factor in favour of prosecution. More specifically, they confirmed that the qualifying phrase ‘and the victim was in his or her care’ applied to the entirety of the clause:

[F]actor fourteen was not intended to embrace healthcare professionals ‘brought in from outside, without previous influence or authority over the victim, or his family, for the simply [sic] purpose of assisting the suicide after the victim has reached his or her own settled decision to end life.’²⁵³

A majority of the Supreme Court considered that while it was not clear that the fourteenth factor had this significance, it was not the role of the Court to advise the DPP on what the policy should say. Instead, the majority determined to afford the DPP the opportunity to re-examine the policy in light of the arguments and concessions made during the appeal.²⁵⁴

The policy was amended following *Nicklinson* with the fourteenth factor being edited so that the words ‘and the victim was in his or her care’ are now in bold and underlined. Additionally, a note was added to the policy stating:

For the avoidance of doubt the words ‘and the victim was in his or her care’ qualify all of the preceding parts of this paragraph [14]. This factor does not apply merely because someone was acting in a capacity described within it: it applies only where there was, in addition, a relationship of care between the suspect and the victims such that it will be necessary to consider whether the suspect may have exerted some influence on the victim.²⁵⁵

Thus, the present iteration of the policy is in line with the dissenting judgment of the Lord Judge in the Court of Appeal who observed:

The Policy certainly does not lead to what would otherwise be an extraordinary anomaly, that those who are brought in to help from outside the family circle ... are more likely to be prosecuted than a family member when they do no more than replace a loving member of the family, acting out of compassion, who supports the ‘victim’ to achieve [their] desired suicide. The stranger who is brought into this situation, who is not profiteering, but rather assisting to provide services which, if

²⁵³ *Nicklinson* (n 7) [192] (Lord Mance).

²⁵⁴ *ibid* for instance: [143]-[146] (President Neuberger); [192]-[195] (Lord Mance); [250]-[252] (Lord Sumption).

²⁵⁵ CPS, ‘Suicide Policy’ (n 79).

provided by the [spouse], would not attract a prosecution, seems to me most unlikely to be prosecuted...²⁵⁶

The question arises whether this ‘clarification’ renders the policy more in line with the legality requirement of Article 8(2) or whether it poses more questions than it answers. According to Lord Sumption, the clarified interpretation raises significant concerns regarding the role of other factors favouring prosecution, in particular factor six (the accused was not ‘wholly motivated by compassion’). While the purely compassionate character of the assister’s motivation is a major head of mitigation, this is far more likely to be demonstrated by a family member or loved one, than by an outsider with no emotional or even a prior professional connection with the individual seeking assistance.²⁵⁷ Similar questions arise with respect to the interplay between factors fourteen and twelve (the ‘suspect’ and ‘victim’ were not known to each other). Those apparent inconsistencies pose but do not answer the questions: what kind of ‘professional carer with no earlier responsibility for the care of the victim’ is covered by the clarified factor fourteen? And how are persons who charge for their services affected by factor thirteen (which covers ‘profiteering’)? Finally, what sorts of conduct are covered by factor sixteen in light of the revised factor fourteen: does this only cover operations such as Dignitas or are less ‘extreme’ enterprises also caught?²⁵⁸ In the absence of information regarding the nature of the cases that are referred by the police but not prosecuted under s 2, it is impossible to ascertain whether any of the issues foreshadowed by his Lordship have arisen following the policy’s post-*Nicklinson* ‘amendment’.

These ambiguities notwithstanding, the law arguably meets the certainty requirements to be ‘in accordance with law’ as required by Article 8(2); citizens clearly know the legal rules applicable (i.e. s 2 of the Suicide Act 1961) and s 2 is plainly formulated with precision: intentional assistance and encouragement of another’s suicide is unlawful without exception. As the ECtHR has held, ‘absolute certainty’ is unattainable and the interpretation and application of many laws ‘is a question of practice’. Such is the case with s 2, as demonstrated by the ensuing analysis of the three post-*Purdy* prosecutions that have led to convictions.

²⁵⁶ *Nicklinson and Lamb* (n 251) [186].

²⁵⁷ *Nicklinson* (n 7) [252] (Lord Sumption).

²⁵⁸ *ibid* [253].

3.1.1. Prosecutions under s 2, Suicide Act 1961

As noted above, only a miniscule number of cases referred for prosecution under s 2 have been successfully prosecuted since the 2010 (post-*Purdy*) policy was introduced (three as at August 2019). Prosecutions for other violent offences (typically manslaughter by way of diminished responsibility) have occurred in circumstances which *might* be described as mercy killings.²⁵⁹ However, the proportion of prosecutions for assisting/encouraging suicide under s 2 compared with the number of referrals from the police illustrates the significant role the discretion in s 2(4) plays in implementing the ban on assisting and encouraging suicide. The question then is what impact this flexibility has on the ban's certainty (and, thus, legality) for the purposes of Article 8 of the ECHR.

3.1.1.1. *R v Howe*

Mr Howe was convicted after trial of assisting suicide contrary to s 2(1).²⁶⁰ Mr Howe, who was 19 at the time of offending, had purchased petrol and a cigarette lighter for his friend, Stephen Walker (who was then aged 30), knowing that Mr Walker intended to set himself alight. Both Mr Howe and Mr Walker had consumed a considerable amount of alcohol in the hours leading up to Mr Howe's purchase. Mr Howe gave the petrol and the lighter to Mr Walker and then left Mr Walker's home. Despite attempts by neighbours to intervene, Mr Walker ignited the petrol and the 'house burst into flames'.²⁶¹ Mr Walker survived the blaze but suffered severe burns to 95 per cent of his body. Mr Howe was initially sentenced to 12 years' detention in a Young Offender Institution.

The Court of Appeal allowed Mr Howe's appeal, and substituted a term of 10 years' imprisonment. In doing so, the Court held that the 2010 CPS policy provided guidance to judges sentencing individuals convicted of an offence under s 2(1) of the Suicide Act 1961. The Court had regard to pre-policy jurisprudence, ranging from suicide pacts (for which sentences of 3 years' imprisonment 'will generally be appropriate') to encouraging and assisting a cellmate to suicide (for which the accused was sentenced to 8 years' imprisonment following a guilty plea). Having examined those cases, the Court 'identif[ied] a number of non-inclusive factors of relevance, stressing the need for each case to be considered on its own facts'.²⁶² Relevantly, the Court held that it:

²⁵⁹ See, for instance, *Gazeley* (n 136).

²⁶⁰ *R v Howe* [2014] 2 WLUK 251, [2014] EWCA Crim 114.

²⁶¹ *ibid* [6].

²⁶² *Howe* (n 260) [24].

[S]hould consider whether the victim had a settled, voluntary and informed intention to commit suicide, or whether his or her state of mind was less certain. Whether the victim solicited assistance or encouragement is relevant, as is the victim's capacity to make a decision as to suicide. In this context, knowledge by the offender of the extent of any vulnerability of the victim will be important. Again, evidence of threats, pressure or persuasion applied to the victim will have a bearing on culpability.²⁶³

In determining that Mr Howe's offending warranted a custodial sentence of 10 years, the Court of Appeal reiterated that while Mr Walker did not die, his injuries were especially grave as was his suffering (and that of his family). Further, Mr Howe 'was well aware of [Mr Walker's] vulnerability and knew that his previous threats of suicide were not idle.'²⁶⁴ The Court also considered there to be a 'degree of premeditation'²⁶⁵ and determined that Mr Walker did *not* have a settled intent to take his own life: '[o]ur judgment is that his state of mind was less certain than that.'²⁶⁶ While it is not clear from the reasons given why their Honours concluded that Mr Walker did not have a 'settled intention', it seems that the Court placed considerable weight on the fact that Mr Walker could not have attempted suicide in the manner in which he did were it not for Mr Howe's actions.²⁶⁷ The Court also emphasised that the actions of Mr Howe 'were not carried out in the context of a very elderly or terminally ill person who was suffering and wanted to be put out of their misery. There were no compassionate circumstances. This is not a mercy killing'.²⁶⁸

3.1.1.2. *R v Desai*

In stark contrast to *Howe, Desai*²⁶⁹ entailed what *could* be considered a 'mercy killing' by a son of his elderly father. Mr Desai had been charged with murdering his father and, in the alternative, assisting his suicide. At the commencement of the trial, the judge ruled that the defendant had no case to answer with respect to the murder charge. Mr Desai had separately pleaded guilty to assisting his father's suicide. Mr Desai's father was 85 years old at the time of his death. The trial judge determined that the defendant's father had expressed a wish, on numerous occasions, to die and that:

²⁶³ *ibid* [28].

²⁶⁴ *Howe* (n 260) [32].

²⁶⁵ *ibid*.

²⁶⁶ *Howe* (n 260) [33].

²⁶⁷ *ibid* [33], [34].

²⁶⁸ *Howe* (n 260) [33].

²⁶⁹ *Desai* (n 135).

[W]ish was the firm and settled wish of a man of sound mind, in his 80's who was suffering from an ever increasing lack of mobility, who was endemically lonely and who was fed up with existence. Evidence was also given in court by third parties who ... described him as a man fed up with life.²⁷⁰

The defendant, a pharmacist, procured a lethal dose of a medication following an administrative error, which he sequestered with the potential to administer to his father at a later date. He kept the dose at his home for 6 months before adding it to a smoothie, which his father, knowing its contents, drank, after which he injected his father with insulin. The defendant voluntarily attended a police station where he admitted his conduct. In sentencing the defendant in respect of the offence of assisted suicide, the trial judge determined that 'this case sits at the very lowest level of seriousness of cases involving a death' as:

- The defendant's actions were motivated by 'pure compassion and mercy';
- The defendant's father 'had a firm, settled and informed wish to die' which he had expressed over a number of years;
- The defendant had reluctantly agreed to assist his father, but only after many months of attempting to deter him;
- The assistance provided by the defendant was intended to 'make death as gentle and comfortable';
- The defendant handed himself into police and was fully cooperative.²⁷¹

The cumulative weight of all of those factors resulted in a custodial sentence of 9 months, suspended for 9 months (and no separate sentence for the charges of theft relating to the drugs and syringes taken from his pharmacy).²⁷²

Of particular relevance for instant purposes are the trial judge's observations with respect to the decision to prosecute Mr Desai for assisting his father's suicide. The trial judge reiterated that 'there is no duty to prosecute every offence that is committed' contrary to s 2(1) of the Suicide Act 1961 and, indeed, 'there are very few prosecutions'.²⁷³ At that point, the only post-*Purdy* prosecution had been that of Mr Howe which the trial judge described as coming 'within a hair's breadth of amounting to a gruesome and brutal

²⁷⁰ *ibid* [8].

²⁷¹ *Desai* (n 135) [29]-[30].

²⁷² *ibid* [49].

²⁷³ *Desai* (n 135) [35] citing *Nicklinson* (n 7) (Lord Neuberger).

murder.²⁷⁴ Referencing the factors outlined in the post-*Purdy* policy, the trial judge noted that the defendant's conduct 'prima facie falls into the category of cases where there would be no prosecution.'²⁷⁵ While not seeking to 'comment upon or criticise the charging decisions in this case', the trial judge nonetheless observed:

I have now sat through the Prosecution case and have formed a judgment on the relevant facts. If these facts had been as evident then as they are to me now *I am strongly of the view that there would have been no prosecution*. I acknowledge that this is a judgment with the benefit of hindsight and it is not intended as criticism of the Crown. But it leaves you in the position that *you have faced charges and punishment where someone else in the same position as you would not have*.²⁷⁶

Significantly, the trial judge said:

There is an underlying point of principle here. The House of Lords in *Purdy* required the DPP to provide proper guidance to meet the requirements of the State under Article 8 of the European Convention on Human Rights. The House of Lords held that a person who was in the position of being asked to assist a suicide - such as you were - had a right to know what factors would be likely to lead to a prosecution. *Transparency and consistency were necessary to avoid the law being arbitrary, in other words being applied in a discriminatory manner.*

I turn to the appropriate sentence. I can see no appropriate or sensible basis upon which a sentence of immediate imprisonment is appropriate. Indeed, the logic of the analysis under the DPP's Guidelines and Article 8 suggests that *you should be given an unconditional discharge because this would place you in the position that, it can be said, you were entitled to be in had you been assessed under the Guidelines on the facts as I have found them*.²⁷⁷

The implications of his Honour's observations in terms of the ban's legality for the purposes of Article 8(2) of the ECHR will be discussed in greater detail shortly. First, however, it is necessary to consider the most recent s 2 prosecution.

²⁷⁴ *ibid.*

²⁷⁵ *Desai* (n 135) [36].

²⁷⁶ *ibid* [38] (emphasis added).

²⁷⁷ *Desai* (n 135) [39]-[40] (emphasis added).

3.1.1.3. *R v Gordon*

Ms Gordon was convicted by a jury of encouraging the suicide of Mr Burkinshaw, who had a history of mental illness and suicidal ideation. The two met on an internet forum where Mr Burkinshaw had ‘posted six messages ... saying that he intended to commit suicide in mid-January, probably by jumping off Beachy Head and he was looking for someone to join him’ and concluded with a post on 16 December that read ‘I’m jumping Beachy Head in 24hrs. I want to be there for the sunrise on Thursday morning. If anyone wants to come they are welcome.’ Mr Burkinshaw gave his telephone number but requested that ‘only genuine people ... contact him and for no one to try to convince him against it.’²⁷⁸

The defendant, who had previously attempted suicide, contacted Mr Burkinshaw and agreed to die by suicide with him. Ms Gordon proposed that Mr Burkinshaw travel to where she lived and they die by carbon monoxide poisoning by lighting a disposable barbeque in Mr Burkinshaw’s car. Mr Burkinshaw travelled to Ms Gordon, purchased a disposable barbeque and died by carbon monoxide poisoning after lighting it in his vehicle. The trial judge accepted that Ms Gordon travelled with Mr Burkinshaw to the place at which he ultimately died but determined not to kill herself. Mr Burkinshaw knew of Ms Gordon’s decision not to proceed with what the trial judge described as a ‘suicide pact’ as originally planned and, indeed, provided her with money so she could get a taxi home. Ms Gordon’s partner had contacted police after becoming concerned by her text messages which indicated that she may be considering suicide. The police collected Ms Gordon approximately a mile from where Mr Burkinshaw’s car was parked. Ms Gordon did not tell police about Mr Burkinshaw at that time, although they were informed some time later, at which point he was deceased.²⁷⁹

Of interest is the trial judge’s finding (in light of the jury’s guilty verdict) that Ms Gordon did encourage Mr Burkinshaw to suicide, although Mrs Justice Cheema-Grubb also accepted, in light of evidence of Mr Burkinshaw’s comments on various suicide chat-forums, that he had a settled intention to suicide.²⁸⁰ The trial judge’s findings warrant extracting in full in this respect:

²⁷⁸ *R v Natasha Gordon* (Leicester Crown Court 19 January 2018) [10] <<https://www.judiciary.gov.uk/wp-content/uploads/2018/01/r-v-gordon-sentencing.pdf>> accessed 31 July 2019.

²⁷⁹ *ibid* [4].

²⁸⁰ *Gordon* (n 278) [16(d)].

[A]lthough [Mr Burkinshaw] *was contemplating committing suicide* towards the end of 2015 he *may not have gone through with it as he did on 17th December* if you had not agreed to accompany him in what he believed to be a genuine suicide pact. However, on this important second question I resolve the issue more favourably to you and conclude that given *his clear indication* on the posts *he would have committed suicide at some time approximate to 17th December*.²⁸¹

Ms Gordon was convicted of encouraging Mr Burkinshaw to suicide because although Mr Burkinshaw had a ‘clear intention’ to die by suicide and would have done so ‘at some time approximate to 17th December’ *regardless of Ms Gordon’s input*, his method of suicide changed following Ms Gordon’s involvement (or, to employ the language of the statute, her ‘encourag[ement]’). It appears that Ms Gordon’s culpability arose as a result of her proposing that instead of ‘jumping off Beachy Head’ on 17 December as Mr Burkinshaw had expressed he would, he travel to her home and they die by carbon monoxide poisoning together. This is consistent with the reasoning in *Howe* discussed above. The trial judge also made much of the fact that Ms Gordon determined not to go through with her suicide. According to Justice Cheema-Grubb, Ms Gordon did not have a ‘settled intention’ to die by suicide and she ‘mised [Mr Burkinshaw] into believing that [she] was genuinely and firmly intent on committing suicide with him’.²⁸² Yet, the accepted evidence was that Mr Burkinshaw *knew* Ms Gordon was not going to suicide before he killed himself; he paid for her to get home and still proceeded to die by suicide. Mr Burkinshaw was, then, fully aware of Ms Gordon’s intentions at the time he died by suicide and it is unclear how Ms Gordon can be said to have misled him. The reasons of the trial judge strongly suggest that Ms Gordon was being punished for not dying by suicide despite s 1 of the Suicide Act 1961 decriminalising suicide to avoid precisely that situation.

One is left to wonder whether Ms Gordon would have been prosecuted if she had responded to Mr Burkinshaw’s online posts by attending with him at Beachy Head on the 17th of December and, having met with him at the allotted time and place, determined not to jump. That is, what would have occurred if Ms Gordon had attended at Beachy Head with no firmer resolution to die by suicide than she had when she got into Mr Burkinshaw’s car? Does her conviction of encouraging Mr Burkinshaw’s suicide rest solely on the fact that she proposed he travel to her home and that they die by carbon monoxide poisoning instead of jumping from Beachy Head? While this case clearly raises important questions

²⁸¹ *ibid* at [12] (emphasis added).

²⁸² *Gordon* (n 278) [14].

about the nature of the offence under s 2(1) of the Suicide Act 1961, its relevance to the instant inquiry rests in the fact that the judgment, together with *Howe* and *Desai*, confirms the observations in both *Desai* and of the Lord Judge in Mr Martin's appeal²⁸³ that prosecutions under s 2 are highly unlikely in cases involving 'compassionate, amateur assistance from nearest and dearest'²⁸⁴ of individuals with life-threatening or life-limiting conditions, or elderly individuals, where they have expressed a settled will to die. This consistency in the practical application of s 2 of the Suicide Act 1961 suggests that individuals are able to foresee, 'to a reasonable degree', the consequences of their actions such as to satisfy the 'legality' requirement of Article 8(2) of the ECHR.

3.1.2. *Legality and Article 8(2): the utility of the post-Purdy CPS guidelines*

While Lord Hughes in *Nicklinson* was of the view that the generic Full Code Test for prosecutors was sufficient to meet the legality requirement of Article 8(2), as the House of Lords in *Purdy* identified, many of the factors in the generic public interest test are irrelevant to a decision to prosecute under s 2 of the Suicide Act 1961.²⁸⁵ Further, there are factors specific to determining whether to prosecute under s 2 which do not fit easily with the Full Code Test. For instance, culpability under the Full Code takes into account the level of premeditation however, such premeditation on the part of a wholly compassionate assister may be a factor *against* prosecution under s 2 insofar as it was actually 'reluctant encouragement or assistance in the face of a determined wish on the part of the victim to [die by] suicide' (per factor 5 tending against prosecution). Such limitations of the generic code in the context of s 2 offences were expressly recognised by the DPP in his reasons for not prosecuting the members of Daniel James's family who assisted him to travel to Switzerland where he could die by suicide at a Dignitas clinic.²⁸⁶

Moreover, during the Second Reading of the Suicide Bill in 1961, the House of Lords noted that the purpose of requiring that the DPP provide their consent before a prosecution under s 2 could occur was to 'ensure that consistency was maintained'.²⁸⁷ It is arguable that consistency has been secured with respect to friends/family assisting a person

²⁸³ *Nicklinson and Lamb* (n 251).

²⁸⁴ HC Deb 11 September 2015, col 674 (Sir Keir Starmer)

<<https://publications.parliament.uk/pa/cm201516/cmhansrd/cm150911/debtext/150911-0001.htm>> accessed 31 July 2019.

²⁸⁵ See, for instance, *Purdy* (n 7) [49] (Lord Hope); [79] (Lord Brown).

²⁸⁶ *ibid.*

²⁸⁷ HL Deb 2 March 1961, vol 229, cols 246-76, 251.

<<http://hansard.millbanksystems.com/lords/1961/mar/02/suicide-bill-hl>> accessed 31 July 2019.

to travel to Dignitas given that over 200 cases²⁸⁸ involving such conduct were known to police and *none* resulted in prosecution.²⁸⁹ Such consistency is bolstered by the successful prosecutions of Mr Howe and Ms Gordon, both of which entailed friends or acquaintances assisting or encouraging another in circumstances where the individual who attempted to/did die by suicide was not terminally ill, suffering intolerably as a result of a life-limiting or similar condition or was not elderly and there was no cogent evidence to suggest that the relevant acts were ‘wholly motivated by compassion’ or mercy. In this respect, the decisions to prosecute Mr Howe and Ms Gordon reflect the CPS’s post-*Purdy* policy and its emphasis on compassion and protecting vulnerable individuals.²⁹⁰ *Desai* also confirms this practice. While the prosecution was dubious, the trial judge confirmed the approach to compassionate assistance of the elderly, terminally ill and those suffering intolerably as a result of a life-limiting condition in the sentence that was passed and in the reasons given. This ‘certainty’ is further supported by the case of Ms Caller who was acquitted by a jury of assisting her friend’s suicide. Ms Caller, aged 22 at the time of her acquittal, admitted she had provided the noxious gas her friend used to bring about her death, though she claimed that she did not think her friend would use the gas to take her life.²⁹¹ The fact that Ms Caller was prosecuted is consistent with the decisions to prosecute Mr Howe and Ms Gordon. As with Mr Howe, Ms Caller was friends with ‘the victim’ and, like both Mr Howe and Ms Gordon (insofar as her culpability derived from her suggestion as to the means of Mr Burkinshaw’s suicide), her level of involvement in her friend’s death was quite significant given that she supplied the means by which her friend was able to bring about her death. While it is possible that these cases would have been prosecuted in the absence of an offence-specific policy, the policy makes it clear (and, indeed, foreseeable) that instances of assistance/encouragement such as those at the centre of the cases of Mr Howe, Ms Gordon and Ms Caller will *likely* lead to prosecution based on the factors set out therein. In this respect, the policy ensures that like cases are treated alike, thereby

²⁸⁸ The latest figures reveal that 457 British members of Dignitas had been accompanied to a clinic in Switzerland where they subsequently die by suicide with assistance: Dignitas (n 6).

²⁸⁹ *Nicklinson* (n 7) [255(5)].

²⁹⁰ While it is not relevant to the instant inquiry, it ought to be noted that debate abounds as to whether the CPS has impermissibly altered the substance of the offences under s 2(1) of the Suicide Act 1961 via its policy and, in particular, its emphasis on compassion. See, for instance, Catherine O’Sullivan, ‘Mens Rea, Motive and Assisted Suicide: Does the DPP’S Policy Go Too far?’ (2015) 35 *Legal Studies* 96.

²⁹¹ See, for instance, Press Association ‘Woman cleared of helping friend to kill herself “did not deserve prosecution”’ *The Guardian* (London, 14 May 2015) <<https://www.theguardian.com/uk-news/2015/may/14/woman-not-guilty-helping-friend-kill-herself-assisting-suicide>> accessed 31 July 2019.

securing the consistency required by Article 8(2)'s legality requirement and, indeed, as was intended by requiring the DPP's consent per s 2(4) of the Suicide Act 1961.

Contrary to Lord Hughes's claim in *Nicklinson*, then, the CPS's offence-specific policy with respect to assisted suicide (which joins a growing number of offence-specific guidance documents)²⁹² was necessary to redress the fact that 'in the absence of any such statement of policy, there is simply no sufficiently clear or relevant guidance available as to how the very widely expressed discretion accorded to the Director in section 2(4) of the 1961 Act will be exercised'.²⁹³ The policy was, then, a means of ensuring that s 2 complies with Article 8(2)'s legality requirement, in particular the need for foreseeability and consistency. The comments of the trial judge in *Desai* serve to highlight this point. In identifying that another individual in Mr Desai's situation would likely not have been prosecuted, his Honour, albeit implicitly, referenced the practice of not prosecuting 'wholly compassionate' acts of assistance involving loved ones/friends who are terminally ill, suffering intolerably as a result of a life-limiting condition or elderly. That trend exists irrespective of the policy, but the policy ensures that the prosecutorial discretion is exercised in a manner that meets Article 8(2)'s requirements of accessibility, foreseeability and transparency. Of course, prosecutors enjoy a residual degree of discretion; the factors enumerated in the policy are not exhaustive. However, the policy serves to ensure that individuals who are considering engaging in acts which *may* run afoul of s 2 are aware as far as is possible of the consequences of their actions, which is imperative to avoid arbitrary interferences with the Article 8(1) right to private life.

In sum, while there remain concerns with respect to the certainty of the 2010 CPS policy concerning prosecutions under s 2 of the Suicide Act 1961, its application has led to a degree of foreseeability and consistency such that the ban can be said to be 'in accordance with the law' (as required by Article 8(2) of the ECHR). The policy's emphasis on compassion and the condition of the victim accounts for the decisions to prosecute Mr Howe, Ms Gordon and Ms Caller and it enabled the trial judge in *Desai* to question the decision to prosecute on the basis of concerns regarding consistency. The CPS policy thus serves two important functions: it ensures the ban satisfies the legality requirement in Article 8(2); and, it enables the DPP to achieve the objective of the discretion in s 2(4),

²⁹² Including, for instance, guidance for offences involving violence against women and domestic abuse guidelines. CPS, 'Prosecution guidance' <<https://www.cps.gov.uk/prosecution-guidance>> accessed 21 July 2019.

²⁹³ *Purdy* (n 7) [102] (Lord Neuberger).

namely consistency. The ECtHR has repeatedly confirmed that secondary legislation, codes of practice and regulations that are available to the public can provide the relevant statutory provision with the certainty and foreseeability required to be ‘in accordance with law’.²⁹⁴ In those circumstances, it would be difficult to maintain a claim that the blanket ban, read in light of the CPS policy, was *not* ‘in accordance with the law’.

Having established that the ban is in accordance with law, the next question is whether the ban is ‘necessary in a democratic society’ which requires, *inter alia*, that the ban pursues a ‘legitimate aim[s]’.²⁹⁵

3.2. ‘Legitimate aim’

While Article 8(2) does not make express reference to ‘legitimate aim’, an aim will typically be found to be ‘legitimate’ ‘provided it falls within one of the categories [of interests] set out in paragraph 2 of Article[8]’.²⁹⁶ Thus, so long as the State can demonstrate to the requisite standard that the impugned measure seeks to achieve an aim related to an interest listed in Article 8(2), it will generally comply with the ‘legitimate aim’ requirement of Article 8(2) of the ECHR.²⁹⁷ The question, then, is whether the objective/s (or aim/s) of s 2 of the Suicide Act 1961 relates to one or more of the interests listed in Article 8(2).

The political and academic debate surrounding assisted suicide is replete with various justifications for continuing to criminalise all assistance, with the most commonly cited being:

- It would devalue the lives of those who would be permitted access;
- Even restricted access could result in desensitisation to such an extent that people who were not originally envisaged as being able to access assistance would eventually be able to die with assistance (or would be killed by euthanasia without consent) (i.e. the ‘slippery slope’ argument);
- It would compromise the relationship of trust between doctors and patients;

²⁹⁴ See, for instance, *Gillan and Quinton v United Kingdom* (2010) 50 EHRR 45 and *Kosaitė-Cyprienė v Lithuania* App no 69489/12 (ECtHR, 4 June 2019).

²⁹⁵ See, for instance, *Pretty* (n 7) [70].

²⁹⁶ *Rotaru v Romania* [2000] 5 WLUK 77 (Judge Wildhaber). Likewise, the Grand Chamber in *S.A.S v France* (2015) 60 EHRR 11 held that in order for an interference with the right to private life to be justified, it must ‘pursue an aim that can be linked to one of those listed in [Article 8(2)]’ ([113]).

²⁹⁷ In *S.A.S v France* (ibid), the Grand Chamber observed ([114]): ‘The Court’s practice is to be quite succinct when it verifies the existence of a legitimate aim within the meaning of the second paragraphs of Articles 8 to 11 of the Convention.’

- It would put pressure on individuals who might be vulnerable to undue influence by family or loved ones such that they would seek assistance in dying by suicide in circumstances where they do not desire to die.

While all the above justifications have featured heavily in the debates of the various Bills proposing amendments to the Suicide Act 1961,²⁹⁸ the primary legal justification is the alleged need to protect people ‘vulnerable’ to undue influence or, to use the vernacular of the ‘interests’ recognised by Article 8(2) ‘the protection of the rights of others’, specifically the right not to be intentionally deprived of their life or, alternatively, the ‘protection of health’.²⁹⁹ Indeed, this is (subject to the anomalous reasoning of the courts in *Conway*³⁰⁰ which is considered below) the sole legal justification for s 2(1) of the Suicide Act 1961. As Lady Hale observed in *Nicklinson*:

The *only* legitimate aim which has been advanced for this interference is the protection of vulnerable people, those who feel that their lives are worthless or that they are a burden to others and therefore that they ought to end their own lives *even though they do not really want to*. In terms of article 8.2, this could be put either as the “protection of health” or as the “protection of the rights of others”, the right in question being the most important right of all, the right to life protected by article 2. As Lord Sumption points out, an alternative aim might be advanced, as the “protection of morals” ... Respect for individual autonomy and human dignity are also important moral principles. *The very complexity of the moral argument, amply demonstrated in the material before this court, tells against relying upon this as the legitimate aim of the legislation.*³⁰¹

Lady Hale had expounded a similar conceptualisation of the ban’s objective in the earlier decision of *Purdy* wherein she described the focus of the ban as ‘people who are vulnerable to all sorts of pressures, both subtle and not so subtle, to consider their own lives a worthless burden to others.’³⁰² Consistent with Lady Hale’s observations in both *Purdy* and *Nicklinson*, Lord Mance in the latter held that the objective of s 2(1) is to protect ‘vulnerable individuals who might feel themselves a burden to their family, friends or society and

²⁹⁸ See, for instance, HL Deb 12 May 2006, cols 1231, 1233-1234, 1237; HL Deb 18 July 2014, cols 824, 832, 835; HC Deb 11 September 2015, cols 665, 669, 670.

²⁹⁹ See, for instance, the Joint Committee on Human Rights, Twelfth Report – 3: Assisted Dying for the Terminally Ill Bill (HL 2004-05, 86-III) [3.7]. See, also, Joint Committee on Human Rights, Seventh Report – Private Members’ Bills (2002-03, HL Paper 74, HC 547) [46].

³⁰⁰ *Conway* (n 7), *Conway* (Court of Appeal) (n 7), *Conway* (Supreme Court) (n 8).

³⁰¹ *Nicklinson* (n 7) [311].

³⁰² *Purdy* (n 7) [65].

might, if assisted suicide were permitted, be persuaded or convince themselves that they should undertake [suicide], *when they would not otherwise do so*.³⁰³

The ECtHR has confirmed the domestic authorities' conceptualisation of the ban's objective:

The law ... was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life. Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of *the class* which provides the rationale for the law in question...³⁰⁴

The ECtHR thus attributed the alleged vulnerability of 'many' terminally ill individuals to 'the [entire] class' of terminally ill individuals who might avail themselves of assistance in dying by suicide should it be decriminalised. Having done so, the Court then afforded the United Kingdom a wide margin of appreciation in determining how to protect against the risks to those 'vulnerable' individuals: '[i]t is primarily for States to assess the risk and the likely incidence of abuse if the general prohibition on assisted suicides were relaxed or if exceptions were to be created'.³⁰⁵

Consistent with the characterisation of the ban's objective proffered by the domestic courts and the ECtHR, the Canadian Supreme Court in *Carter* described the 'target' of that jurisdiction's analogous blanket prohibition as 'preventing vulnerable persons from being induced to commit suicide at a time of weakness'.³⁰⁶ Similarly, the Supreme Court of the United States in *Glucksberg* held that one of the central objectives of Washington State's (then) blanket ban was 'protecting the poor, the elderly, disabled persons, the terminally ill, and persons in other *vulnerable groups* from indifference, prejudice, and psychological and financial pressure to end their lives'.³⁰⁷

There is, then, a significant degree of consensus across the various jurisdictions that have examined the human rights implications of their respective bans on assisted suicide that one of the primary legal justifications, if not the sole legal justification, is the need to

³⁰³ *Nicklinson* (n 7) [171] (Lord Mance). Emphasis added. Likewise, the Select Committee on Medical Ethics (1994) considered that permitting assisted dying would pose too great a risk to the 'vulnerable' who were characterised as 'the elderly, the lonely, the sick or the depressed'. More specifically, the Committee was concerned that allowing voluntary euthanasia would 'send a message' to those vulnerable individuals which would, 'however obliquely, encourage them to seek death'. HL Deb 9 May 1994, vol 554, cols 1381, 1383.

³⁰⁴ *Pretty v United Kingdom* (n 7) [74] (emphasis added).

³⁰⁵ *ibid.*

³⁰⁶ *Carter* (Supreme Court) (n 1) [78]. See, also, [29].

³⁰⁷ *Glucksberg* (n 92) 704 (emphasis added).

protect ‘vulnerable’ people from feeling pressured into taking their lives. Notwithstanding this consensus and seemingly in direct conflict with the jurisprudence of the UK Supreme Court (in particular, Lady Hale’s observations at [311] in *Nicklinson* extracted above) and the ECtHR, the Divisional High Court in *Conway* accepted the State’s claim that the ban had multiple objectives namely, to protect: the vulnerable; the doctor/patient relationship; and, society’s moral value in the sanctity of life. The subsequent appellate decisions in the *Conway* litigation have perpetuated this contention. Given its significance to the instant inquiry, this finding warrants closer inspection. It is certainly necessary to examine the merits of the High Court’s reasoning before moving on to consider whether the ban is necessary to achieve its objective(s) since the decision, if valid, significantly expands the Article 8(2) inquiry.

3.2.1. *Conway and the blanket ban’s legitimate aim(s)*

The High Court in *Conway* held that because of the findings of the UK Supreme Court in *Nicklinson* and the ECtHR in *Pretty* and *Nicklinson* (and, in particular, the asserted lack of a finding of incompatibility by either court), Mr Conway was *not* seeking a ‘declaration of incompatibility with Convention rights as contained in the ECHR’ but, rather, he was seeking a ‘declaration of incompatibility with the Convention rights as set out as distinct provisions in domestic law under the HRA.’³⁰⁸ The distinction between ECHR rights as contained in the Convention and ECHR rights as contained in domestic law derives from the decision of the House of Lords in *Re G*³⁰⁹ which confirmed that ‘a distinct claim of incompatibility with such rights can be maintained *even where there is no breach of the Convention itself*.’³¹⁰ While the distinction is largely immaterial to the remedies available to a successful applicant, it does have the potential to effect the outcome of an appeal and/or a complaint before the ECtHR.

There are several issues with the High Court’s classification of Mr Conway’s claim as concerning ECHR rights contained in domestic law as opposed to the ECHR itself. The first is that it is based on a mischaracterisation of the Supreme Court’s decision in *Nicklinson* which is discussed in greater detail below. A majority of the Supreme Court (5:4) determined that the Court had the competence to examine the question of the ban’s compatibility with Article 8 of the ECHR, though only two members of the bench proceeded to undertake that exercise, both reaching the conclusion that the ban was

³⁰⁸ *Conway* (n 7) [45].

³⁰⁹ *Re G* (n 239).

³¹⁰ *Conway* (n 7) [45] (emphasis added).

incompatible with Article 8. The remainder of the majority decided the more appropriate course was to give Parliament the opportunity to consider the issue. The Supreme Court thus did not determine that the ban was compatible with Article 8 of the ECHR. Insofar as members of the minority expressed their views on the ban's compatibility, such musings constitute *obiter* given that they determined that the Court lacked the competence to consider the issue of compatibility. The decision of the Supreme Court in *Nicklinson* thus did not foreclose a finding of a breach of the ECHR itself.

A second, and perhaps more significant issue with the High Court's decision to adopt a *Re G* examination of Mr Conway's complaint lies in the fact that that decision seemingly emboldened the Court to depart from the relevant case law of the Supreme Court and the ECtHR and expand the list of legitimate aims which the ban allegedly seeks to secure. In addition to protecting vulnerable individuals, the High Court accepted the submission of the State that the ban's legitimate aims included 'respect for the sanctity of life and promotion of trust between patient and doctor in the care relationship.'³¹¹ The Court clarified that promotion of trust between patient and doctor is secured by 'reinforcing the ethical standards applied by doctors, so that patients get and have the confidence to make use of the best advice and treatment available.'³¹² As counsel for the State and the Divisional High Court itself noted, neither the Supreme Court in *Nicklinson* nor the ECtHR in *Pretty* considered such objectives to be legitimate aims of the ban. Neither decision involved an assessment of whether such objectives could appropriately be considered legitimate aims of the ban, nor did they examine whether the ban was necessary and proportionate to securing those objectives. Somewhat ironically, perhaps, a consequence of the High Court's expansion of the ban's legitimate aims is that, insofar as the additional objectives specified by the High Court in *Conway* can be said to be 'legitimate aims' for the purposes of Article 8(2) of the ECHR, the question of whether the ban is proportionate to those aims remains at large and Mr Conway's complaints ought to have been considered under the ECHR itself as opposed to a *Re G* assessment under domestic law. This, in turn, enlarges the bases upon which the ban could be said to be incompatible with Article 8 and raises the possibility of a successful complaint to the ECtHR on the basis that the ban does, in fact, violate the ECHR because the blanket ban remains disproportionate to the objective of protecting vulnerable individuals (as found by Lady Hale and Lord Kerr in *Nicklinson*) and it is not necessary to secure the additional objectives.

³¹¹ *Conway* (Court of Appeal) (n 7) [201].

³¹² *Conway* (n 7) [47].

This in turn begs the question whether the new objectives are, in fact, legitimate aims for the purposes of Article 8(2) of the ECHR. Turning first to the ‘promotion of the doctor and patient relationship’, the Divisional High Court considered that such an objective could be characterised as the ‘protection of morals’, ‘protection of health’ and ‘protection of the rights and freedoms of others’. It is unclear how promotion of the doctor and patient relationship could be characterised as the protection of morals which has ‘usually been interpreted as a synonym of sexual morality.’³¹³ Insofar as ‘morals’ extends beyond sexual morality, it has been cited as a justification for the Republic of Ireland’s ban on abortion; it was argued in *A, B and C v Ireland* that the ban on abortion was necessary for the purpose of protecting morals ‘of which the protection in Ireland of the right to life of the unborn was one aspect.’³¹⁴ It is difficult to see how promotion of the doctor and patient relationship falls within the protection of morals beyond the claim that criminalising assistance of suicide by doctors protects the sanctity of life, which the High Court recognised as a discrete aim pursued by the ban. Rather, promotion of the doctor/patient relationship most cogently falls within the objective of either protecting the rights of others or the protection of health. Indeed, the High Court seemingly accepted as much when it described the ‘aim’ of promoting trust between a doctor and patient in the following terms:

The evidence before us shows that there is a real concern amongst doctors and a real risk that if the prohibition against assistance for suicide were relaxed, patients (particularly vulnerable and elderly patients) would have less confidence in their doctors and the advice they might give. This could well have deleterious consequences on the extent to which patients are willing to share information about their conditions freely with their doctors and the extent to which patients would be willing to accept and act upon medical advice given to them. Both these things would tend to *undermine the quality and efficacy of medical treatment made available to them.*³¹⁵

Plainly, insofar as promotion of trust between doctors and patients is a legitimate aim for the purposes of Article 8(2) of the ECHR, it is because it protects the rights of individuals to quality and efficacious medical treatment or, in Article 8(2) terms, because it protects the rights of others and/or it protects health, as opposed to the protection of morals.

³¹³ Ivana Roagna, ‘Protecting the right to respect for private and family life under the European Convention on Human Rights’ Council of Europe human rights handbooks (Council of Europe 2012) 43.

³¹⁴ *A, B and C v Ireland* (2011) 53 EHRR 13 [222].

³¹⁵ *Conway* (n 7) [94].

Whether a blanket ban is, in fact, necessary to secure such an objective is a separate issue which will be considered below.

As for the finding that the ban also secures the legitimate aim of the protection of the sanctity of life and, thus, the protection of morals, there is no doubt that, insofar as a society values the sanctity of life, it constitutes society's morals for the purposes of Article 8(2) of the ECHR (as argued in *A, B and C v Ireland* and, more recently, in the *Northern Ireland Abortion Case*). The question, however, is whether it can properly be said that English society values the sanctity of life over all other competing values. It is in this respect that the observations of Lady President Hale in *Nicklinson* assume significance, especially that '[r]espect for individual autonomy and human dignity are also important moral principles. *The very complexity of the moral argument, amply demonstrated in the material before this court, tells against relying upon [the sanctity of life as manifestation of the protection of morals] as the legitimate aim of the legislation.*'³¹⁶

It bears noting that these observations of Lady Hale were overlooked by the Divisional High Court and the Court of Appeal in *Conway* in favour of extracts from Lord Sumption's reasons, even though Lord Sumption did not examine the ban's compatibility with Article 8 of the ECHR. Beyond the issues with prioritising equally weighty values identified by Lady Hale, as Lord Kerr noted in *Nicklinson*, significant doubt attends the issue of whether 'the sanctity of life [is] protected or enhanced by insisting that those who freely wish to but are physically incapable of bringing their lives to an end, should be required to endure untold misery until a so-called natural death overtakes them'.³¹⁷ Moreover, polls of the public and doctors indicate increasing support of assisted suicide. In a 2015 Populus study of 5018 people, 4 out of 5 of those surveyed supported Lord Falconer's Bill which contemplated affording terminally ill, incapacitous, individuals the right to obtain assistance in dying by suicide.³¹⁸ As for the medical profession, recent research suggests that the position of doctors – insofar as it is possible to characterise such a diverse group so homogeneously – with respect to assisted dying is far more nuanced than that reflected in the reasons of the High Court in *Conway* in which it was said that 'there is a real concern amongst doctors ... that if the prohibition against assistance for suicide were relaxed, patients (particularly vulnerable and elderly patients) would have less confidence in their

³¹⁶ *Nicklinson* (n 7) [311] (emphasis added).

³¹⁷ *ibid* [357].

³¹⁸ Populus, 'Dignity in Dying poll' (March 2015) <<http://www.populus.co.uk/wp-content/uploads/2015/12/DIGNITY-IN-DYING-Populus-poll-March-2015-data-tables-with-full-party-crossbreaks.compressed.pdf>> accessed 31 July 2019.

doctors and the advice they might give.³¹⁹ Certainly, there is concern amongst doctors. But, there is also support for physician assisted suicide. A 2017 poll of over 700 doctors indicated that 55 per cent were in favour of allowing assisted suicide.³²⁰ Indeed, a recent poll of 6885 members of the Royal College of Physicians (from over 30 specialities) revealed increasing support amongst members for permitting assisted suicide which, significantly, led the College to adopt a position of neutrality with respect to assisted suicide in place of its erstwhile negative position. While the proportion of physicians who considered that the College should be opposed to a change in the law remained relatively consistent (43.4 per cent in 2014 versus 44.4 per cent in 2019) the percentage of members in favour of the College supporting a change to s 2 to allow assisted dying rose significantly from 24.6 to 31.6 per cent. The neutral position arose as 25 per cent of members thought the College's position should be neutral, thus 56.6 per cent of members were in favour or neutral on the question of permitting assisted suicide. The survey also asked the physicians for their personal views on a change to the law. Those supporting a change rose from 32.3 per cent in 2014 to 40.5 per cent in 2019 while those personally against fell from 57.5 per cent to 49.1 per cent.³²¹ Such evidence demonstrates that the public and the medical profession value autonomy, self-determination and dignity as well as the sanctity of life. This, in turn, supports the contention that the 'protection of morals', insofar as that refers to protecting the sanctity of life, should not be relied upon as a 'legitimate aim' of the blanket ban. The legitimacy of the aim of protecting the sanctity of life, as a manifestation of the protection of morals, is, thus, questionable.

The preceding analysis has highlighted several fundamental issues with the High Court's reasoning in *Conway* with respect to the ban's additional 'legitimate aims'. Assuming, however, for the purposes of the instant inquiry that the aims identified by the High Court (and accepted, at least implicitly, as valid by the Court of Appeal and unchallenged by the Supreme Court in its reasons rejecting the appeal)³²² in *Conway* are 'legitimate', the ensuing discussion will consider whether the blanket ban is 'necessary' in order to secure such aims

³¹⁹ *Conway* (n 7) [94].

³²⁰ Jacky Davis, 'Most UK doctors support assisted dying, a new poll shows: the BMA's opposition does not represent members' (2018) *BMJ* 360.

³²¹ Royal College of Physicians, 'No majority view on assisted dying moves RCP position to neutral' (21 March 2019) <<https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral>> accessed 31 July 2019.

³²² *Conway* (Court of Appeal) (n 7) [201]. See, also, *Conway* (Supreme Court) (n 8) [6]: 'several justifications have been put forward to support a hard and fast rule – the protection of weak and vulnerable people from insidious pressures, respect for the sanctity of all human life, and the preservation of trust and confidence in the medical profession'.

as well as the recognised legitimate aim of protecting individuals vulnerable to undue pressure.

3.3. ‘Necessary in a democratic society’

As with the legality requirement of Article 8(2), the courts (both domestic and Strasbourg) have examined the scope and content of the ‘necessity requirement’ in considerable detail. According to the Supreme Court, the necessity requirement ‘implies a *pressing social need* and requires that [the challenged] measure ... be *proportionate to the legitimate aim* pursued ... *Proportionality involves striking a fair balance between the interests of the individual and those of the community as a whole.*³²³

The Grand Chamber of the ECtHR described the necessity requirement – and the attendant function of the margin of appreciation – in the following terms:

An interference will be considered ‘necessary in a democratic society’ for a legitimate aim if it answers a *‘pressing social need’* and, in particular, if it is *proportionate to the legitimate aim pursued* and if the *reasons adduced by the national authorities to justify it are ‘relevant and sufficient’*...

While it is for the national authorities to make the *initial assessment* in all these respects, *the final evaluation of whether the interference is necessary remains subject to review by the court for conformity with the requirements of the convention. A margin of appreciation must be left to the competent national authorities in this assessment.* The breadth of this margin varies and depends on a number of factors including the nature of the convention right in issue, its importance for the individual, the nature of the interference and the object pursued by the interference...³²⁴

The domestic courts have clarified what is required for an interference with Article 8 to be necessary in a democratic society. In *Nicklinson*, Lord Kerr described the ‘test to be applied’ in such cases in the following manner (given its significance to the instant examination, it will be quoted in full, including references):

Justification of interference with a right to bring intolerable suffering to an end *must be of a different order from that which will be required to warrant intervention in most species of article 8 rights.* One should not fail to confront the stark reality of this. *The appellants*

³²³ R (ZH and CN) v *Lewisham London Borough Council* [2015] AC 1259, [2014] UKSC 62 [62] (citations omitted and emphasis added).

³²⁴ *Fernandez Martinez* (n 159) [124]-[125] (emphasis added).

are condemned to a life bereft of pleasure or quality. They live in the knowledge of the distress that their condition and their own misery causes to those close to them.

The nature of the interference in this case is not in dispute, and the test for whether it is justified is set out in the decisions of the House of Lords in *Huang v Secretary of State for the Home Department* [2007] 2 AC 167 and of this court in *R (Aguilar Quila) v Secretary of State for the Home Department* [2012] 1 AC 621. In the latter case, Lord Wilson said at para 45:

‘... In *Huang v Secretary of State for the Home Department* [2007] 2 AC 167, Lord Bingham of Cornhill suggested, at para 19, that in such a context four questions generally arise, namely: (a) is the legislative objective sufficiently important to justify limiting a fundamental right?; (b) are the measures which have been designed to meet it rationally connected to it?; (c) are they no more than are necessary to accomplish it?; and (d) do they strike a fair balance between the rights of the individual and the interests of the community? ...’³²⁵

Other members of the *Nicklinson* Supreme Court described the test in similar terms, citing both *Aguilar* and *Huang*,³²⁶ while Lord Mance described the test to be applied by reference to the Court’s decision in *Bank Mellat v HM Treasury (No 2)*:

The main justification advanced for an absolute prohibition on assisting suicide, even in cases as tragic as Mr Nicklinson’s and Mr Lamb’s, is the perceived risk to the lives of other, vulnerable individuals who might feel themselves a burden to their family, friends or society and might, if assisted suicide were permitted, be persuaded or convince themselves that they should undertake it, when they would not otherwise do so. The relevant measure is the prohibition, which on this basis has a legitimate aim. Whether it is rationally connected to that aim depends upon the existence of the perceived risk. Whether it is necessary depends upon whether a lesser measure would have achieved, or at least not “unacceptably” have compromised, the aim. Whether it is proportionate depends upon identifying what

³²⁵ *Nicklinson* (n 7) [336]-[337] (Lord Kerr).

³²⁶ *ibid*, for instance, [80]ff (Lord Neuberger), [171] (Lord Mance), and, [310] (Lady Hale). Citing *R (Aguilar Quila) v Secretary of State for the Home Department* [2012] 1 AC 621, [2011] UKSC 45 and *Huang v Secretary of State for the Home Department* [2007] 2 AC 167, [2007] UKHL 11.

the measure achieves and balancing this against the consequences for other interests...³²⁷

Each of the nine members of the *Nicklinson* Supreme Court delivered separate reasons in which they applied the ‘test’ to varying extents and with differing outcomes:

- Lord Clarke, Lord Sumption, Lord Reed and Lord Hughes considered that the nature of the subject matter and, in particular, its moral complexity, rendered it ‘institutionally [in]appropriate’ for the Court to consider the compatibility of the ban with the ECHR,³²⁸
- Lord Neuberger, Lord Mance and Lord Wilson determined that while the Court *could* consider the ban’s compatibility with the ECHR, ‘it was such a controversial issue’ that it was institutionally inappropriate to issue a declaration without first giving Parliament the opportunity to (re)consider the issue;³²⁹ and, finally,
- Lady Hale and Lord Kerr proceeded to examine the compatibility of s 2 of the Suicide Act 1961 with Article 8 of the ECHR and, having done so, determined that the blanket ban was incompatible and would have issued declarations to that effect under s 4 of the HRA 1998.

The majority Supreme Court thus did *not* consider the ban’s compatibility and certainly did not issue a determination with respect to the compatibility of the ban with Article 8 of the ECHR. The absence of a finding of incompatibility cannot be used as proof of its corollary: the majority did *not* conclude that the ban was *compatible* with Article 8. Indeed, Lord Neuberger was unable to reach a conclusion with respect to the third and fourth elements of the proportionality test and any determination that the ban was compatible with Article 8 would depend on a positive finding with respect to *all* aspects of the proportionality test.³³⁰ If there is any assumption, it must be that the interference which the ban poses to the right to private life is unjustified. Since it is accepted that the ban poses an interference

³²⁷ *Nicklinson* (n 7) [171] citing *Bank Mellat v HM Treasury (No 2)* [2014] AC 700, [2013] UKSC 39.

³²⁸ Although, as Elizabeth Wicks has identified, it is arguable that Lord Sumption and Lord Clarke were less fervent in their view that this was (and would always remain) solely the concern of Parliament; the separate judgments of each of their Lordships make reference to the possibility of the Court having a role to play should Parliament ‘abdicate’ its responsibility (Lord Sumption) by ‘choos[ing] not to debate these issues’ (Lord Clarke). See, Elizabeth Wicks, ‘The Supreme Court judgment in *Nicklinson*: One step forward on assisted dying; two steps back on human rights’ (2015) 23 *Medical Law Review* 144, 147-8 citing *Nicklinson* (n 7) [233] (Lord Sumption) and [293] (Lord Clarke).

³²⁹ Lord Neuberger, ‘The Supreme Court and the Rule of Law’ (The Conkerton Lecture, Liverpool, October 2014) <<https://www.supremecourt.uk/docs/speech-141009-lord-neuberger.pdf>> accessed 31 July 2019.

³³⁰ *Nicklinson* (n 7) [120] (Lord Neuberger).

with the Article 8 right of some individuals such as Diane Pretty, Tony Nicklinson and Noel Conway, the burden was thus on the State to justify that interference. In the absence of a finding with respect to the ban’s justifiability by the majority, the ban remains *unjustified*. As the following will demonstrate, when the proportionality test *is* applied to the blanket ban, the inescapable conclusion is that the ban is *disproportionate* and, thus, incompatible with Article 8 as found by both Lady Hale and Lord Kerr.

3.3.1 *Section 2 of the Suicide Act and the domestic proportionality test*

3.3.1.1 *Sufficiently important objective?*

There can be little doubt that protecting individuals vulnerable to undue influence, protecting the doctor/patient relationship, and, protecting the sanctity of life, are sufficiently important objectives to justify interfering with certain rights. Greater dispute, however, attends the question of whether the ban on assisting suicide is ‘rationally connected’ to those objectives.

3.3.1.2 *Rational Connection?*

a. Protecting ‘vulnerable individuals’

As Figure 1 demonstrates, the ban covers *everyone* in society, even though only a very small number of people (Group B) require protection (precise figures are elusive given the subjectivity of ‘vulnerability’, although it is highly likely that, were Figure 1 to reflect the numbers of individuals in each group, Groups B and D would be considerably smaller than Groups A and C). More significantly, the ban does not prevent people in Group A (i.e. those who are vulnerable to pressure but are nonetheless able to die by suicide without assistance) from taking their own lives by way of suicide as a result of undue influence. The question, then, is whether the ban, which covers all groups, including those who are not vulnerable, can be said to be ‘rationally connected’ to its objective, namely the protection of those individuals in Group B.

| | |
|---|---|
| Group A Vulnerable but physically capable of suicide | Group B Vulnerable and physically incapable of suicide |
| Group C Not vulnerable and physically capable of suicide | Group D Not vulnerable but physically incapable of suicide |

Figure 1: All individuals are caught by the ban, while the ban’s objective is only directed at protecting those in Group B (highlighted yellow).

Arguably, a blanket ban (i.e. one which covers everyone) will, because of its breadth, be ‘rationally connected’ to the objective. Ostensibly, it prevents everyone, including those who are vulnerable, from being assisted to die by suicide and, as such, is ‘rationally connected’ to the objective of protecting vulnerable individuals. Whether the ban does in fact protect such individuals is a separate issue and one which will be explored in greater detail below. For now, it is sufficient to note that while the connection between the ban and its objective may be ‘tenuous’, ‘in general terms ... a blanket ban on assisting suicide will protect the weak and vulnerable’.³³¹

There is, however, an alternative view which was articulated by Lord Kerr. His Lordship held that there was *no* rational connection on the basis that ‘[i]t is reasonable to assume that this “vulnerable class of persons” [which the ban is said to be aimed at protecting] is composed of persons who are physically able to commit suicide. Why should they feel more vulnerable because those who cannot do so are enabled to bring their lives to an end?’³³² Lord Kerr thus took a more holistic approach to the examination of rational connection and combined Groups A and B into one monolithic group: the ‘vulnerable class of persons’ which comprised both those capable of bringing about their own death and those who were incapable (see Figure 2 below).

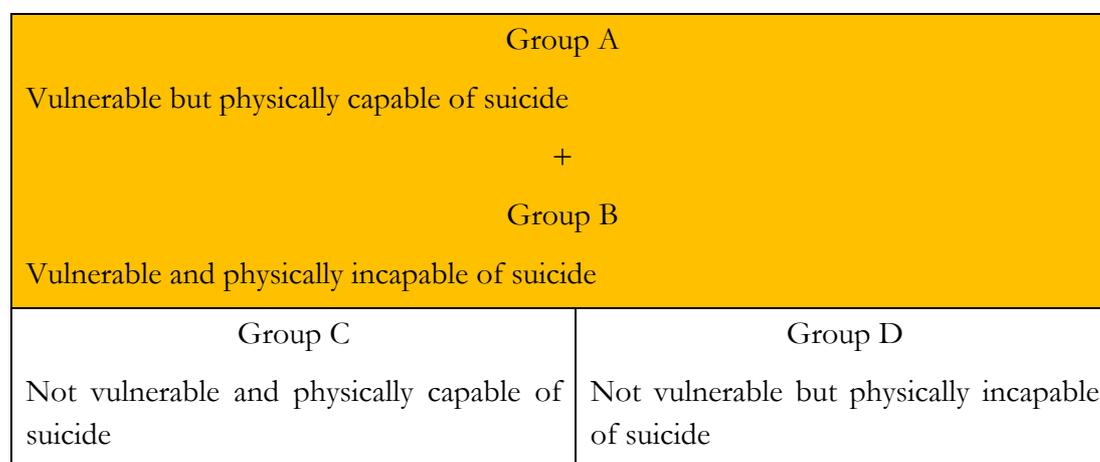


Figure 2: Lord Kerr’s conceptualisation of the ban’s rational connection.

When examined from this perspective, Lord Kerr’s conclusion has some appeal: the State provided no evidence that permitting Group D to access assistance in dying by suicide would increase the risk of pressure on Group A save for a bald statement to that effect³³³

³³¹ *Nicklinson* (n 7) [85] (Lord Neuberger). Lord Neuberger also considered that ‘section 2 is a somewhat indirect and blunt instrument in that it is, as a matter of practice, aimed at those who need assistance in committing suicide rather than those who are weak and vulnerable’ (ibid).

³³² *Nicklinson* (n 7) [350] (Lord Kerr).

³³³ The absence of evidence should not, however, suggest an absence of argument. The claim that permitting assisted suicide would lead to a change in society’s norms such that individuals who are vulnerable but

and, when that group is included with Group B – i.e. a monolithic ‘vulnerable’ group comprising both those capable and incapable of dying by suicide without assistance – it is easier to dismiss the alleged rational connection between the ban and that monolithic, vulnerable class of persons.

However, such an approach seems to have greater force with respect to the ban’s proportionality, as included within the monolithic ‘vulnerable’ group are – at least potentially – individuals who are incapable of dying by suicide without assistance *and* who are vulnerable to undue influence (i.e. Group B). The sheer breadth of the *blanket* ban, and the corresponding scope of the people ‘caught’ by it, presents a fairly decisive reply to any contention that it is not rationally connected to the objective of protecting ‘vulnerable’ people. Insofar as the connection depends on the existence of a ‘perceived risk’,³³⁴ any contention that the blanket ban is not rationally connected to protecting Group B from being pressured into taking their lives is difficult to sustain, even if the connection is highly ‘tenuous’ and even when Groups A and B are combined. Nonetheless, the ‘fairly weak connection’ between the ban and its objective is ‘not irrelevant when one turns to [the third and fourth] requirements’ of the proportionality analysis.³³⁵

b. Additional objectives post-*Conway*

It is arguable that there is a rational connection between a blanket ban on assisted suicide and promoting the sanctity of life provided ‘sanctity of life’ is taken to refer to the fact of life itself, as distinct from qualitative considerations. If, however, ‘sanctity of life’ is taken to have a meaning consistent with that espoused by Lord Kerr in *Nicklinson*, greater doubt attends the question of whether there is a rational connection between a ban that precludes capacitous individuals with terminal or degenerative conditions from suiciding with assistance and promoting the sanctity of life. As Lord Kerr queried ‘is the sanctity of life protected or enhanced by insisting that those who freely wish to but are physically incapable of bringing their lives to an end, should be required to endure untold misery until a so-called natural death overtakes them?’³³⁶

capable of suiciding without assistance would feel increased pressure to do so, has featured in both the Parliamentary debates and litigation challenging s 2 of the Suicide Act 1961. See, for instance, Select Committee on Medical Ethics (n 19) [26], [239] and, more recently, HC Deb 4 July 2019 (n 11) cols 1426, 1440. See, also, *Nicklinson* (n 7) [50] (Lord Neuberger).

³³⁴ *Nicklinson* (n 7) [171] (Lord Mance).

³³⁵ *ibid* [111] (Lord Neuberger).

³³⁶ *Nicklinson* (n 7) [357] (Lord Kerr).

Yet, as Lord Kerr himself recognised, questions regarding the appropriate characterisation of the ‘sanctity of life’ and whether, in fact, it is secured by a blanket ban on assisted suicide are more appropriately considered when examining whether the ban strikes a fair balance between competing interests. For now, then, it is sufficient to observe that a ban which covers all individuals and, thus, at least ostensibly ‘protects’ all forms of life from assisted suicide – regardless of their character and/or quality – is arguably ‘rationally connected’ to the objective of protecting morals by virtue of promoting the sanctity of life.

As for whether the ban is rationally connected to promoting the doctor/patient relationship, there is evidence to suggest that allowing terminally ill patients the freedom to openly discuss their end of life care by permitting physician assisted suicide better promotes trust between patients and doctors since it ensures an open and honest dialogue.³³⁷ It also has the potential to redirect power *away* from doctors and back to the patients given that they are legally permitted to make plans (and, in some jurisdictions, including England and Wales, advance directives) with respect to when their life-sustaining treatment should be ceased. That power and control has led some researchers to conclude that allowing physician assisted suicide promotes a healthier relationship between doctors and patients.³³⁸ There is, then, scope for the argument that a blanket ban on assisted suicide is not, in fact, rationally connected to the promotion of the doctor/patient relationship. There is also, however, a consistent line of argument that allowing doctors to take steps to bring about their patients’ deaths is the antithesis to their role and contrary to the Hippocratic oath.³³⁹ And, as with every system based on human assessment, there is always a risk that a doctor will act, whether with *mala fides* or not, in a way that is deleterious to a patient’s interests. There is, then, a ‘perceived risk’ that allowing assisted suicide will undermine the doctor/patient relationship and, consequently, the ban can be said to be ‘rationally connected’ to the objective of promoting the relationship between doctors and patients (i.e. protection of health or the rights of others). Whether a *blanket* ban is necessary to secure that objective is an entirely separate question.

³³⁷ See, for instance, Ina Otte, Corinna Jung, Bernice Elger and Klaus Bally, “‘We need to talk!’ Barriers to GPs’ communication about the option of physician-assisted suicide and their ethical implications: results from a qualitative study” (2017) 20 *Medicine, Health Care and Philosophy* 249.

³³⁸ *ibid.*

³³⁹ See, for instance, Richard Momeyer, ‘Does Physician Assisted Suicide Violate the Integrity of Medicine?’ (1995) 20 *Journal of Medicine and Philosophy* 13; Cheryl Smith, ‘What about Legalised Assisted Suicide?’ (1992-93) 8 *Issues in Law and Medicine* 503.

3.3.1.3 No less restrictive alternative available?

The third stage of the domestic proportionality test ‘asks whether the aim could have been achieved without significant compromise by some less intrusive measure?’³⁴⁰ That is, is the measure in its current iteration ‘necessary’, which depends on ‘whether a lesser measure would have achieved, or at the least not, “unacceptably” have compromised, the aim.’³⁴¹

a. Protecting vulnerable individuals

According to the majority in *Nicklinson*, in order for the ban to be considered *disproportionate*, the Court would have to be satisfied that there was:

[A] physically and administratively feasible and robust system whereby [individuals] could be assisted to kill themselves, and that the reasonable concerns expressed by the Secretary of State (particularly the concern to protect the weak and vulnerable) were sufficiently met *so as to render the absolute ban on suicide disproportionate*.³⁴²

Such a contention is wholly inconsistent with the principles underpinning Article 8 of the ECHR. Once an applicant has demonstrated that a measure interferes with a right protected by the ECHR, if that right is qualified (as is the case with Article 8) the onus shifts to the State to prove that the interference is justified.³⁴³ It is accepted, following the ECtHR decision in *Pretty* and subsequent case law,³⁴⁴ that the blanket ban on assisted suicide in s 2 of the Suicide Act 1961 constitutes an interference with the right to private life protected by Article 8(1) of the ECHR. That being the case, the onus is on the State to demonstrate that the ban is in accordance with law and necessary in a democratic society. Insofar as the requirement espoused by the majority in *Nicklinson* to prove a ‘physically and administratively feasible and robust system’ suggests that the onus is on the *applicant* alleging incompatibility to establish that there is a less restrictive means available, it is plainly erroneous.

The *State* bears the onus of proving that the interference is, *inter alia*, proportionate and this includes establishing to the requisite standard of proof that the objective could not

³⁴⁰ *Nicklinson* (n 7) [171] (Lord Mance).

³⁴¹ *ibid.*

³⁴² *Nicklinson* (n 7) [120] (Lord Neuberger) (emphasis added). See, also, [201] (Lord Wilson) and [188] (Lord Mance).

³⁴³ See, generally, *Parillo v Italy* App no 46470/11 (ECtHR, 27 August 2015); *Biao v Denmark* App no 38590/10 (ECtHR, 24 May 2016); *Mozer v The Republic of Moldova and Russia* (Grand Chamber) App no 11138/10 (ECtHR, 23 February 2016). See, also, for instance, Mary Arden, *Human Rights and European Law: Building New Legal Orders* (OUP 2015), 36; David Hoffman and Jermyn Rowe, *Human Rights in the UK: An Introduction to the Human Rights Act 1998* (3rd edn, Pearson Education Limited 2010), 116.

³⁴⁴ See, for instance, *Koch* (n 174); *Gross v Switzerland* (2014) 58 EHRR 7; *Haas* (n 66).

‘have been achieved without significant compromise by some less intrusive measure.’³⁴⁵ Where the evidence is insufficient to enable a finding of proportionality in accordance with the domestic proportionality test,³⁴⁶ the State has plainly failed to discharge its onus and the interference which the ban poses to the Article 8 right to choose the manner and timing of one’s death remains unjustified. Any suggestion that the applicants bear responsibility for ‘meeting’ the concerns of the State when the State has failed to meet its burden of proving that the ban was proportionate in the first place patently lacks merit; there is no presumption of compatibility, no matter how wide the margin of appreciation. And, while the margin of appreciation affords a degree of latitude to the State in determining whether a measure is necessary, the courts including, ultimately, the ECtHR, retain responsibility for making a ‘final evaluation’ of whether the interference is, in fact, necessary.³⁴⁷ Indeed, ‘the approach of the ECtHR to the question of what margin of appreciation member states should be accorded is not mirrored by the exercise which a national court is required to carry out in deciding whether an interference with Convention rights is justified’ which reaffirms the role of the domestic courts in ascertaining whether the ban is justified.³⁴⁸ In sum, the blanket ban must be *intrinsically* proportionate: ‘If it is disproportionate measured by *its* capacity to achieve its *own purpose*, it cannot be saved from that condition by the claim that a less intrusive restriction that would have excluded the appellants has not been articulated.’³⁴⁹ Further, imposing on applicants challenging the ban’s compatibility the obligation to provide evidence of a ‘fully-formed, guaranteed-to-function, less intrusive means of achieving the objective’ ‘would herald a significant circumscription of the operation of the principle of proportionality generally.’³⁵⁰

Even if the requirement on the applicants to prove a ‘fully-formed, guaranteed-to-function, less intrusive means of achieving the objective’ were valid, it cannot be permissible to require applicants to prove that a less intrusive alternative is ‘guaranteed-to-function’ when the current measure is not itself ‘guaranteed-to-function’. Notwithstanding the ban, people *are* taking their lives with assistance, both domestically and overseas. As Lord Mance acknowledged in *Nicklinson*, ‘it may be argued that the current blanket prohibition is

³⁴⁵ *Nicklinson* (n 7) at [171], per Lord Mance.

³⁴⁶ As was the case for Lord Neuberger, Lord Mance and Lord Wilson in *Nicklinson* (n 7). See, for instance, *Nicklinson* (n 7) [120] (Lord Neuberger).

³⁴⁷ *Fernandez Martínez* (n 159) [125].

³⁴⁸ R (*On the application of Steinfeld and Keidan*) v Secretary of State for International Development [2018] 1 WLR 415, UKSC 32 [28]. See, also, *Re G* (n 239) [118]: ‘the doctrine of the “margin of appreciation” as applied by Strasbourg has no application in domestic law.’

³⁴⁹ *Nicklinson* (n 7) [354] (Lord Kerr) (emphasis added).

³⁵⁰ *ibid.*

unnecessary or disproportionate. The present position is that some persons (whether or not capable of committing suicide unaided) are assisted to do so (unlawfully though it be) without any such prior review [of their vulnerability].³⁵¹ The fact that people are already taking their lives by suicide with assistance was also recognised by Lord Neuberger, who observed that ‘between 1998 and 2011, a total of 215 people from the UK used [Dignitas’s] services, and ... nobody providing assistance in that connection has been prosecuted.’³⁵² Similarly, Lord Hope noted in *Purdy* that:

A number of other people have already made the journey to countries where assisted suicide is lawful, and those who have assisted them have not been prosecuted. Your Lordships were told that by the time of the hearing [2 June 2009] there had been 115 such cases. Of those cases only eight had been referred to the Director for a decision as to whether or not the assistants should be prosecuted. In all but two of them the decision not to prosecute had been taken on the ground that there was insufficient evidence.³⁵³

Records indicate that, as at 2018, over 400 British members of Dignitas have been ‘accompanied’ to a clinic in Switzerland where they have subsequently died by suicide with assistance.³⁵⁴ These figures only cover those individuals who were accompanied to a Dignitas clinic in Switzerland. They do not include the numbers of individuals using other bodies in Switzerland which provide assistance to non-citizens to die nor do they cover the numbers of people who are assisted to suicide in England and Wales. As the sentencing judge in *Desai* made abundantly clear, there are cases which might otherwise fall within the remit of s 2 of the Suicide Act 1961 or, indeed, constitute murder, which are not (properly, in his Honour’s opinion based on CPS practice) prosecuted. Indeed, as outlined above, the latest statistics from the CPS reveal that while 152 cases have been referred by police as assisted suicides, only three cases have been ‘successfully prosecuted’ under s 2.³⁵⁵ Plainly, a very significant number of cases which are classified as assisted suicide are not prosecuted (at least 86 per cent of the cases referred). People are, thus, being assisted to varying extents to die by suicide both domestically and internationally, notwithstanding the ban.

In addition to the fact that the ban does not stop people dying by suicide with assistance, there are fundamental problems with the way in which the ban allegedly achieves the

³⁵¹ *Nicklinson* (n 7) [186] (Lord Mance).

³⁵² *ibid* [48] (Lord Neuberger).

³⁵³ *Purdy* (n 7) [30] (Lord Hope).

³⁵⁴ *Dignitas* (n 6).

³⁵⁵ CPS (n 248).

objective of protecting vulnerable individuals. Given the ban, the only ‘formal’ assessment of vulnerability that occurs in cases of individuals dying by suicide with assistance in England and Wales is an *ex post facto* examination undertaken by police and possibly the CPS in those cases which come to their attention and, in the even fewer number of cases that are prosecuted, the courts. Such a system plainly does not protect vulnerable individuals. And while clinics in Switzerland such as Dignitas have their own processes in place to protect vulnerable individuals (individuals seeking assistance must make a ‘reasoned request’)³⁵⁶ there is no oversight beyond the organisation’s own internal procedures (the position in the Benelux jurisdictions is different for a number of reasons including the fact that there are regulatory bodies which provide an additional layer of, *ex post facto*, oversight). The ban in England and Wales thus precludes an examination of the individual’s capacity and whether they are acting as a result of undue pressure *before* they suicide. What the preceding reveals in stark detail is that, notwithstanding the blanket ban on assisted suicide, people *are* dying by suicide with assistance both in England and Wales and overseas. And in those cases, it is not possible to determine with certainty if any were vulnerable to the pressure which the ban is said to be necessary to protect against or, indeed, how many were acting because of that pressure since, at least in England and Wales, no independent individuals or bodies are tasked with assessing the specific individual’s reasons and competence *before* they die. Leaving aside its dubious legal validity, the unfairness of expecting applicants challenging the compatibility of the ban with the ECHR to provide evidence of a ‘guaranteed-to-function’ alternative to a ban which is not, itself, ‘guaranteed-to-function’ is manifest.

Even if the apparent need to prove a fully formed alternative was valid, there is nothing to suggest that the vulnerability which the ban is said to be directed at could not be protected against by the medical profession which is well accustomed to dealing with vulnerable patients, including when providing end-of-life care. To examine this issue in detail it is first necessary to determine what the ‘vulnerability’ is which the State contends can only be protected against by way of a blanket ban. The following extract from Lord Sumption’s judgment in *Nicklinson* aptly describes that vulnerability:

³⁵⁶ There is also an ‘in-depth evaluation of the member’s written request and medical information’ and ‘at least two face-to-face meetings with the member’: Dignitas, ‘Brochure of Dignitas: Legal assistance for suicide with Dignitas’ <http://dignitas.ch/index.php?option=com_content&view=article&id=22&Itemid=62&lang=en> (accessed 31 July 2019).

The problem is not that people may decide to kill themselves who are not fully competent mentally. I am prepared to accept that mental competence is capable of objective assessment by health professionals. The real difficulty is that even the mentally competent may have reasons for deciding to kill themselves which reflect either overt pressure upon them by others or their own assumptions about what others may think or expect. The difficulty is particularly acute in the case of what the Commission on Assisted Dying called ‘indirect social pressure’. This refers to the problems arising from the low self-esteem of many old or severely ill and dependent people, combined with the spontaneous and negative perceptions of patients about the views of those around them ... It is one thing to assess some one’s mental ability to form a judgment, but another to discover their true reasons for the decision which they have made and to assess the quality of those reasons. I very much doubt whether it is possible in the generality of cases to distinguish between those who have spontaneously formed the desire to kill themselves and those who have done so in response to real or imagined pressure arising from the impact of their disabilities on other people.

Leaving aside the fact that an increasing number of jurisdictions (including those with rights documents which enshrine the right to life) have determined that it *is* possible to distinguish between those cases in which the ‘desire’ to kill oneself has arisen free from pressure and those in which the desire is a ‘response to real or imagined pressure arising from the impact of their [condition] on other people’, the more pressing flaw in Lord Sumption’s reasons concerns the fact that that assessment is central to the existing end-of-life ‘system’ in England and Wales. However, instead of being able to directly question the individual seeking assistance to suicide and test their motives *before* they die – as occurs when a capacitous individual seeks withdrawal of/refuses life-sustaining treatment – the blanket ban on assisted suicide restricts the police, CPS and courts to an *ex post facto* examination of the evidence which, in the vast majority of cases, is unlikely to involve evidence of the sort obtained by doctors and other professionals in those jurisdictions which permit assisted suicide and, thus, involve an *ex ante facto* examination of the individual’s motives.³⁵⁷ Arguably then, the fears of Lord Sumption – which sit at the core of the opposition to permitting assisted suicide³⁵⁸ – are misplaced. Plainly, a system which entails direct assessment of the individual seeking assistance, including their reasons for

³⁵⁷ See, for instance, Victoria’s Voluntary Assisted Dying Act 2017, Divisions 4-6.

³⁵⁸ As summarised in Keown (n 16).

wanting to die, is better able to achieve the aim of protecting potentially vulnerable individuals than the present situation. Certainly, an *ex ante facto* assessment of the individual by appropriately qualified professionals would be more likely to identify those who are vulnerable to undue pressure than an *ex post facto* assessment which, even if it were to reveal that the individual was acting as a result of undue influence, has patently failed to protect them.

Moreover, even if the fears expressed by Lord Sumption were well placed, in the absence of any evidence to the contrary, the pressure which the ban is said to protect against – namely, the ‘real or imagined pressure arising from the impact of [the individual’s condition] on other people’ – must necessarily exist for individuals who suffer from similar conditions but who are receiving life-sustaining treatment. Indeed, a person’s concerns regarding ‘the impact of their disabilities on other people’ may well inform their decision to discontinue life-sustaining treatment and must be respected by their treating physicians provided they do not reflect undue influence. The Supreme Court has confirmed that such concerns, insofar as they are discernible, must be taken into account when determining an incapacitous patient’s best interests.³⁵⁹ As was observed by Charles J in *Briggs* (which concerned withdrawal of life-sustaining treatment of an incapacitous patient):

[T]he factors that will give indications as to what the individual ... wants *include the interests of other people who [the patient] would have been likely to take into account* and so, for example, many if not most [of the patients] when they had capacity would have taken into account their relationships with others (e.g. spouse and children), how they think they their children should be parented *and the impact on those closest to them of what they decide to do.*³⁶⁰

It would be wholly unrealistic to assume that the decisions made by capacitous individuals to cease life-sustaining treatment are not, in at least some circumstances, affected by concerns regarding the impact their illness has on those around them. Indeed, as the preceding extract from *Briggs* demonstrates, such concerns, provided they can be ascertained from the available evidence, are relevant to an assessment of whether the continuation of life-sustaining treatment is in an incapacitous patient’s best interests. That being the case – that individuals who make decisions regarding life-sustaining treatment

³⁵⁹ Law Commission, *Mental Incapacity* (Law Com No 231, 28 February 1995) [3.31]: ‘altruistic sentiments and concern for others’, which formed the basis of the Mental Capacity Act 2005 and which was cited in *James* (n 111) [24].

³⁶⁰ *Briggs* (n 38) [56] (emphasis added).

may well be ‘afraid that their lives have become a burden to those around them’ or, at the least, are ‘acutely conscious that their disabilities make them dependent on others’ and are permitted to act on those concerns by refusing life-sustaining treatment – it is difficult to reconcile the fact that the law recognises (and protects) the right of capacitous patients to refuse life-sustaining treatment even if they are doing so because of concerns regarding their being a burden on others, while the blanket ban on assisted suicide is said to be directed at preventing such individuals (i.e. those acting as a result of concerns about being a burden) from acting on that concern. In the absence of any reasons not only in the case law but also in Parliamentary debate and academic literature to suggest that the former individuals are ‘less vulnerable’ than the latter, the claim that a *blanket* ban is necessary to protect the latter from acting on concerns which the former are fully entitled to act upon – including by way of bringing about their death – is dubious and paternalistic in the extreme.

In addition, vulnerability is not a novel issue in the context of medical treatment. It is a factor which is directly relevant to a doctor’s assessment of whether a patient’s consent to treatment is valid, including in situations involving withdrawal/refusal of life-sustaining treatment.³⁶¹ Voluntariness is central to informed consent: pressure that amounts to undue influence will vitiate consent for the purposes of medical treatment.³⁶² As Lord Donaldson in *Re T* observed in the context of capacity to refuse treatment:

In some cases doctors will not only have to consider the capacity of the patient to refuse treatment, but also whether the refusal has been vitiated because it resulted not from the patient’s will, but from the will of others. It matters not that those others sought, however strongly, to persuade the patient to refuse, so long as in the end the refusal represented the patient’s independent decision. If, however, his will was overborne, the refusal will not have represented a true decision. In this context the relationship of the persuader to the patient, for example, spouse, parents or religious adviser, will be important, because some relationships more readily lend themselves to overbearing the patient’s independent will than do others.³⁶³

³⁶¹ Guidance provided by the British Medical Association regarding consent provides: ‘Doctors must respect a refusal of treatment if the patient is an adult who is competent, properly informed and is not being coerced’. BMA, ‘Consent tool kit: 2 – General information’ (6 June 2016) <<https://www.bma.org.uk/advice/employment/ethics/consent/consent-tool-kit/2-general-information>> accessed 31 July 2019.

³⁶² See, for instance, *Re T* (n 30), 108.

³⁶³ *Ibid*, 116.

In the same decision, Lady Butler-Sloss noted that:

[I]t has long been recognised that an influence may be subtle, insidious, pervasive and where religious beliefs are involved especially powerful. It may also be powerful between close relatives where one may be in a dominant position vis-à-vis the other.³⁶⁴

There is, however, no presumption that certain patients are going to be subject to such influence merely because of their condition. Rather, whether influence or pressure has vitiated informed consent depends on the specific circumstances of a given patient including the source of the influence/pressure and the relationship between the patient and the influencer. Being terminally ill does not *ipso facto* render a patient ‘vulnerable’ to such influences. Doctors are required to ensure, as far as is practicable, that consent to *any* medical treatment in *any* given case has not been vitiated by undue influence. A patient may be more susceptible to such influence because of their condition. But, likewise, they may also be more susceptible because of the relationship between them and the influencer. Equally as likely is the possibility that they are not susceptible to undue influence. Regardless, doctors are required to be attuned to such influence when ascertaining whether a patient’s request to cease or their refusal of life-sustaining treatment is the result of undue influence such as to vitiate their informed consent. Presumably, then, doctors would be capable of ascertaining whether a patient’s request for assistance in dying was the result of undue influence. Certainly, doctors providing end-of-life care are already required to ensure that their patients’ consent is not vitiated by the pressure identified by Lord Sumption in the quote above.

As the preceding demonstrates, the ‘vulnerability’ which the ban is said to protect against is not unique to the assisted suicide context; it pervades medicine generally, including end-of-life care. In that context, feelings of being a burden or, more generally, concerns regarding the impact of one’s condition on family members and loved ones, have been recognised both by the courts and the medical profession, as being factors relevant to – and, thus, requiring respect when considering – a decision to cease/withdraw life-sustaining treatment. In the absence of reasons and/or evidence illustrating how individuals who seek assistance in dying by suicide are uniquely vulnerable, it must be the case that Lord Sumption’s concerns are, in fact, directed at *undue* influence, something which the medical profession is acutely familiar with and required to protect against in *all*

³⁶⁴ *Re T* (n 30), 120.

instances of medical treatment. Insofar as his Lordship does, in fact, contend that the ban on assisted suicide is necessary because the State must protect people from their valid concerns regarding the impact of their condition on loved ones, it reflects a paternalism that is unsupported by any evidence cited by his Lordship beyond the bald assertion that '[t]here is a good deal of evidence that this problem exists' (which was made in respect of both direct and indirect pressure). Given that such pressures must necessarily exist for individuals with similar conditions who are receiving life-sustaining treatment, there is no justification for respecting a decision by such an individual to cease life-sustaining treatment even when that individual's decision is motivated by concerns regarding the impact of their condition on loved ones – provided those concerns do not evidence undue influence – while denying other individuals with similar conditions who are not receiving life-sustaining treatment the ability to act upon such concerns by way of assisted suicide.

The preceding discussion reveals a fundamental misunderstanding of the ban's objective in respect to vulnerable individuals which is reflected in Lord Sumption's reasons in *Nicklinson* extracted above. The legitimate aim of the ban is not to protect capacitous individuals from feeling that they are burden. Such a contention reflects a paternalism that has no place in a society that respects autonomy and self-determination. Rather, the ban's aim is to protect individuals who are vulnerable to undue influence from acting as a result of such influence. Or, as Lord Mance opined, to protect those individuals who 'might ... be persuaded or convince themselves that they should undertake [assisted suicide], *when they would not otherwise do so*'.³⁶⁵ Indeed, the Scottish Court of Sessions explicitly recognised this in the judgment of *Ross* wherein the Court held that it is 'well established that the interference [posed by s 2 of the Suicide Act 1961] did have a legitimate aim; *viz.* the protection of the vulnerable *from undue influence*, or other acts that would circumvent their will.'³⁶⁶ There is nothing to suggest that medical practitioners could not apply the techniques they already employ when ascertaining whether a patient is acting under undue influence to ensure that a patient seeking assistance in dying by suicide is not doing so in circumstances where they 'would not otherwise do so.' There is nothing in the reasons of the majority in *Nicklinson* to indicate that the State had demonstrated that only a *blanket* ban could protect against such pressure given the medical profession's existing familiarity in dealing with it in other end-of-life contexts. Certainly, the CPS's *de facto* authorisation of benevolent assisted suicide by loved ones reflects the fact that this 'vulnerability' *can be*

³⁶⁵ *Nicklinson* (n 7) [171] (Lord Mance) (emphasis added).

³⁶⁶ *Ross* (n 40) [6].

adequately protected against by a less restrictive measure. Further, there was no consideration by the majority in *Nicklinson* or indeed the Divisional High Court in *Conway* of whether an *ex post facto* assessment of vulnerability – which is what the present system involves – better secures the ban’s objective than an *ex ante facto* examination of the individual seeking assistance and their reasons for doing so. In those circumstances, it is difficult to maintain the argument that a *blanket* ban, as distinct from one which permits certain exceptions (i.e. one that reflects the reality in England and Wales as a result of the CPS’s discretion), is the ‘least restrictive means available’ to protect individuals from what are, in reality, concerns regarding undue influence.

This conclusion is consistent with the recent decision of the Supreme Court in *Re Y*³⁶⁷ which confirmed that there is no statutory or common law obligation to obtain judicial consent to withdraw life-sustaining treatment from incapacitous patients when there is agreement between family and treating physicians. While the State argued that such authorisation was necessary in all cases involving such patients for the obligations under, *inter alia*, Article 8 of the ECHR to be complied with, the Supreme Court determined that the existing statutory and regulatory system provided sufficient protections for individuals who are undeniably extremely vulnerable. While such individuals are incapable of refusing further treatment and are thus not directly vulnerable to undue influence, their family members or others charged with making decisions regarding their medical treatment may nonetheless be acting with the motivations which would lead them to exert such influence on a capacitous patient. The Supreme Court’s finding in *Re Y* confirms that the medical profession is well placed to protect patients from undue influence, however it manifests.

In sum, the contention that a *blanket* ban is necessary to protect individuals vulnerable to undue influence or, alternatively, that there is no lesser measure which would not ‘unacceptably’ compromise the aim, is difficult to sustain given that:

- Individuals are already accessing assistance in dying by suicide, both internationally and domestically;
- As opposed to being an impossibility (as claimed by Lord Sumption in *Nicklinson* and the Divisional High Court in *Conway*), the present system already requires an (albeit *ex post facto*) examination of vulnerability by the police, CPS and courts
- Such an *ex post facto* examination will, in the vast majority of cases, fail to include evidence that would be available if the examination was *ex ante facto* including, in

³⁶⁷ *Re Y* (n 35).

particular, as assessment of the reasons for the individual seeking assistance to die by suicide;

- The ‘vulnerability’ which the ban is said to protect against pervades medicine more generally, and in particular end-of-life care, and is protected against by doctors ensuring consent is freely given and not vitiated by undue influence.

These factors demonstrate that there *is* a less restrictive means available, namely a legal system which reflects the *de facto* system of benevolent assistance of loved ones who have terminal or life-limiting conditions or are elderly, which exists in England and Wales as a result of the exercise of the CPS’s discretion. These factors also have relevance for the fourth requirement of the domestic proportionality test, namely, ‘identifying what the measure achieves and balancing this against the consequences for other interests.’³⁶⁸ Before considering that issue, however, the necessity of the additional objectives identified by the *Conway* High Court must be examined.

b. Additional aims post-*Conway*

A number of the factors considered above which are relevant to an assessment of whether the *blanket* ban is necessary to protect vulnerable individuals are similarly relevant to an examination of whether the blanket ban is necessary to promote the sanctity of life and to protect the doctor/patient relationship.

Commencing with the objective of promoting the ‘sanctity of life’, it is important to consider what is meant by that phrase. As discussed in Chapter One, the sanctity of life, while a fundamental principle in English law, is not absolute. It can, and does, give way to considerations of autonomy, dignity and self-determination, particularly in the context of decisions by capacitous patients (and incapacitous patients who have made a valid advance directive) to cease/refuse life-sustaining treatment. As the Grand Chamber observed in *Lambert*, quality of life considerations – which are typically considered under Article 8 of the ECHR – take on significance under Article 2 of the ECHR when considering whether a State has complied with its positive obligation to protect individuals in the context of withdrawal of life-sustaining treatment.³⁶⁹ That observation reflects the fact that sanctity of life considerations are not absolute and the obligation to protect life does not prevail in circumstances in which a person’s quality of life is such that ongoing treatment is inimical to their best interests. Recognising the importance of sanctity of life considerations does

³⁶⁸ *Nicklinson* (n 7) [171] (Lord Mance).

³⁶⁹ *Lambert* (n 172) [142]-[143].

not lead to a presumption favouring the preservation of life for its own sake.³⁷⁰ And, again, it must be queried whether ‘the sanctity of life is protected or enhanced by insisting that those who freely wish to but are physically incapable of bringing their lives to an end, should be required to endure untold misery until a so-called ‘natural death’ overtakes them?’³⁷¹ The evidence cited in Chapters Two and Three on Articles 2 and 3 of the ECHR clearly demonstrates that in the case of some individuals, such as Noel Conway, Omid T, Tony Nicklinson and Diane Pretty, the ban does *not* secure *their* sanctity of life. If the blanket ban does not secure the sanctity of life of individuals who are compelled to suicide prematurely or whose quality of life is (or will be) significantly diminished, whether because of a terminal or degenerative illness or because they are elderly or otherwise suffering intolerably as a result of a life-limiting or similar disease, then it is failing to meet its objective and is a disproportionate interference with the Article 8 rights of those individuals. So much appears to be reflected in the practical application of the ban and the CPS’s practice of not prosecuting ‘compassionate, amateur assistance’ of the terminally ill and/or elderly by loved ones.³⁷² That practice strongly suggests that there is a less intrusive means of securing the objective of protecting the sanctity of life of *all* individuals, while also ensuring that individuals such as Noel Conway, Omid T and Diane Pretty are able to exercise their right to choose the manner and timing of their death. When that is considered in light of the extensive experience the medical profession has in identifying patients acting under undue influence, it is clear that the *blanket* ban is not the least restrictive means available of securing the aim of protecting morals by protecting the sanctity of life.

As for the objective of protecting the doctor/patient relationship, as the examination above reveals, doctors who treat terminally ill patients or patients receiving life-sustaining treatment will likely encounter a situation in which they are required to oversee (or perform) the withdrawal of life-sustaining treatment. Similarly, a key – albeit controversial – aspect of palliative care is palliative sedation.³⁷³ To suggest, then, that doctors are not

³⁷⁰ See, for instance, *An NHS Trust v H* [2012] EWHC B18 (Fam) at [35].

³⁷¹ *Nicklinson* (n 7) [357] (Lord Kerr).

³⁷² *Starmer* (n 284).

³⁷³ See, for instance, Bert Broeckaert, ‘Palliative Sedation, Physician-Assisted Suicide, and Euthanasia: “Same, Same but Different?”’ (2011) 11 *American Journal of Bioethics* 62; Nathan Cherny and Lukas Radbruch, ‘European Association for Palliative Care recommended framework for the use of sedation in palliative care’ (2009) 23 *Palliative Medicine* 581, 581; National Institute for Health and Care Excellence, ‘Guideline NG31’ (n 36); Lukas Radbruch, Carlo Leget, Patrick Bahr, Christof Müller-Busch, John Ellershaw, Franco de Conno and Paul Vanden, ‘Euthanasia and physician-assisted suicide: A white paper from the European Association of Palliative Care’ (2016) 30 *Palliative Medicine* 104, 111.

already engaged in end-of-life practices is nonsense. There is, however, the legal artifice by which acts that comprise the withdrawal of life-sustaining treatment (for instance, removal of artificial ventilation, nutrition and/or hydration) are considered ‘omissions’ to ensure that doctors are not liable for murder.³⁷⁴ And the doctrine of double effect operates to insulate doctors from culpability even when the act they engage in undoubtedly leads to, or at the least hastens, the patient’s death.³⁷⁵ Regardless of how such conduct is *legally* classified, the reality is that doctors, particularly those treating terminally ill patients, are regularly engaged in acts which cause or, at the very least, hasten the patient’s death. Insofar as the argument is that in such cases doctors do not do those acts (or ‘omit’ to act) with the intention of bringing about the patient’s death, there is research which plainly reveals that doctors *do* in fact withdraw treatment and palliatively sedate patients with the express intention of bringing about their deaths.³⁷⁶ Such research has also revealed that doctors engage in that conduct without the patient’s involvement/prior knowledge.³⁷⁷ Arguably, a system in which patients are able to have open and honest conversations with their doctors about their end-of-life care, including at which point in their deterioration they would like to be palliatively sedated or, indeed, to die, would be more conducive to securing a trusting and efficacious doctor/patient relationship than the current system in which doctors can make unilateral decisions regarding the patient’s end-of-life care.³⁷⁸ It is arguable, then, that the *blanket* ban is not the least restrictive means possible of securing the ban’s objective of protective the doctor/patient relationship. This is bolstered by the recent poll by the Royal College of Physicians discussed above which revealed an increase in support amongst the members polled for a change to the law on assisted dying in England and Wales. Arguably, in adopting a neutral position, the College’s official position is that assisted dying does not damage the doctor/patient relationship.

³⁷⁴ See, for instance, *Bland* (n 31).

³⁷⁵ Pursuant to the ‘doctrine of double effect’, doctors are not liable for a patient’s death, even if through the administration of pain relieving medication they bring about (or hasten) a patient’s death, provided they have acted in order to address a patient’s symptoms without the intention of bringing about their death: see, for instance, Adams [1957] *Criminal Law Review* 365 cited by Suzanne Ost, ‘Euthanasia and the defence of necessity: advocating a more appropriate legal response’ (2005) *Criminal Law Review* 355.

³⁷⁶ Clive Seale, ‘National survey of end-of-life decisions made by UK medical practitioners’ (2006) 20 *Palliative Medicine* 3; Clive Seale, ‘End-of-life decisions in the UK involving medical practitioners’ (2009) 23 *Palliative Medicine* 198.

³⁷⁷ *ibid.*

³⁷⁸ Samia Hurst and Alex Mauron, ‘The ethics of palliative care and euthanasia: exploring common values’ (2006) 20 *Palliative Medicine* 107, 108. See, also, Louise Campbell, ‘Current debates about legislating for assisted suicide: ethical concerns’ (2018) 24 *MLJI* 20.

3.3.1.4 *Fair balance?*

Protecting vulnerable individuals from undue influence, securing the sanctity of life and protecting the doctor/patient relationship are lofty objectives and, as the domestic case law demonstrates, are quite difficult to argue against. However, when one looks at what the blanket ban actually achieves (the task required by this step of the domestic proportionality test³⁷⁹), the narrative fundamentally shifts. Returning to Figure 1, it is apparent that the ban:

- Prevents individuals in each group from exercising their Article 8(1) right to choose the manner and timing of their death by way of assisted suicide;
- Does not prevent individuals in any of the groups, including Groups A and B (i.e. those who are vulnerable), from dying by suicide *without* assistance;
- Does not prevent individuals in any of the groups, including Groups A and B, travelling to permissive jurisdictions such as Switzerland to die by suicide with assistance;
- Does not, in fact, prevent individuals in any of the groups from dying by suicide with assistance in the UK.

The ban, thus, ‘condemn[s] ... [individuals who would die by suicide with assistance if it were permitted] to a life bereft of pleasure or quality’ while not necessarily securing its objective of protecting individuals who may be vulnerable to undue influence.³⁸⁰

Lord Sumption considered that ‘The *real question* [at this stage of the proportionality test] ... is how much risk to the vulnerable we are prepared to accept in this area in order to facilitate suicide by the invulnerable.’³⁸¹ Given the real impact of the present ban, there is a strong argument that a less extensive ban (i.e. one which reflects practical implementation of the law as a result of the exercise of the CPS’s discretion) with attendant safeguards aimed at ensuring that individuals are not acting under undue influence (which, as noted above, is a requirement familiar to medicine generally) will pose a lesser risk than the existing blanket ban. Certainly, the balancing act is not as one-sided as the majority’s reasons in *Nicklinson* and the judgments of the High Court and the Court of Appeal in *Conway* suggest.

³⁷⁹ *Nicklinson* (n 7) [168] (Lord Mance).

³⁸⁰ *Nicklinson* (n 7) [336] (Lord Kerr).

³⁸¹ *ibid* [229] (Lord Sumption) (emphasis added).

As discussed above, the ban is not stopping people taking their lives with assistance both in England and Wales and internationally. And, in the absence of a system which requires inquiries into the individual's motivations for seeking assistance to die by suicide *before* they take their own lives, there is no way of knowing, beyond inferences made during an *ex post facto* assessment, if any of those individuals were acting as a result of undue influence.

Further, given the absence of a central database (and the fact that suicide conclusions are not regularly publicly reported), it is not possible to ascertain how many of the 6,507 people who died by suicide in 2018 (the latest available data from the Office for National Statistics) took their lives as a result of terminal illness or unbearable suffering and would have availed themselves of assistance if it were permitted instead of being compelled to take their lives by means which may be extremely traumatic for them and their loved ones and by no means guaranteed to be effective. It is unrealistic to assume, however, that terminal illness and/or unbearable suffering was not a motivating factor in at least some of the almost 6,500 cases of suicide in 2018. The cases of *Pretty, Purdy, Nicklinson, Conway* and *Omid T* provide irrefutable evidence of the fact that there are individuals in the UK who have a terminal illness or are otherwise suffering unbearably as a result of a life-limiting or similar condition and would, if they could, avail themselves of assisted suicide if it were permitted. There is also evidence of people suiciding prematurely to avoid a prolonged, painful or undignified death.³⁸² Further, in the absence of a system which requires an *ex ante facto* inquiry into the individual's reasons, there is no way of knowing if any of those individuals who took their lives by suicide in 2018 did so as a result of undue influence.

Separate chapters have also revealed that the ban forces some individuals to take their lives prematurely (in violation of Article 2 of the ECHR) and subjects some individuals to ill-treatment contrary to Article 3 of the ECHR. When one examines what the ban achieves *vis-à-vis* the catastrophic impact it has on individuals who would seek assistance if permitted, the contention that the *blanket* ban is proportionate to its objectives loses much, if not all, of its force. The ban does *not* stop people from dying by suicide with assistance. Rather, it forces individuals overseas or puts them and their loved ones in an exceedingly difficult situation domestically given that they must secure a means of bringing about their death (generally by way of unlawfully procuring pentobarbital or other similar barbiturate) and then their 'assister' is left to face potential prosecution under s 2 of the Suicide Act 1961 (which, while exceedingly rare, is nevertheless a risk). Similar difficulties confront

³⁸² See, in this respect, Chapters Two and Three.

those individuals who would die by suicide with assistance if it were permitted but, as a result of the ban, take their own lives without assistance. This often involves use of methods that pose tremendous risk of (potentially further) catastrophic injury if unsuccessful in bringing about the individual's death (for instance, hypoxic brain injury as a result of near hanging).³⁸³ And, in some cases, the individual is compelled to take their life sooner than they would choose to before they lose the ability to do so unaided. That is dealing only with those individuals who, despite the ban, nevertheless attempt to bring about their death by suicide. The ban also has the effect of forcing individuals such as Ms Petty, Ms Purdy, Mr Nicklinson and Mr Conway, to live in conditions which they consider inimical to their dignity and autonomy and which, in some cases, constitutes ill-treatment contrary to Article 3 of the ECHR.³⁸⁴ The ban also significantly curtails conversations between patients and their doctors regarding their end-of-life care. And that, in turn, has a deleterious impact on patients.

There is, then, a very strong argument that the blanket ban fails to strike a fair balance 'between, on the one hand, the rights of those who wish to, but who are physically incapable of, bringing their lives to an end [or, indeed, those who can suicide but would prefer to do so assisted, in a controlled and safe manner] and, on the other, the interests of the community as a whole.'³⁸⁵ Insofar as the argument is that the blanket ban strikes the appropriate balance given that against the rights of those seeking assistance is the 'sanctity of life' of others, it is questionable whether the sanctity of life is protected or enhanced by a ban which precludes those individuals who freely wish but are physically unable to bring their lives to an end. Arguably, to force such individuals to 'continue to endure the misery that is their lot is not to champion the sanctity of life; it is to coerce them to endure unspeakable suffering.'³⁸⁶ Further, if the sanctity of life cannot justify a ban on suicide by the able-bodied (which was decriminalised by the Suicide Act 1961), 'it is difficult to see how it can justify prohibiting a physically incapable person from seeking assistance to bring about the end of their life.'³⁸⁷ And, that is to say nothing of the treatment of sanctity of life concerns elsewhere in medical law, which has been discussed at length above.

³⁸³ The most common means of suicide is hanging, suffocation and strangulation (all grouped together) with poisoning the second most common: Office for National Statistics, 'Suicides in the UK' (n 118).

³⁸⁴ See, Chapter Three.

³⁸⁵ *Nicklinson* (n 7) [357] (Lord Kerr).

³⁸⁶ *ibid* [358] (Lord Kerr).

³⁸⁷ *Nicklinson* (n 7) [358] (Lord Kerr).

The preceding analysis leads to the conclusion that the blanket ban is neither necessary nor proportionate as was, in fact, recognised by Lord Kerr in *Nicklinson*.³⁸⁸ The absence of a ‘guaranteed-to-function’ alternative does not alter the fact that the ban fails to achieve its objectives in the manner required to be justifiable under Article 8(2) of the ECHR not least since the present ban is not itself guaranteed-to-function. Even if that requirement *was* legally valid, as the ensuing chapter reveals, the evidence from permissive jurisdictions clearly demonstrates that, insofar as ‘guaranteed-to-function’ is taken to mean that the risks which the ban is said to protect against do not materialise, there are ‘guaranteed-to-function’ alternatives to the current blanket ban. And those alternatives meet both the third and fourth requirements of the domestic proportionality test: they are less restrictive and do not significantly compromise the legitimate aims, and they strike a fairer balance between the competing rights.

4. Rectifying the incompatibility

The preceding analysis has demonstrated that the current *blanket* ban on assisted suicide is incompatible with Article 8 of the ECHR. It is not the least restrictive means possible of achieving any of the aims espoused by the various domestic courts and it fails to strike a fair balance between the competing interests. As for what is necessary to rectify the incompatibility, there is presently a *de facto* system in which benevolent assistance of a loved one who is terminally ill, elderly or suffering intolerably as a result of a life-limiting condition is, if not permitted, then condoned given the CPS’s practice of not prosecuting such cases of assistance. Such a system is not, however, practicable for a number of reasons. As discussed above, such an *ad hoc* system which is based on an *ex post facto* assessment of the evidence fails to protect individuals who are acting as a result of undue influence. Further, there is no guidance as to what form of assistance is permitted and who is eligible. The sentencing reasons in *Desai* suggest that conduct which constitutes euthanasia could, and indeed, should be permitted in some instances. Yet, Mr Desai was successfully prosecuted. Likewise, Mr Gazeley was convicted of manslaughter based on diminished responsibility after smothering his terminally ill wife, notwithstanding her repeated requests for assistance in dying.³⁸⁹ A *de jure* system regulating assistance will best comply with the requirements of Article 8 of the ECHR and secure the objectives of the present ban. The question is what such a system should look like.

³⁸⁸ *ibid* at [358] (Lord Kerr).

³⁸⁹ *Gazeley* (n 136).

Based on the current practice of the CPS, certain individuals should be able to receive assistance from someone close to them (i.e. individuals who are not acting in a professional capacity) to travel to a permissive jurisdiction such as Switzerland to die by assisted suicide. In such cases, individuals like Omid T and Daniel James would be able to travel to those countries without fear that their loved ones may face prosecution for assisting them (or, alternatively, encouraging them) to die by suicide. The question, then, is *who* should be able to receive such assistance. Allowing individuals with terminal conditions to be able to receive such assistance would not compromise the objective of protecting the sanctity of life since, as discussed above, sanctity of life concerns regularly give way to self-determination and autonomy, as well as quality of life considerations, in cases involving terminally ill individuals. Likewise, individuals receiving life-sustaining treatment (but who are not terminally ill) also ought to be permitted to receive assistance to travel overseas since, consistent with authorities such as *Re B*,³⁹⁰ the self-determination and autonomy of those individuals takes precedence over sanctity of life considerations. Finally, qualitative considerations, together with the sentencing remarks in *Desai*, suggest that elderly individuals who are suffering intolerably as a result of infirmity or other geriatric syndromes should also be permitted assistance in travelling to permissive jurisdictions. But that only addresses relatively minor ‘assistance’ and ignores the practicalities of terminally ill individuals or those receiving life-sustaining treatment getting overseas, as well as financial constraints. The same considerations, in particular the importance of self-determination and autonomy and assessments of a person’s quality of life, favour a system in which doctors are permitted to prescribe lethal doses of medication such as pentobarbital, which a capacitous patient can take themselves. Consistent with CPS policy and existing medical practice, individuals who are terminally ill or whose quality of life is deleteriously affected by a life-limiting or similar condition (for instance, a person in a similar situation as Tony Nicklinson, Daniel James or Omid T) should be permitted access to assistance if compatibility with Article 8 of the ECHR is to be secured. But individuals like Daniel James and/or Tony Nicklinson cannot take the ‘final step’ (i.e. ingestion of the medication) for an act to constitute what is traditionally understood to be ‘suicide’.

If the definition of suicide distilled in Chapter Six is correct, the medical system has a long history of assisting patients to die by suicide through the withdrawal of life-sustaining

³⁹⁰ *Re B* (n 33).

treatment.³⁹¹ If that definition is correct, then permitting doctors to administer lethal doses of medication to individuals such as Tony Nicklinson who have the capacity to consent to such treatment and who are not acting under undue influence is not so far removed from the realms of their existing ‘treatment’ practices as to render the ban on that form of conduct compatible with Article 8 of the ECHR. The same considerations with respect to sanctity of life concerns apply equally to these patients; as Lord Kerr put it in *Nicklinson* they are ‘condemned to a life bereft of pleasure or quality’.³⁹² Arguably, their conditions, particularly for an individual like Tony Nicklinson who suffered from locked-in syndrome and thus had little to no control over his day-to-day existence, exemplify the benefit of a system in which they can openly discuss their end-of-life care with their treating practitioner, insofar as such a system wrests control away from doctors and returns it to patients. When considered in that light, and bearing in mind that doctors can and do withdraw treatment from and/or provide palliative sedation to patients who are incapable of providing their consent, the claim that permitting a doctor to administer a lethal dose of medication to a capacitous patient who is not acting under undue influence would pose a threat to the doctor/patient relationship loses much of its force. If the current system is to be amended to enable euthanasia, which, it is submitted, is necessary in order to comply with Article 8 of the ECHR, it would require an amendment to the offence of murder, for instance to include an exception for the provision of assistance to individuals where specified criteria is met, such as occurred in Canada following *Carter*.³⁹³

Beyond the terminally ill, elderly and/or individuals suffering from life-limiting or similar conditions however, the argument that a ban on assisted suicide is necessary to protect the doctor/patient relationship gains some traction. Outside of the end-of-life context, any act which results in a patient’s death – whether it is done with or without the intention of bringing about their death – will fall foul of not just the doctor’s professional and/or ethical obligations but also English criminal law. If a doctor takes steps to intentionally bring about a patient’s death outside of the recognised, therapeutic, spheres outlined above, they may be charged with murder and if they unintentionally but negligently cause

³⁹¹ Palliative sedation refers to the administration of sedatives with the intention of reducing the level of consciousness of a terminally ill patient, in order to relieve refractory symptoms: Chapter One, section 2.

³⁹² *Nicklinson* (n 7) [336].

³⁹³ Criminal Code (RSC 1985, c.C-46), s 227(1) provides that ‘No medical practitioner or nurse practitioner commits culpable homicide if they provide a person with medical assistance in dying in accordance with section 241.2’ and s 241.2 sets out the eligibility for medical assistance in dying, which includes euthanasia.

or contribute to the patient's death, they may be charged with manslaughter.³⁹⁴ There is, then, scope for the argument that a ban on assisted suicide of patients who are not terminally ill/suffering from a life-limiting illness or suffering intolerably as a result of infirmity and/or geriatric syndromes is both consistent with the approach taken elsewhere in medical law and is necessary to secure the doctor/patient relationship. Likewise, the balance between competing values such as self-determination and autonomy on the one hand and sanctity of life on the other is more finely balanced in a case involving an individual who is seeking assistance in dying by suicide as a result of suffering caused by a condition that is neither terminal nor life-limiting. Considering that the CPS does tend to prosecute cases of assisted suicide which involve individuals who are suffering from mental health issues (for example, *Howe*) or who are not terminally ill, elderly or otherwise suffering from life-limiting or similar conditions (for example, *Gordon* and the case of Ms Caller), there is no existing, less restrictive system in place in contrast to the situation involving individuals who are terminally ill, elderly or suffering as a result of life-limiting or similar conditions who receive benevolent assistance from friends or family. These factors, taken in isolation and cumulatively, tend to support the contention that the current iteration of the ban is proportionate to the objectives of protecting individuals vulnerable to undue influence, promoting the sanctity of life and protecting the doctor/patient relationship insofar as it applies to individuals who are not elderly, terminally ill or do not suffer from a life-limiting or similar condition.

5. Conclusion

When examining whether an interference is compatible with Article 8 of the ECHR, the first question (a jurisdictional fact of sorts) is whether the challenged measure (here, the blanket ban) interferes with a right protected by Article 8. There can be no doubt that a ban prohibiting a person from taking their life with assistance interferes with the recognised right to choose the manner and timing of their death (an aspect of the right to private life protected by Article 8(1)). The question, then, is whether the ban can be justified by reference to Article 8(2): namely, is the interference 'in accordance with law' and 'necessary in a democratic society'?

³⁹⁴ See, for instance, *R v Cox* (1992) 12 BLMR 38; *R v Moor* [2000] Crim LR 31 (Crown Ct). See, also, the trial and acquittal of Dr Howard Martin discussed in *Moss v HM Coroner for the North and South Districts of Durham and Darlington* [2008] 11 WLUK 764, [2008] EWHC 2940 (Admin).

It has been shown, by reference to the relevant (albeit scarce) domestic case law, that the question of whether the ban is in ‘accordance with law’ is perhaps more complicated than the authorities would suggest. Nevertheless, the Suicide Act 1961, together with the 2010 CPS policy specific to s 2, has the certainty and foreseeability required to ensure that the ban is ‘in accordance with law.’ As for whether the ban is ‘necessary in a domestic society’, this requires that it pursues a legitimate aim and is proportionate to that aim. Protecting individuals from taking their lives as a result of undue influence is plainly a pressing aim. Greater doubt attends the question of whether the additional aims identified by the courts in the *Conway* litigation can be classified as legitimate. Either way, this chapter has demonstrated that a *blanket* ban is not proportionate to securing *any* of those objectives. Applying the domestic proportionality test, it is apparent that the ban is neither the least restrictive means available nor does it strike a fair balance between the competing interests. The analysis undertaken in this chapter is unique in its focus on the ban itself. The debate before the courts and in Parliament has, erroneously, focused on proposed alternatives to the ban and their ability to achieve the aims. In adopting that focus, the courts (excluding Lady Hale and Lord Kerr in *Nicklinson*) and Parliament have neglected to examine whether the present ban is actually successful in securing the aim(s) pursued. As this chapter has shown, the present system under s 2 of the Suicide Act 1961 and, in particular, its reliance on *ex post facto* analysis, is neither the best means of securing its aims nor the least restrictive. The ban does not stop people taking their lives with assistance either domestically or overseas. The ban forces people to die by suicide with assistance overseas or unlawfully domestically, to take their lives prematurely and by means that are not guaranteed to be effective, or to live a life ‘bereft’ of ‘pleasure’ and inimical to the life they have erstwhile led. When the reality of what the ban actually ‘achieves’ is weighed against competing interests, and bearing in mind that the ban is not, in practice, blanket in its application, the claim that the ‘balance struck’ is fair is dubious to say the least. The conclusion reached by the only two Supreme Court justices to examine the question of s 2’s compatibility with Article 8 persists: the *blanket* ban on assisted suicide is incompatible with Article 8.

CHAPTER FIVE

JUSTIFYING THE BLANKET BAN ON ASSISTED SUICIDE: CONSIDERING THE EMPIRICAL EVIDENCE

1. Introduction

The previous chapter demonstrated the error in the requirement adopted by members of the Supreme Court in *Nicklinson*³⁹⁵ that in order for the blanket ban on assisted suicide to be *incompatible* with Article 8 of the ECHR, there had to be evidence of a ‘guaranteed-to-function’ alternative. While, for the reasons given in that chapter, that is not a valid legal requirement in the context of an assessment of the ban’s compatibility with Article 8, the analysis in this chapter considers whether the less restrictive alternatives in permissive jurisdictions do in fact meet that threshold. More specifically, the empirical evidence from permissive jurisdictions is examined with a view to ascertaining whether the risks which the *blanket* ban is said to be necessary to protect against have materialised in jurisdictions that allow assisted dying. If they have not, then those permissive schemes arguably meet the ‘guaranteed-to-function’ requirement and, consequently, demonstrate that the current blanket ban in England and Wales is a disproportionate (and unjustified) interference with the right to choose the manner and timing of one’s death protected by Article 8 of the ECHR. As demonstrated in this chapter, the trial judgment in *Carter* contains an extraordinarily comprehensive analysis of the evidence regarding the impact of allowing assisted dying. Justice Smith considered at considerable length evidence from permissive jurisdictions and determined that that evidence did not support a blanket ban on assisted suicide. One would expect domestic courts considering the English ban to have, at the least, some regard to Justice Smith’s findings. Yet, the Divisional Court in *Conway* expressly rejected the trial judgment in *Carter* as being irrelevant to the question of the compatibility of the Suicide Act 1961 with the ECHR. This chapter, thus, commences with an analysis of the (de)merits of the Divisional High Court’s treatment of *Carter*. Having examined the errors in the High Court’s treatment of *Carter* – and, relatedly, having established the relevance of the judgment of Justice Smith to the question of the compatibility of the Suicide Act 1961 with the ECHR – the chapter proceeds to examine the key findings in *Carter* and considers what impact, if any, more recent empirical evidence has on those findings, in particular as they pertain to the three alleged legitimate aims of s 2 of the Suicide Act 1961 discussed at length in Chapter Four concerning Article 8 of the ECHR.

³⁹⁵ And perpetuated in the subsequent decisions in *Conway* (n 7) and *Conway* (Court of Appeal) (n 7).

This, in turn, reveals that there is a ‘guaranteed-to-function’ alternative to the blanket ban in England and Wales.

2. The applicability of *Carter*

In June 2012, Madam Justice Lynn Smith – sitting in the Supreme Court of British Columbia (Canada) – delivered her judgment in the matter of *Carter* which concerned Canada’s blanket ban on assisted suicide. The trial before her Honour took place over more than 20 days between November 2011 and April 2012. The judgment, which spans over 1400 paragraphs, was, and remains, the most comprehensive assessment of the empirical evidence relating to assisted suicide. Akin to a meta-analysis, Justice Smith referenced the opinion evidence of 57 of the world’s leading experts in assisted dying. Unlike England and Wales, where first-hand evidence and the cross-examination thereof is the exception not the rule in judicial review proceedings,³⁹⁶ not only did the experts in *Carter* give evidence during the trial proceedings, but they were also subject to cross-examination. This is in stark contrast to the proceedings that have been before the English courts concerning s 2 of the Suicide Act 1961. Indeed, Omid T’s application to have evidence heard and cross-examined was refused.³⁹⁷ There is a strong argument, then, that the evidence Justice Smith relied upon when making her findings was of a quality and robustness that far surpassed that which the English courts have considered in the judicial review proceedings involving s 2 of the Suicide Act 1961. Indeed, Lord Mance in *Nicklinson* expressly acknowledged the need for an equivalent exercise to that conducted in *Carter* (including, significantly, cross-examination of the expert witnesses) in order to reach a proper determination regarding the ban’s proportionality.³⁹⁸ Further, Lady Hale noted in *Nicklinson* that the decision of the Canadian Supreme Court in the *Carter* proceedings, which was at that stage forthcoming, would ‘be interesting’ in terms of how it approached the issue of the question of compatibility.³⁹⁹

³⁹⁶ See, for instance, *R (On the application of Bancoult) v The Secretary of State for Foreign and Commonwealth Affairs* [2012] EWHC 2115 (Admin) [14].

³⁹⁷ *Omid T* (n 85).

³⁹⁸ See, for instance, *Nicklinson* (n 7) [182] (Lord Mance):

[I]t would be impossible for this Court to arrive at any reliable conclusion about the validity of any risks involved in relaxing the absolute prohibition on assisting suicide, or (which is surely another side of the same coin) the nature or reliability of any safeguards which might accompany and make possible such a relaxation, without detailed examination of first-hand evidence, accompanied by cross-examination.

³⁹⁹ *Nicklinson* (n 7) [320].

For the reasons given below, Justice Smith’s judgment – an invaluable resource for *any* court considering the human rights implications of a ban on assisted suicide – was of particular worth to the English courts given the similarities between the two jurisdictions in terms of the relevant rights and the legal analysis applicable to same. Despite its utility, and notwithstanding the UK Supreme Court’s appreciation of the judgment and its interest in the outcome of the appeal to the Canadian Supreme Court (which unanimously confirmed the trial judge’s findings), subsequent, lower, English courts have refused to consider Justice Smith’s reasons and findings. Of particular relevance is the Divisional High Court’s statement in *Conway* that:

We did not find the decision in *Carter* to be of assistance. It turned critically on provisions of the Canadian Charter (section 1 and section 7) which are in different terms from Article 8 of the ECHR and which engage a different analysis; see in particular [76]-[78]. It also turned critically on findings by the trial judge in the proceedings on evidence before her in relation to the effectiveness of safeguards for vulnerable people which the Supreme Court held could not be challenged on appeal: [108]-[121]. The evidence before us is different and we have made our own findings in the light of it ... Moreover, the decision in *Carter* was concerned with the category of people who face unbearable suffering, rather than the category which Mr Conway identifies of people who face death within six months.⁴⁰⁰

The emphasised elements of this quote reflect three errors in the High Court’s reasoning. As the ensuing analysis will demonstrate, contrary to the claims of the High Court:

1. The provisions of the Canadian Charter that were in issue in *Carter* are, in fact, materially similar to Article 8 of the ECHR and the analysis employed in respect of the Charter bears striking similarities to the proportionality assessment employed under the ECHR;
2. Any difference in the evidence before the Divisional High Court *vis-à-vis* that before Justice Smith arose as a result of the comprehensiveness of the latter and the superficiality of the former. In fact, two of the experts whose evidence was before the Divisional High Court also gave evidence before Justice Smith, who also had the benefit of their cross-examination. Justice Smith had before her similar, if not identical, evidence to that which was before the High Court and

⁴⁰⁰ *Conway* (n 7) [123] (underlined emphasis added).

could balance that evidence against the myriad of other sources, including cross-examination, which were admitted into evidence in the *Carter* trial;

3. The decision in *Carter* and the subsequent legislative amendments cover individuals whose suffering is unbearable *and* whose natural death is reasonably foreseeable and would, then, apply to an individual like Mr Conway.

2.1 The rights and analyses in issue

The proceedings in *Carter* centred on the rights enshrined in s 7 of the Canadian Charter which provides that '[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice'. Also relevant was s 1 which, in effect, qualifies s 7: 'The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.' At the centre of the proceedings in *Conway* was Article 8 which protects the right to, *inter alia*, private life. While, on a reading of the terms of the relevant rights, there are limited similarities between the rights in issue in *Carter* and those at the centre of the proceedings in *Conway*, closer inspection reveals significant parallels in the principles underpinning the rights enshrined in s 7 of the Canadian Charter and Article 8 of the ECHR. The Supreme Court of Canada in *Carter* described the protections afforded by s 7 in the following terms:

The right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly ... The rights to *liberty and security of the person, which deal with concerns about autonomy and quality of life*, are also engaged. An individual's response to a grievous and irremediable medical condition is a matter critical to their *dignity and autonomy*.⁴⁰¹

The ECtHR has similarly held that autonomy is 'an important principle' underpinning the right to privacy enshrined in Article 8:

*The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance.*⁴⁰²

⁴⁰¹ *Carter* Supreme Court (n 1) [335] (emphasis added).

⁴⁰² *Pretty v United Kingdom* (n 7) [61], [65] (emphasis added).

In fact, the ECtHR observed in *Pretty* that while s 7 of the Canadian Charter is ‘framed in different terms’ to Article 8, ‘comparable concerns arose regarding the principle of personal autonomy in the sense of the right to make choices about one’s own body’.⁴⁰³

Thus, while the rights in issue in *Carter* are ‘in different terms’ to those in *Conway*, there is considerable overlap between the rights at the centre of *Carter* and those upon which Noel Conway’s and Omid T’s challenges to s 2 of the Suicide Act 1961 rested. Certainly, the difference in terms does not undermine the relevance of *Carter* to domestic proceedings concerning the Suicide Act 1961. The next issue is whether the analyses undertaken in respect of those rights are different.

While similarities between the rights in issue are central to legitimising the placing of weight on the analysis and findings in *Carter*, the validity of that comparative exercise depends on there being sufficient overlap between the analyses undertaken with respect to each. The proportionality assessment encapsulated in Article 8(2) of the ECHR requires proof that:

1. The legislative objective of the measure is sufficiently important to justify limiting a fundamental right;
2. The measures designed to meet that objective are rationally connected to it;
3. Those measures are no more than are necessary to achieve it; and,
4. The measure strikes a fair balance between the rights of the individual and the interests of the community.⁴⁰⁴

At each stage, the onus is borne by the State. The approach to ascertaining whether there has been a violation of s 7 under the Canadian Charter is somewhat different. The onus is on the applicant to demonstrate that they have been deprived of a s 7 right *and* that the deprivation is not in accordance with the principles of fundamental justice. According to those principles – which bear a striking resemblance to the proportionality analysis under Article 8(2) of the ECHR – the challenged measure must not be:

1. Arbitrary (i.e. there is no rational connection between the object of the law and the limit it imposes on the s 7 right);
2. Overbroad (i.e. the law goes too far by denying the rights of some individuals in a way that bears no connection to the object);

⁴⁰³ *ibid* [66].

⁴⁰⁴ See, *Aguilar* (n 326) [45] (Lord Wilson JSC) and *Bank Mellat* (n 327) [72ff] (Lord Reed JSC).

3. Grossly disproportionate (i.e. the negative effects on the individual are completely out of sync with the object of the provision).⁴⁰⁵

At no stage of the inquiry into the principles of fundamental justice do broader social interests come into play; the court is concerned solely with the rights and experiences of the applicant.

If the applicant demonstrates that there has been a deprivation of a s 7 right which is not in accordance with one or more of the principles of fundamental justice, the onus then shifts to the State to prove, pursuant to s 1 of the Canadian Charter, that the deprivation is justified. It is at this stage that broader social interests may be relevant. As the following table demonstrates, the s 1 inquiry largely mirrors the proportionality assessment undertaken in an Article 8 dispute:

| ECHR (Art 8(2)) | Canadian Charter (s 1⁴⁰⁶) |
|--|--|
| The legislative objective is sufficiently important to justify limiting a fundamental right | The law has a pressing and substantial object |
| The measure which has been designed to meet the objective is rationally connected to it | The means adopted are rationally connected to it |
| The measure is no more than is necessary to accomplish the objective | The measure is minimally impairing of the right in question |
| The measure strikes a fair balance between the rights of the individual and the interests of the community | There is proportionality between the deleterious and salutary effects of the law |

The preceding reveals that the onus on an applicant alleging a violation of s 7 of the Canadian Charter is heavier than that on an applicant alleging a violation of Article 8 of the ECHR, given the two-stage nature of the former inquiry. While an applicant alleging a violation of Article 8 of the ECHR discharges their legal burden by demonstrating that the relevant provision interferes with a right (in the case of both Noel Conway and Omid T, that s 2(1) of the Suicide Act 1961 interferes with their Article 8 right to choose the manner and timing of their death), an applicant under s 7 of the Canadian Charter must demonstrate not only that the provision interferes with their s 7 right(s) but also that the

⁴⁰⁵ *Carter* Supreme Court (n 1) [72], [83]-[90].

⁴⁰⁶ See, for instance, *ibid* [94].

interference is not in accordance with the principles of fundamental justice (i.e. it is arbitrary, overbroad and/or grossly disproportionate). If the applicant successfully demonstrates that the interference with their s 7 right(s) is *not* in accordance with the principles of fundamental justice, the onus shifts to the State to prove that the interference or deprivation of the applicant's s 7 rights is justified pursuant to s 1 of the Canadian Charter. As the preceding demonstrates, there is considerable overlap between the proportionality assessment under Article 8(2) of the ECHR and the analysis of the State's justification under s 1 of the Canadian Charter. There are also significant similarities in the principles of fundamental justice and the proportionality assessment under Article 8(2).

Thus, contrary to the claim by the Divisional High Court in *Conway*, the rights and the analyses under Article 8 of the ECHR and s 7 (and s 1) of the Canadian Charter are extremely similar, if not analogous. But that was only one of three reasons given by the High Court for disregarding the *Carter* trial judgment. The second was the contention that the evidence was not materially similar to that before Justice Smith.

2.2 The evidence before the courts

The contention by the High Court that the evidence before it was 'different' to that before Justice Smith is perplexing. The High Court stated that the nature of the inquiry before the Court 'does not require us to set out and analyse in full detail the expert and other evidence placed before us.'⁴⁰⁷ Readers are, then, left without reasons detailing how the evidence that the High Court described in its judgment was different to that before the trial judge in *Carter*. It is, thus, necessary to consider what evidence was before the High Court and whether it was, in fact, different to that before Justice Smith in *Carter*.

2.2.1 *The evidence before the Conway Divisional High Court*

According to the reasons of the Divisional High Court, the evidence before it comprised:

- House of Lords Select Committee Report on the Joffe Bill;⁴⁰⁸
- An expert report from Professor Penney Lewis on the comparative legal position;

⁴⁰⁷ *Conway* (n 7) [76].

⁴⁰⁸ Select Committee on the Assisted Dying for the Terminally Ill Bill (n 19).

- British Medical Association Report on ‘End-of-life care and physician-assisted dying’;⁴⁰⁹
- Surveys and consultations of members by the Royal College of Physicians (2014) and the Royal College of General Practitioners (2013);
- A statement by the British Geriatrics Society (2015);⁴¹⁰
- A public statement by Scope, a charity for disabled people in response to the Falconer Bill;
- A witness statement by Baroness Campbell on behalf of Not Dead Yet UK;
- Expert medical reports on various topics including capacity and specific issues relating to Mr Conway’s condition including life expectancy and the efficacy of palliative care;
- An expert report by Professor the Baroness Finlay.

Aside from Professor Lewis’s comparative evidence and the evidence concerning Mr Conway’s medical condition, likely prognosis and palliative care, the remainder of the evidence confirmed that the relevant medical bodies opposed the introduction of assisted dying, primarily to protect vulnerable individuals and to protect the doctor/patient relationship and the disability advocacy groups opposed the introduction because of the risk of undue pressure on individuals with disabilities. Having outlined that evidence ([53]-[75]), the High Court proceeded to note that ([76]):

This is not a trial of an issue of clinical negligence or the like. The resolution of the claim for a declaration of incompatibility did not require there to be cross-examination of any of the expert or other witnesses. The question at issue is whether Parliament has a proper basis for maintaining in place the prohibition against provision of assistance for suicide contained in section 2. This does not require us to set out and analyse in full detail the expert and other evidence placed before us. We refer to the evidence to the extent that it is necessary to do so to determine Mr Conway’s claim for a declaration of incompatibility.

Given the High Court’s mischaracterisation of the ‘question at issue’, it is perhaps unsurprising that they adopted a perfunctory approach to the evidence. As discussed at

⁴⁰⁹ BMA, ‘End-of-life care and physician-assisted dying’ (December 2014) <<https://www.bma.org.uk/collective-voice/policy-and-research/ethics/end-of-life-care>> accessed 31 July 2019.

⁴¹⁰ British Geriatrics Society, ‘Physician Assisted Suicide’ (10 July 2015) <<https://www.bgs.org.uk/policy-and-media/physician-assisted-suicide>> accessed 31 July 2019.

length in Chapter Four, in an Article 8 challenge such as that mounted by Noel Conway, *one* of the questions at issue is whether the State has a ‘proper basis’ for the interference (i.e. whether the interference has a legitimate aim). But that is only one aspect of the analysis. Another issue is whether the means adopted by the State are proportionate to that aim. And that issue requires a detailed examination of what the measure achieves and whether there is a less restrictive means available. As for the evidence that the Court did consider, given how UK-centric it was, it is unsurprising that the High Court described the evidence before it as different to that before Justice Smith. But that difference does not justify discounting the relevance of the trial judgment in *Carter*, particularly given the breadth and depth of the evidence before Justice Smith. If the evidence before the High Court was inconsistent with or otherwise contrary to that considered by Justice Smith in *Carter*, that would go *some way* in accounting for the former’s disregard for the latter. But the High Court did not consider *Carter* and thus cannot be said to have determined that the evidence before it was contrary to that in *Carter*. If the justices did, they failed to give reasons for it. Significantly, both Professors Lewis and Baroness Finlay gave evidence before Justice Smith, with the latter’s evidence *and cross-examination* being considered in considerable detail by the trial judge and the High Court failed to indicate how, if at all, the evidence of Baroness Finlay before them was different to that before Justice Smith.

It is impossible from the (lack of) reasons (and, thus, the public record of the proceedings) to ascertain why the evidence before the Divisional High Court was sufficiently different to justify disregarding Justice Smith’s judgment. As stated above, Justice Smith had the benefit of evidence from over 50 experts, many of whom were cross-examined including, pertinently, Baroness Finlay, and whose judgment extends over 1400 paragraphs, many of which are dedicated to an examination of the evidence. *If* the evidence was different, it was because the Divisional High Court *lacked* the evidence that was before Justice Smith. As will be discussed below, it was certainly not the case that Justice Smith failed to have regard to evidence that was, if not the same, then materially similar to that before the Divisional High Court. Indeed, the following extracts from the opening paragraphs in Justice Smith’s judgment aptly demonstrate the similarities in the issues and evidence before her and the Divisional High Court:

Medical practitioners disagree about the ethics of physician-assisted death. There are respected practitioners who would support legal change. They state that providing physician-assisted death in defined cases, with safeguards, would be consistent with their ethical views. However, other practitioners and many

professional bodies, including the Canadian Medical Association, do not support physician-assisted death.

Despite a strong societal consensus about the extremely high value of human life, public opinion is divided regarding physician-assisted death. The substantial majority of committees that have studied the question, in Canada and elsewhere, oppose physician-assisted death but a minority support it.

The most commonly expressed reason for maintaining a distinction between currently accepted end-of-life practices and physician-assisted death is that any system of safeguards will not adequately protect vulnerable people.

...

The defendants identify a number of areas of risk for patients if physician-assisted death is permitted, for example relating to the patients' ability to make well-informed decisions and their freedom from coercion or undue influence, and to physicians' ability to assess patients' capacity and voluntariness. The evidence shows that risks exist, but that they can be very largely avoided through carefully-designed, well-monitored safeguards.⁴¹¹

This is precisely the nature of the evidence before the Divisional High Court in *Conway*. Insofar as the evidence before Justice Smith was 'different', that difference stemmed from the fact that the British Columbia Supreme Court had before it considerably more evidence, which does not preclude an examination of the judgment by the English courts examining the ban's compatibility but, rather, bolsters the relevance and utility of the Canadian judgment.

2.2.2 *The 'beneficiaries' of the Carter decision*

The third and final issue with the Divisional High Court's reasons for disregarding *Carter* is that the judgment 'was concerned with the category of people who face unbearable suffering, rather than the category which Mr Conway identifies of people who face death within six months.' This alleged difference can be disposed of swiftly, when regard is had to the characteristics of the applicants in *Carter*, the conclusions reached by Justice Smith and the amendments ultimately made to Canadian criminal law to permit medical assistance in dying.

⁴¹¹ *Carter* (n 13) [6]-[8], [10].

There were several applicants in *Carter* including, notably, Gloria Taylor who, like Noel Conway, had a fatal neurodegenerative disease. Justice Smith considered the impact of Canada's analogous ban on a wide group of individuals including those with disabilities whose deaths were not imminent but who nevertheless suffered unbearably as a result of an irremediable medical condition. While that was a broader focus than Mr Conway's case which was confined to an individual who had a terminal illness with a prognosis of 6 months or less, it is not clear how a broader focus which necessarily encompassed individuals like Mr Conway renders *Carter* of no assistance to the Divisional High Court. The Canadian Supreme Court, in confirming Justice Smith's decision, issued a declaration that the relevant provisions giving rise to the ban:

[W]ere void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. 'Irremediable', it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.⁴¹²

Ultimately, the Canadian Government introduced amendments to the Criminal Code to allow medical assistance in dying for adults who have a grievous and irremediable medical condition. The definition of grievous and irremediable medical condition requires, *inter alia*, that the individual's 'natural death has become reasonably foreseeable'.⁴¹³

While the decision in *Carter* was not confined to individuals who were terminally ill with a life expectancy of 6 months or less, Justice Smith determined that Canada's analogous ban was overbroad and grossly disproportionate as it applied to individuals who, like Mr Conway, had a terminal neurodegenerative disease. The Divisional High Court failed to provide any reasons for why the broader category of people to which the *Carter* judgment applied supported its claim that the decision was of little assistance and in the absence of such reasons, it is clear that the decision's broader focus bolstered, rather than undermined, its utility in other courts considering the human rights implications of domestic bans on assisted suicide.

The preceding discussion of the rights, analysis and evidence at the centre of the *Carter* proceedings clearly demonstrates that, contrary to the Divisional High Court's contention

⁴¹² *Carter* Supreme Court (n 1) [127].

⁴¹³ Criminal Code (RSC 1985, c.C-46), s 241.2(2)(d).

in *Conway*, a decision that an analogous ban was incompatible with remarkably similar rights in respect of individuals with analogous conditions would have been of very significant assistance to the Court when considering the compatibility of s 2 of the Suicide Act 1961 with Article 8 of the ECHR. Having established the relevance of *Carter*, the ensuing sections will consider the findings of Justice Smith and the impact, if any, of subsequent research on those findings.

3. The material findings in *Carter*

As discussed in Chapter Four concerning Article 8 of the ECHR, the legitimate aims proffered by the Divisional High Court in *Conway* for the blanket ban were:

1. Protecting individuals from undue influence (frequently referred to as ‘protecting vulnerable individuals’);
2. Protecting the doctor/patient relationship; and,
3. Protecting/maintaining the sanctity of life.

Justice Smith addressed each of those concerns to varying extents⁴¹⁴ and determined that:

[A] permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error. While there are risks, to be sure, a carefully designed and managed system is capable of adequately addressing them.

[I]t was feasible for properly qualified and experienced physicians to reliably assess patient competence and voluntariness, and that coercion, undue influence, and ambivalence could all be reliably assessed as part of that process ... It would be possible for physicians to apply the informed consent standard [applied in other medical decision-making in Canada, including end-of-life decision-making] to patients who seek assistance in dying ...

[T]here was no evidence from permissive jurisdictions that people [who may be considered vulnerable to undue pressure, such as people with disabilities] are at heightened risk of accessing physician-assisted dying ... [A]nd in some cases palliative care actually improved post-legalization ... [W]hile the evidence suggested that the law had both negative and positive impacts on physicians, it did support the conclusion that physicians were better able to provide overall end-of-life

⁴¹⁴ *Carter* (n 13) [314], [352], [1154].

treatment once assisted death was legalized ... Finally, [there was] no compelling evidence that a permissive regime in Canada would result in a ‘practical slippery slope’.⁴¹⁵

Each of those aspects of Justice Smith’s reasons will now be considered in greater detail, together with subsequent research from permissive jurisdictions.

3.1 Protecting vulnerable individuals

It is important to have a clear understanding of what is meant by ‘vulnerable individuals’. As was canvassed in Chapter Four, reference to ‘vulnerable individuals’ in the context of assisted dying refers to persons susceptible to undue influence. There is no characteristic that *ipso facto* renders a person ‘vulnerable’ to such influence; a person with a disability is no more likely to be vulnerable to undue influence than an individual who has a terminal illness, and there are any number of factors that can coalesce to leave a person vulnerable to undue influence. It is, then, misleading to suggest that individuals who access assisted suicide are, solely by virtue of their request for assistance, more vulnerable to undue influence than individuals who receive other forms of medical treatment, including end-of-life care. Insofar as there are characteristics which *may* be associated with vulnerability to undue influence (for instance, socioeconomic status, age, private health insurance) Justice Smith determined that based on the evidence before her, which included evidence from Baroness Finlay, data from regulatory bodies in permissive jurisdictions, and additional studies by academics in those jurisdictions, ‘the predicted abuse and disproportionate impact on vulnerable populations has not materialised.’⁴¹⁶ Further, ‘although none of the [permissive] systems has achieved perfection, empirical researchers and practitioners who have experience in those systems are of the view that they work well in protecting patients from abuse while allowing competent patients to choose the timing of their deaths.’⁴¹⁷

While Justice Smith was cautious in her approach to the evidence from other permissive jurisdictions given the different demographic and cultural contexts and methods of health care delivery, she nevertheless noted the concerns of several experts regarding the reporting rates of physicians assisting in their patients’ deaths in certain permissive jurisdictions, especially Belgium and the Netherlands.⁴¹⁸ There was evidence before the

⁴¹⁵ *Carter* Supreme Court (n 1) [105]-[107].

⁴¹⁶ *Carter* (n 13) [684].

⁴¹⁷ *ibid* [685].

⁴¹⁸ *Carter* (n 13) [646]-[660], [674]-[685].

trial judge of ‘low rate[s] of reporting’ in Belgium and the Netherlands. However, that data could not be considered in isolation from the context in which medical assistance in dying had arisen in both jurisdictions. Importantly, in both Belgium and the Netherlands, there was a practice of medically assisted dying prior to the introduction of legislation permitting same and there was evidence that ‘in some measure the impetus toward permissive legislation [in those jurisdictions] came from a desire to achieve better understanding, and regulation, of practices of assisted death that were already prevalent and embedded in the medical culture.’⁴¹⁹ Further, a significant amount of unreported cases could be attributed to ‘mislabelling’ by physicians who do not consider death following the administration of pain relieving medication to be euthanasia.⁴²⁰ Indeed, in England and Wales, provided the patient’s death follows the appropriate administration of pain relief and there is no express intention to bring about the patient’s death, it would not be considered euthanasia and would be covered by the doctrine of double effect.⁴²¹

3.2 Protecting the doctor/patient relationship

As with the State in *Conway*, the defendants in *Carter* ‘argue[d] that legalizing physician-assisted death would negatively impact the physician-patient relationship.’⁴²² It was argued that permitting medical assistance in dying would lead to a radical change in the concept of what a physician is.⁴²³ Having considered evidence from a number of practitioners and academics, again including Baroness Finlay, Justice Smith stated:

My review of the evidence leads me to conclude, with respect to the impact on the doctor-patient relationship, that patients’ trust in their physicians, and physicians’ commitment to their patients’ well-being, would not necessarily change for the worse if the law permitted physician-assisted death in highly constrained circumstances. The risk of misconceptions and distrust may be counterbalanced by the possibility of enhanced trust arising from more open communications. In brief, it is likely that the relationship would change, but the net effect could prove to be neutral or for the good.⁴²⁴

⁴¹⁹ *ibid* [660].

⁴²⁰ *Carter* (n 13) [655], [659].

⁴²¹ See, Chapters One and Six.

⁴²² *Carter* (n 13) [737].

⁴²³ *ibid* [739].

⁴²⁴ *Carter* (n 13) [746].

3.3 Protecting the sanctity of life

Consistent with the analysis of English law in Chapter One, Justice Smith noted that while ‘[t]he sanctity of human life is a fundamentally important ethical principle, central to our society’, it ‘is a principle that is not absolute in our society ... and, while it is central to the value system of a number of religions, that does not settle its place in a secular society.’⁴²⁵

In reaching that conclusion, Justice Smith considered the current state of law and practice in Canada concerning end-of-life care and observed that patients were not required to submit to medical treatment even where their refusal of or withdrawal from treatment would hasten their deaths, and doctors could legally administer medications even though they knew that the doses might hasten death, provided the intention was to ease the patient’s pain.⁴²⁶

Justice Smith then considered evidence from ethicists, practitioners, professional bodies and public polls concerning the ‘ethical debate’ relating to end-of-life care and concluded that:

In summary, there appears to be relatively strong societal consensus about the following: (1) human life is of extremely high value, and society should never, or only in very exceptional circumstances, permit the intentional taking of human life; and (2) current end-of-life practices, including administering palliative sedation to relieve physical suffering and acting on patients’ or substituted decision-makers’ directions regarding withholding or withdrawal of life-sustaining treatment, are ethically acceptable.

As to physician-assisted death, weighing all of the evidence, I do not find that there is a clear societal consensus either way, in an individual case involving a competent, informed, voluntary adult patient who is grievously ill and suffering symptoms that cannot be alleviated. However, there is a strong consensus that if physician-assisted dying were ever to be ethical, it would be only be with respect to those patients, where clearly consistent with the patient’s wishes and best interests, and in order to relieve suffering.⁴²⁷

⁴²⁵ *ibid* [314(a)], [315(a)].

⁴²⁶ *Carter* (n 13) [231].

⁴²⁷ *ibid* [357]–[358].

In sum, then, Justice Smith noted that, while fundamentally important, the principle of sanctity of life was not absolute and there was no societal consensus that medically assisted suicide would be contrary to the principle of sanctity of life.

4. Subsequent data

4.1 Protecting the vulnerable

Justice Smith assessed the risk to individuals vulnerable to undue influence by reference to rates of compliance by doctors with the regulations in permissive jurisdictions and the characteristics of individuals accessing assistance in dying. As the trial judge recognised, differing cultural and medical contexts demands a cautious approach to extrapolating data from other jurisdictions. Nevertheless, the experience in permissive jurisdictions is the best evidence available of the impact of introducing assisted dying and, where trends are apparent across varied samples, conclusions can be made more confidently. The question, then, is whether subsequent evidence from permissive jurisdictions alters the findings of Justice Smith.

In April 2019, the Canadian Government published the fourth and final federal interim report concerning access to medical assistance in dying (thereafter, reporting will be in accordance new federal regulations). The report is based on information provided by provincial and territorial governments.⁴²⁸ Since the enactment of legislation permitting medical assistance in dying, 6,749 people have had medically assisted deaths.⁴²⁹ Rates of medically assisted death have increased each year since the introduction of the legislation in 2016, with the overwhelming majority of deaths occurring in hospital or the patient's home (there was a near-even split between deaths in hospital and deaths at home in 2018).⁴³⁰ In 2018, medically assisted deaths accounted for 1.12 per cent of the estimated total deaths in Canada.⁴³¹ The overwhelming majority of people who received medical

⁴²⁸ Health Canada, 'Fourth Interim Report on Medical Assistance in Dying in Canada' (April 2019) <<https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf>> accessed 31 July 2019. Information from Yukon, Northwest Territories and Nunavut was not supplied given the comparatively small size of those territories and concerns regarding privacy. Further, 7 months of data was missing from the information provided by Quebec due to an alteration in the reporting period by the Quebecois Commission.

⁴²⁹ That figure is likely an underrepresentation of the total number of medically assisted deaths given the lack of data from three territories and the missing seven months of data from Quebec (see, *ibid*). Other estimates including the missing data from Quebec puts the total at 7,900 or more. See, for instance, Stephanie Green, 'Medical Assistance in Dying: The Canadian Experience' (Third International Conference on End-of-Life Law, Ethics, Policy and Practice, Ghent, 6-8 March 2019).

⁴³⁰ 'Fourth Interim Report' (n 428), Table 2, 5.

⁴³¹ *ibid*, 7.

assistance in dying were above the age of 65 years (79 per cent in the last reporting period), with the average age being 72 years.⁴³² There was a near-equal division between women (49 per cent) and men (51 per cent) with the most common underlying medical circumstances of those receiving medical assistance being ‘cancer-related’ (64 per cent), ‘circulatory/respiratory system’ (16 per cent) and ‘neurodegenerative’ (11 per cent).⁴³³

The report also reveals that considerably more people make inquiries about medical assistance in dying than request it and an even smaller number of individuals ultimately receive medical assistance in dying. For instance, in Alberta there were 737 inquiries about medical assistance in dying, 407 requests and 252 medically assisted deaths. Interestingly, 8 of the requests in Alberta were declined, 21 were withdrawn by the individual and 77 individuals died before the assessment was completed. Similar patterns were observable in other provinces/regions.⁴³⁴ ‘Investigating instances of non-compliance with eligibility criteria is beyond the scope of the federal monitoring regime and is under the purview of local law enforcement’ and, as a result, there is no federal data concerning compliance by practitioners administering medical assistance in dying.⁴³⁵ It is, then, necessary to consider other jurisdictions which do collate data concerning compliance.

The 2018 report by Oregon’s Health Authority on the State’s Death with Dignity Act provides a summary of information collected by the Authority about the patients who sought medical assistance in dying in 2018 and the physicians who provided that assistance. Before examining compliance, the characteristics of individuals accessing medical assistance in dying by suicide should be considered. Of the 249 people who received prescriptions under the Death with Dignity Act for the purposes of suicide, the overwhelming majority were aged 65 years or older (79.2 per cent) – the median age was 74 years – and most had cancer (62.5 per cent).⁴³⁶ Notably, 97 per cent of individuals were white and well educated (43.7 per cent had at least a baccalaureate degree) and 99.3 per cent had some form of health care.⁴³⁷ It is also notable that the mean duration of the

⁴³² ‘Fourth Interim Report’ (n 428), Table 2, 5.

⁴³³ *ibid.*, 6.

⁴³⁴ ‘Fourth Interim Report’ (n 428), Table 3b.

⁴³⁵ Regulations for the Monitoring of Medical Assistance in Dying (SOR/2018-166) <<http://www.gazette.gc.ca/rp-pr/p2/2018/2018-08-08/html/sor-dors166-eng.html>> accessed 31 July 2019.

⁴³⁶ Oregon Health Authority: Public Health Division, ‘Oregon Death with Dignity Act: 2018 Data Summary’ (15 February 2019), 6 <<https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year21.pdf>> accessed 31 July 2019.

⁴³⁷ *ibid.*

doctor-patient relationship was 10 weeks.⁴³⁸ The data available from other US permissive states largely mirrors the evidence from Oregon.⁴³⁹

As for compliance, during 2018, two physicians were referred to the Oregon Medical Board for failure to comply with the requirements of the Death with Dignity Act.⁴⁴⁰ Given that 103 physicians wrote 249 prescriptions during 2018, 98 per cent of doctors fully complied with the requirements. It is not apparent from the available records of the Oregon Medical Board whether those two physicians have been the subject of disciplinary proceedings.⁴⁴¹

The Dutch review system comprises five Regional Euthanasia Review Committees ‘that receive notifications on termination of life on request and assisted suicide on the basis of the due care criteria laid down in [the relevant legislation].’⁴⁴² In 2018, the Committees received 6,126 notifications of euthanasia which represented 4 per cent of the total number of deaths in that year.⁴⁴³ The number of notifications in 2018 was *less than* the number in 2017.⁴⁴⁴ As with the data from Canada and Oregon, there was near-equal numbers of men and women, 86.6 per cent were aged in their sixties or older, and 90.6 per cent of cases involved patients with ‘incurable cancer, neurological conditions ... cardiovascular disease,

⁴³⁸ ‘Oregon Death with Dignity Act: 2018’ (n 436), 13.

⁴³⁹ California Department of Public Health, ‘California End of Life Option Act 2017 Data Report’ (June 2018) <<https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/2017EOLADataReport.pdf>> accessed 24 May 2019; Colorado Department of Public Health and Environment, ‘Colorado End-of-Life Options Act, Year Two 2018 Data Summary, With Updates to 2017 Data’ (2018) <<https://www.colorado.gov/pacific/cdphe/medical-aid-dying#Annual>> accessed 24 May 2019; Vermont Department of Health, ‘Report to The Vermont Legislature: Report Concerning Patient Choice at the End of Life’ (15 January 2018) <<https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf>> accessed 24 May 2019; Washington State Department of Health, ‘Death with Dignity Act Report’ (March 2018) <<https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf>> accessed 24 May 2019.

⁴⁴⁰ ‘Oregon Death with Dignity Act: 2018’ (n 436), 7.

⁴⁴¹ Reports from the Board indicate that Dr Rose Jeannine Kenny (MD 23253) voluntarily entered into an Interim Stipulated Order to ‘cease prescribing any medication for patients enrolled in hospice or requesting Death with Dignity, pending the completion of the Board’s investigation’ (Oregon Medical Board, ‘Board Action Report’ (15 September 2018)

<<https://www.oregon.gov/OMB/BoardActions/August%2016,%202018%20-%20September%2015,%202018.pdf>> accessed 15 May 2019.

⁴⁴² Regional Euthanasia Review Committees, ‘Annual Report 2017’ (28 September 2017), 9 <<https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>> accessed 15 May 2019.

⁴⁴³ ‘Euthanasia’ refers to both assisted suicide and terminating life on request. Of the 5,898 notifications, 96.2 per cent were termination of life on request, and 212 were assisted suicide. Regional Euthanasia Review Committees, ‘Annual Report 2018’ (27 January 2020), 13 <<https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>> accessed 6 February 2020.

⁴⁴⁴ *ibid*, 11.

pulmonary disease ... or a combination of [these] conditions.⁴⁴⁵ Unlike Canada and Oregon, there is no life-expectancy eligibility requirement in the Netherlands; the individual must be suffering intolerably as a result of an incurable condition (see, Chapter One, Table 1). Consequently, of the 6,126 individuals who died by way of euthanasia, 144 involved patients with ‘early-stage dementia’, 67 involved patients whose suffering was caused by a ‘psychiatric disorder’ and 205 involved unbearable suffering stemming from multiple geriatric syndromes (for instance, sight impairment, hearing impairment, osteoporosis).⁴⁴⁶

Particularly noteworthy is the section of the Report on compliance with due care criteria. ‘In 6 of the 6,126 notified cases [0.10 per cent of all notifications], the [Committees] found that the physician who performed euthanasia did not comply with all the due care criteria’.⁴⁴⁷ The Report describes these cases as follows:

In two of these cases the committee found that the physician had not fulfilled the requirements regarding the patient’s suffering and no reasonable alternative; in one case the particular caution that is required in cases involving psychiatric patients had not been exercised; in one case consulting an independent physician was at issue and in two cases the committee found that the procedure to terminate the patient’s life had not been carried out with due medical care.⁴⁴⁸

The Report discusses three of those cases in detail. The cases concerned a terminally-ill patient in his sixties with a malignant tumour, a woman in her seventies with psychiatric disorders who had been diagnosed with an aortic aneurysm and lung cancer who had refused treatment ‘because she was suffering unbearably without prospect of improvement due to her psychiatric disorders’ and a man in his fifties who had ‘suffered from psychiatric disorders for 30 years’ and whose treatment ‘had no significant effect on his suffering’.⁴⁴⁹ Each of the three cases discussed were ‘non-straightforward notifications’, that is, cases

⁴⁴⁵ ‘Annual Report 2018’ (n 443), 11.

⁴⁴⁶ *ibid.*, 12. See, also, Kirsten Evenblij, H. Roeline W. Pasman, Agnes van der Heide, Trynke Hoekstra and Bregje D. Onwuteaka-Philipsen, ‘Factors associated with requesting and receiving euthanasia: a nationwide mortality follow-back study with a focus on patients with psychiatric disorders, dementia, or an accumulation of health problems related to old age’ (2019) 17 *BMC Medicine* 39 in which the authors conclude (39-40):

EAS [euthanasia and assisted suicide] in deceased patients with psychiatric disorders, dementia, and/or an accumulation of health problems is relatively rare. Partly, this can be explained by the belief that the due care criteria cannot be met. Another explanation is that patients with these conditions are less likely to request EAS.

⁴⁴⁷ ‘Annual Report 2018’ (n 443), 19.

⁴⁴⁸ *Ibid.*, 29.

⁴⁴⁹ ‘Annual Report 2018’ (n 443), 52-65.

with complex facts involving, *inter alia*, reasonable disagreement between professionals as to the nature of the patient's suffering and the availability of 'reasonable alternatives'.⁴⁵⁰

It is notable that in the 17 years since the introduction of the Dutch assisted dying legislation, only one case has proceeded to prosecution, in 2018, with the doctor involved ultimately being acquitted.⁴⁵¹ The case was – unsurprisingly – complex. The patient, a woman in her seventies, was in the advanced stages of dementia and:

Shortly before the dementia diagnosis, [she] had set out her wishes concerning euthanasia in an advance directive and discussed them with her general practitioner and her geriatrician both of whom confirmed that she was decisionally competent at the time.⁴⁵²

The patient renewed this advance directive a year before her death and, again, her general practitioner considered her to be competent at that time. In both advance directives, the patient stated that she:

[D]id not want to be placed in an institution for elderly people with dementia (dementia clause). She stated that she wanted to say goodbye to her loved ones at a sufficiently early stage, in a dignified manner, and that she did not want to experience the process that her mother had gone through in an institution.⁴⁵³

The relevant terms of the directives provided:

In the first ... that she wanted euthanasia when she was 'still to some degree decisionally competent but no longer able to live at home with my husband'. In the second ... that she wanted to make use of the option of euthanasia 'when I myself think the time is ripe'. The closing sentence read: 'Trusting that, by the time the quality of my life has become so poor that ... euthanasia will be performed at my request.'⁴⁵⁴

The patient was placed in a nursing home and while she frequently stated that she wanted to die, she would caveat those statements with 'not now though.' The patient's husband requested that the physician - an elderly-care physician - perform euthanasia on his wife

⁴⁵⁰ *ibid.*

⁴⁵¹ Elizabeth Mahase, 'Euthanasia: Dutch doctor is acquitted in landmark test case' (2019) *BMJ* 366.

⁴⁵² Regional Euthanasia Review Committees, 'Judgments: 2016-85, elderly-case specialist, dementia, not acted in accordance with due care criteria' (1 January 2016) <<https://english.euthanasiecommissie.nl/judgments/a/a-71-80/documents/publications/judgments/2016/2016-85/2016-85>> accessed 22 May 2019.

⁴⁵³ *ibid.*

⁴⁵⁴ 'Judgments: 2016-85' (n 452).

on the basis of her advance directive(s). The physician observed the patient, spoke with her and determined that the patient was expressing a wish to die. The physician twice consulted physicians from a specialist network of euthanasia specialists who both confirmed that the patient was decisionally competent and suffering unbearably. The physician subsequently performed euthanasia on the patient, who ‘awoke when the thiopental was being injected and put up physical resistance.’⁴⁵⁵ Inquiries by the Committees revealed that the patient had attended upon her general practitioner prior to her admission to the nursing home, and was, according to her doctor, ‘no longer able to indicate what her wishes were concerning euthanasia.’ While the patient had made two advance directives stating that she wanted euthanasia, as the Committees recognised, ‘the dementia clause written [in the most recent advance directive] could be interpreted in more than one way.’ Given that ambiguity and the absence of an oral request from the patient, the Committees found that ‘the physician could not have concluded unequivocally that she had made a voluntary and well-considered request for euthanasia.’⁴⁵⁶ The Committees also determined that the manner in which the physician performed the patient’s euthanasia, which included the covert administration of sedatives and the restraining of the patient when she physically resisted the administration of medication, fell below the due care standard; the physician should have halted the procedure in order to reconsider the current situation. As noted above, the doctor was prosecuted and acquitted, with judges finding that the doctor had complied with the due care criteria.⁴⁵⁷

This case was patently complex; it involved ambiguous advance directives and treatment of a patient with advanced dementia, an issue that is the subject of a growing body of research.⁴⁵⁸ The physician consulted other doctors, who confirmed her analysis and she acted in accordance with what she considered to be the patient’s wishes, in consultation with the patient’s husband. Indeed, the patient’s own general practitioner confirmed that she was decisionally competent when she made the advance directives. In an era in which people are living longer, and dementia and Alzheimer’s disease are the leading causes of

⁴⁵⁵ *ibid.*

⁴⁵⁶ ‘Judgments: 2016-85’ (n 452).

⁴⁵⁷ Mahase, ‘Euthanasia’ (n 451).

⁴⁵⁸ Indeed, the case has been critically examined in the academic literature. See, for instance, Scott Kim, David Gibbes Miller and Rebecca Dresser, ‘Advance euthanasia directives: a controversial case and its ethical implications’ (2019) 45 *Journal of Medical Ethics* 84; Karin Jongma, Marijke Kars and Johannes van Delden, ‘Dementia and advance directives: some empirical and normative concerns’ (2019) 45 *Journal of Medical Ethics* 92; Scott Kim, David Gibbes Miller and Rebecca Dresser, ‘Response to: “Dementia and advance directives: some empirical and normative concerns” by Jongma et al’ (2019) 45 *Journal of Medical Ethics* 95.

death,⁴⁵⁹ cases such as this will inevitably increase, in both permissive and restrictive jurisdictions. Legalisation allows regulators to examine such cases and to provide guidance to physicians and patients as to what is required in order for an advance directive to be sufficiently clear and in providing end-of-life care to patients with dementia. Indeed, in 2018, the Euthanasia Code was published by the Dutch Regional Euthanasia Review Committees. The Code gives a ‘practical overview of how the [Committees] interpret the due care criteria’ including, relevantly, in the case of patients with dementia.⁴⁶⁰

The Belgian Federal Control and Evaluation Commission receives registration forms which must be submitted by physicians who perform euthanasia (which covers assisted suicide) and makes an assessment as to whether the legal requirements have been complied with. The Commission publishes a biennial report to the Government outlining the data from the registration documents including compliance by physicians. The most recent report covers the 2016-2017 period during which there were 4,337 notifications and, as was the case in Canada, Oregon and the Netherlands, there was near-equality between males (50.9 per cent) and females (49.1 per cent) and the majority of patients were aged 60 or above (85.7 per cent), with the leading medical conditions being cancer (64.1 per cent), polypathologies (16.4 per cent), respiratory/circulatory conditions (7.1 per cent), and neurological conditions (6.9 per cent).⁴⁶¹ As with the Netherlands, there is no life-expectancy requirement and intolerable suffering can arise from psychiatric conditions, with 1.8 per cent of all notifications based on ‘mental or behavioural disorders.’⁴⁶² In 2014, Belgian law was amended to extend assisted dying to competent minors in certain circumstances, with three minors dying by ‘euthanasia’ in 2016-2017 (0.07 per cent of patients who died by euthanasia).⁴⁶³ The three children were aged 9, 11 and 17 and their

⁴⁵⁹ ‘Deaths registered in England and Wales: 2018’ (n 4).

⁴⁶⁰ Regional Euthanasia Review Committees, ‘Euthanasia Code 2018: Review Procedures in Practice’, 4 <<https://english.euthanasiacommissie.nl/the-committees/code-of-practice>> accessed 22 May 2019.

⁴⁶¹ Commission fédérale de Contrôle et d’Évaluation de l’Euthanasie, ‘Huitième rapport aux Chambres législatives années 2016 – 2017’ (12 June 2018), 3 <https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf> accessed 16 May 2019.

⁴⁶² *ibid.*

⁴⁶³ ‘Huitième rapport aux Chambres législatives années 2016 – 2017’ (n 461). To be eligible, the minor must be ‘capable of discernment’ and ‘conscious at the time the request is made’. Additionally, the consent of the child’s parents is mandatory, and doctors must confirm that the child is ‘in a hopeless medical situation of constant and unbearable physical suffering that cannot be eased and will cause death in the short term resulting from a serious and incurable accidental or pathological condition’. See, Loi modifiant la loi du 28 mai 2002 relative à l’euthanasie, en vue d’étendre l’euthanasie aux mineurs (Belgium) <http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&table_name=loi&cn=2014022803> accessed 16 May 2019. See, also, Sara Eteddhui, ‘Belgium: Report Reveals Euthanasia Commission Authorized Euthanasia of Three Minors in 2016–17’ (Library of Congress, 29 October 2018)

suffering emanated from a malignant tumour of the eye, brain and other parts of the central nervous system (i.e. glioblastomas), cystic fibrosis, and severe Duchenne muscular dystrophy.⁴⁶⁴ The Report further notes that, beyond the obligation to consult with independent doctor(s), in 62 per cent of cases there was engagement with the patient's broader medical team (for instance, palliative care nurses and doctors, and psychologists), with this 'multidisciplinary approach' helping to ensure transparency in the decision-making process.⁴⁶⁵

As for compliance, the Report states that all notifications complied with the essential conditions and none were transmitted to the public prosecutor.⁴⁶⁶ Notifications were correctly completed and the legal requirements were satisfied in 76.3 per cent of cases. The Commission requested further information in 23.7 per cent of cases. In 6.9 per cent of those cases, the reason for requesting further information was to inform the physician of imperfections in their answers or in the procedures followed, but none called into question compliance with the legal conditions.⁴⁶⁷ In 16.8 per cent of the cases in which further information was requested, the additional information concerned documents that were incorrectly or insufficiently completed, with the majority of these oversights or errors concerning administrative or procedural details.⁴⁶⁸ Notably, the Commission reports an improvement in physicians' compliance with the notification requirements since 2014.⁴⁶⁹

4.2 Conclusions on the evidence concerning vulnerable individuals

The recent data from Canada, Oregon, the Netherlands and Belgium is consistent with the evidence that was before Justice Smith in *Carter*. Insofar as there are factors that can be said to be objective evidence of vulnerability to undue influence, the overwhelming majority individuals seeking assistance in permissive jurisdictions are aged 60 years or older and have a terminal illness. Data from Oregon confirms that almost all individuals who died by assisted suicide had a form of health care and the overwhelming majority were white and had at least a baccalaureate degree. There is, then, no indication that individuals who *may* be vulnerable to undue influence are accessing assistance in dying. More presciently, however, is the data concerning compliance. Rates of non-compliance with

<<http://www.loc.gov/law/foreign-news/article/belgium-report-reveals-euthanasia-commission-authorized-euthanasia-of-three-minors-in-2016-17/>> accessed 16 May 2019.

⁴⁶⁴ 'Huitième rapport aux Chambres législatives années 2016 – 2017' (n 461), 12.

⁴⁶⁵ *ibid.*, 22.

⁴⁶⁶ 'Huitième rapport aux Chambres législatives années 2016 – 2017' (n 461), 26.

⁴⁶⁷ *ibid.*

⁴⁶⁸ 'Huitième rapport aux Chambres législatives années 2016 – 2017' (n 461).

⁴⁶⁹ *ibid.*

legal requirements including due care criteria, remain extremely low and, as the evidence from the Netherlands demonstrates, those cases in which issues arise are typically complex involving, *inter alia*, non-verbal communication, advance directives and questions about reasonable alternatives to euthanasia. These are not cases of flagrant disregard of the safeguards. Rather, they are cases in which reasonable physicians can and do disagree as to the proper approach in cases on the margins (or, to employ the nomenclature of the Dutch report: ‘non-straightforward cases’) and in which regulatory bodies and the courts disagree. An issue in any permissive scheme is the ‘risk’ of under-reporting of instances of assisted dying. It is impossible to distil the precise number of cases of assisted death to compare with the number of notifications to the relevant regulatory bodies in any given jurisdiction. The use of death certificates can, however, provide some insight into the rates of reporting. A 2018 study in Flanders, Belgium, confirmed previous findings of underreporting of euthanasia on death certificates.⁴⁷⁰ Consistent with the reasons of Justice Smith, the authors suggested that underreporting might arise as a result of, *inter alia*, ‘physicians consciously or unintentionally not recognising their cases of euthanasia as such’ and ‘because [physicians] do not consider it necessary to report it on the death certificate.’⁴⁷¹ These – and other – reasons were accepted as valid by Justice Smith.⁴⁷² Given the debate that attends the treatment and classification of palliative sedation, and the utilisation of legally dubious constructs such as the doctrine of double effect including in England and Wales, it is unsurprising that there are cases that *could* be classified as euthanasia which are not considered to be such by the doctors administering the treatment.⁴⁷³ Notably, a recent study of the drugs used by doctors in Belgium at the end of a patient’s life confirm that a

⁴⁷⁰ Joachim Cohen, Sigrid Dierckx, Yolanda Penders, Luc Deliens and Kenneth Chambaere, ‘How accurately is euthanasia reported on death certificates in a country with legal euthanasia: a population-based study’ (2018) 33 *European Journal of Epidemiology* 689, 690.

⁴⁷¹ *ibid.*

⁴⁷² Carter (n 13) [653]–[660].

⁴⁷³ See, for instance, Sam Rys, Reginald Deschepper, Freddy Mortier, Luc Deliens, Douglas Atkinson, Johan Bilsen, ‘The moral difference or equivalence between continuous sedation until death and physician-assisted death: word games or war games?’ (2012) 9 *Journal of Bioethical Inquiry* 171; Tinne Smets, Joachim Cohen, Johan Bilsen, Yanna Van Wesemael, Mette Rurup and Luc Deliens ‘The labelling and reporting of euthanasia by Belgian physicians: a study of hypothetical cases’ (2012) 22 *European Journal of Public Health* 19; Kenneth Chambaere, Jan L. Bernheim, James Downar and Luc Deliens, ‘Characteristics of Belgian “life-ending acts without explicit patient request”: a large-scale death certificate survey revisited’ (2014) 2 *CMAJ Open* 4, E262–E267; Sam Rys, Reginald Deschepper, Freddy Mortier, Luc Deliens, Johan Bilsen, ‘Bridging the Gap Between Continuous Sedation Until Death and Physician-Assisted Death: A Focus Group Study in Nursing Homes in Flanders, Belgium’ (2015) 32 *American Journal of Hospice and Palliative Care* 4.

leading reason for failing to report euthanasia is the physician's classification of the act as palliative sedation.⁴⁷⁴

It is trite to say that under-reporting cases of euthanasia is problematic. However, rates of under-reporting must be considered in light of the fact that research has shown that doctors in England and Wales *do* intentionally take their patients' lives even when euthanasia is not legal⁴⁷⁵ and a system that formalises that practice and provides safeguards and transparency is better able to protect individuals vulnerable to undue influence. This perspective was highlighted by Justice Smith⁴⁷⁶ and, given evidence that some doctors in England and Wales administer pain relief with the intention of hastening a patient's death notwithstanding the criminal prohibitions on such conduct,⁴⁷⁷ the risk of under-reporting (bearing in mind the reasons for same) is far outweighed by the risk that unregulated conduct poses to patients. Indeed, research has confirmed that unreported cases of euthanasia in Belgium 'are in general carried out with less care than reported ones.'⁴⁷⁸ Given that cases of unregulated euthanasia are occurring in England and Wales notwithstanding the ban on assisted suicide, and considering the evidence from permissive jurisdictions such as Oregon concerning the characteristics of people accessing assisted dying and the rates of compliance with legal safeguards, legalising those practices at the least in certain circumstances would provide greater protection to potentially vulnerable individuals.

In sum, the recent empirical evidence from a number of permissive jurisdictions confirms the evidence that was before Justice Smith and the consistency in data across permissive jurisdictions supports the trial judge's finding that a permissive scheme does not pose an unacceptable risk to individuals who may be vulnerable to undue influence. While none of the jurisdictions has achieved 'perfection' in reporting and compliance, the safeguards 'work well in protecting patients from abuse while allowing competent patients to choose the timing of their deaths.'⁴⁷⁹ It bears noting that 'perfection' is not the benchmark in terms of Article 8 of the ECHR. Rather, the empirical evidence confirms the findings in Chapter

⁴⁷⁴ Sigrid Dierickx, Joachim Cohen, Robert Vander Stichele, Luc Deliens and Kenneth Chambaere, 'Drugs used for euthanasia: A repeated population-based mortality followback study in Flanders, Belgium, 1998-2013' (2018) 56 *Journal of Pain and Symptom Management* 551.

⁴⁷⁵ See, for instance, Seale (2006) and (2009) (n 376).

⁴⁷⁶ *Carter* (n 13) [660].

⁴⁷⁷ *Seale* (2006) and (2009) (n 376). Much research has been done into the practice of palliative sedation including, inter alia, the intention to hasten death in cases of palliative sedation. See, for instance, Sam Rhys et al (n 473) and Kenneth Chambaere et al (n 473).

⁴⁷⁸ Luc Deliens and Tinne Smets, 'Euthanasia (requests) after the implementation of the euthanasia law in Belgium in 2002. Results of empirical studies in Flanders, Belgium', in *The Patient's Wish to Die* (n 25), 57.

⁴⁷⁹ *Carter* (n 13) [685].

Four that the blanket ban *is* more than is necessary to secure the legitimate aims and there is a less restrictive means of balancing the competing interests.

4.3 Protecting the doctor/patient relationship

As discussed in Chapter Four, there is evidence that allowing assisted dying can benefit the doctor/patient relationship by ensuring transparency and honesty in the relationship. The ensuing will consider that and other data in order to ascertain whether the findings of Justice Smith in respect of the doctor/patient relationship remain valid.

On 21 March 2019, after a poll of members, the Royal College of Physicians altered its erstwhile objection to legalising assisted dying to a neutral stance. Of the 6,885 members who responded to the poll, 49.5 per cent responded ‘no’ to the question: ‘Do you support a change in the law to permit assisted dying?’, while 40.5 per cent responded ‘yes’ (with 10.5 per cent undecided). In the absence of a supermajority, the neutral position was adopted. Relevantly, the percentage of members in favour of a change rose from 32.3 per cent in 2014, while the number against dropped from 57.5 per cent. The percentage of members prepared to participate in assisted dying rose from 21.4 to 24.6 per cent, while the percentage who would not dropped from 58.4 to 55.1 per cent.⁴⁸⁰ The change in the position of the Royal College of Physicians reflects broader societal support for assisted dying.⁴⁸¹

Victoria (Australia) very recently introduced assisted dying legislation, following an extensive consultation period that included a Parliamentary inquiry which recommended, *inter alia*, the legalisation of assisted dying for certain patients. The final report of the inquiry noted the arguments for and against legalising assisted dying in the context of the doctor/patient relationship and concluded that permitting assisted dying in certain circumstances with attendant safeguards would benefit the relationship.⁴⁸² As the report noted, permitting assisted dying ‘would enable people to discuss their preferred end of life care with their general practitioner, who is best placed to assist in the process given their longstanding, trusted relationships with patients.’⁴⁸³ This conclusion reflects a significant

⁴⁸⁰ Royal College of Physicians, ‘Assisted dying survey 2019 results’ (21 March 2019) <<https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral>> accessed 16 May 2019.

⁴⁸¹ See, for instance, My Death, My Decision, ‘Polls’ <<https://www.mydeath-mydecision.org.uk/info/polls/>> accessed 16 May 2019.

⁴⁸² Parliament of Victoria: Legislative Council, Legal and Social Issues Committee, Inquiry into end of life choices: Final Report (LSIC Report No. 5, 58th Parliament, 9 June 2016) <<https://www.parliament.vic.gov.au/lpic/article/2611>> accessed 20 May 2019.

⁴⁸³ *ibid*, 147.

body of research into the impact of legalising assisted dying on the doctor/patient relationship.⁴⁸⁴ A qualitative thematic analysis of interviews with patients making explicit requests for euthanasia found that:

[T]he nature and quality of the patient–physician relationship were crucial during decision-making. The patient’s request put a strain on the patient–physician relationship – cutting across the usual curative role. When physicians, patients and relatives established effective relationships, positive relational effects resulted, even if initial requests were declined. Effective relationships included mutual respect for autonomy, clear communication and collaboration. When patients were aware of the burden that providing EAS [euthanasia/assisted suicide] placed on the physician, this improved relationships.⁴⁸⁵

This quote encapsulates the complexity of the doctor/patient relationship both generally and in the specific context of assisted dying. It demonstrates that while assisted dying does have an impact on the doctor/patient relationship, it is not necessarily negative. Effective relationships between all parties (including relatives) can lead to positive outcomes even if the request for assisted dying is denied. There is also evidence that effective engagement by doctors with a patient’s family can further improve the doctor/patient relationship and assisted dying can also improve a family’s experience of a loved one’s death.⁴⁸⁶

The empirical data demonstrates that legalisation of assisted dying does not *per se* deleteriously affect the doctor/patient relationship. Rather, it will have a negative impact where the relationship is already defective: where there is a lack of ‘mutual respect for autonomy, clear communication and collaboration.’ Where, however, the relationship is one involving ‘mutual respect for autonomy, clear communication and collaboration’, assisted dying does not have a negative impact and may, in fact, have a positive impact on

⁴⁸⁴ See, for instance, Marianne Snijdwind, Donald van Tol, Bregje Onwuteaka-Philipsen, Dick Willems, ‘Complexities in Euthanasia or Physician-Assisted Suicide as Perceived by Dutch Physicians and Patients’ Relatives’ (2014) 48 *Journal of Pain and Symptom Management* 1125; Jamie Fujioka, Raza Mirza, P. Lynn McDonald and Christopher Klinger, ‘Implementation of Medical Assistance in Dying: A Scoping Review of Health Care Providers’ Perspectives’ (2018) 55 *Journal of Pain and Symptom Management* 1564; Laura Brooks, ‘Health Care Provider Experiences of and Perspectives on Medical Assistance in Dying: A Scoping Review of Qualitative Studies’ (2019) *Canadian Journal on Aging* (10 January 2019).

⁴⁸⁵ Marianne K Dees, Myrra J Vernooij-Dassen, Wim J Dekkers, Glyn Elwyn, Kris C Vissers and Chris van Weel, ‘Perspectives of decision-making in requests for euthanasia: A qualitative research among patients, relatives and treating physicians in the Netherlands’ (2013) 27 *Palliative Medicine* 27, 31.

⁴⁸⁶ See, for instance, Bernadette Roest, Margo Trappenburg, Carlo Leget, ‘The involvement of family in the Dutch practice of euthanasia and physician assisted suicide: a systematic mixed studies review’ (2019) 20 *BMC Medical Ethics* 23; Marianne C Snijdwind, Donald van Tol, Bregje Onwuteaka-Philipsen, Dick Willems, ‘Complexities in Euthanasia or Physician-Assisted Suicide as Perceived by Dutch Physicians and Patients’ Relatives’ (2014) 48 *Journal of Pain and Symptom Management* 1125.

the doctor/patient relationship. This evidence confirms the findings of Justice Smith in *Carter* set out above.

4.4 Protecting sanctity of life

As discussed at length in Chapters One and Four, while the sanctity of life is a principle of paramount importance in England and Wales, it is not absolute. It can and does give way to a patient's autonomy and self-determination in cases involving withdrawal/refusal of life-sustaining treatment and it does not prevent doctors ceasing life-sustaining treatment of incapacitous patients. In 2018, the UK Supreme Court confirmed that where there is agreement between an incapacitous patient's treating physicians and their family or loved ones that continuing life-sustaining treatment is not in the patient's best interests, the treatment can be ceased without obtaining declaratory relief from the courts.⁴⁸⁷ Similarly, citing its decision in *Pretty*, the Grand Chamber in *Lambert*⁴⁸⁸ held that when considering whether continuing life-sustaining treatment is in the best interests of an incapacitous patient, questions concerning quality of life are relevant:

The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.

The Court will take these considerations into account in examining whether the State complied with its positive obligations flowing from Article 2...⁴⁸⁹

The decisions of *Re Y* and *Lambert* – both of which postdate *Carter* – confirm that autonomy and self-determination can take precedence over concerns regarding the sanctity of life. The conflicting weight of these principles was acknowledged by Lady Hale in *Nicklinson*, who observed that:

Respect for the intrinsic value of all human life is probably the most important principle in Judaeo-Christian morality. It would surely justify an absolute refusal to

⁴⁸⁷ *Y* (n 35).

⁴⁸⁸ *Lambert* (n 172).

⁴⁸⁹ *ibid* [142]–[143].

oblige any person to help another commit suicide. It would not so obviously justify prohibiting those who freely judged that, in the circumstances of a particular case, there was no moral impediment to their assisting suicide. Respect for individual autonomy and human dignity are also important moral principles. The very complexity of the moral argument, amply demonstrated in the material before this court, tells against relying upon this as the legitimate aim of the legislation.⁴⁹⁰

Considering that sanctity of life concerns do not preclude capacitous patients from exercising their autonomy and self-determination to refuse, or withdraw their consent to, life-sustaining treatment, nor does it stop doctors from withdrawing life-sustaining treatment from incapacitous patients, the principle should not preclude capacitous individuals exercising control over the manner and timing of the death.

Further, the empirical evidence considered above with respect to the individuals most likely to access assistance in dying and the rates of compliance in permissive jurisdictions, when considered in light of the *de facto* system of assisted dying which exists in England and Wales as a result of the exercise of the CPS's discretion, demonstrates that permitting assisted dying does not violate the sanctity of life, at least insofar as that term is understood in the broader medical context.

Finally, 'slippery slope' concerns are frequently cited in support of claims that legalising assisted dying will undermine the sanctity of life.⁴⁹¹ In addressing this concern, it is imperative to have a clear understanding of what a 'slippery slope' argument is:

Typically, 'slippery slope' arguments claim that endorsing some premise, doing some action or adopting some policy will lead to some definite outcome that is generally judged to be wrong or bad. The 'slope' is 'slippery' because there are claimed to be no plausible halting points between the initial commitment to a premise, action, or policy and the resultant bad outcome. The desire to avoid such projected future consequences provides adequate reasons for not taking the first step.⁴⁹²

Applied to the potential legalisation of assisted dying, the slippery slope argument holds that allowing a specified group of individuals access to assistance in dying will, inevitably,

⁴⁹⁰ *Nicklinson* (n 7) [311].

⁴⁹¹ See, for instance, Select Committee on the Assisted Dying for the Terminally Ill Bill (n 19) [91]-[102]; *Pretty* (n 7) [54]; *Nicklinson* (n 7) [201] (Lord Mance); HC Deb 4 July 2019 (n 11) cols 1412-13.

⁴⁹² Walter Wright, 'Historical Analogies, Slippery Slopes, and the Question of Euthanasia' (2000) 28 *Journal of Law, Medicine and Ethics* 176, 177.

lead to an expansion of the eligibility criteria to include individuals who were not initially foreseen as having access. The only jurisdiction to expand the eligibility criteria initially specified in its permissive legislation is Belgium, which amended its assisted dying law to include competent minors in certain circumstances in 2014. Specifically, euthanasia in Belgium is legal for minors who are in a ‘medically futile condition of constant and unbearable *physical* suffering that cannot be alleviated and that will, *within a short period* of time, *result in death*, and results from a serious and incurable disorder caused by illness or accident’.⁴⁹³ While on its face, the 2014 amendment may be evidence of a slippery slope insofar as the eligibility criteria has been expanded beyond that which was initially contemplated, this ignores several important facts. Euthanasia in Belgium has, since its legalisation, been available to emancipated minors (children aged 15 years or older who are legally emancipated⁴⁹⁴) and, perhaps more significantly, the expansion to children in specific circumstances (subject to the consent of the child’s ‘legal representatives’) was the result of a democratic process, reflecting the wishes of the public and, thus, the expansion, was not judged as wrong or bad by a majority of Belgians.⁴⁹⁵ The expansion to certain children is not, then, evidence of a ‘slippery slope’. Further, the inclusion of competent children in the assisted dying system in Belgium is wholly consistent with the approach taken to treatment of competent children in England and Wales, where Gillick-competent children are afforded the opportunity to make decisions about their treatment, including where those decisions will lead to their death, subject to the consent of the child’s parents and/or a determination of the court.⁴⁹⁶ Finally, the expansion of the assisted dying regime to include capacitous minors in the Belgian system had been a matter of inquiry from the outset, as is the case in Canada (where the amending legislation expressly requires the federal Ministers of Health and Justice to consider expanding the scheme to include

⁴⁹³ Kasper Raus, ‘The Extension of Belgium’s Euthanasia Law to Include Competent Minors’ (2016) 13 *Journal of Bioethical Inquiry* 305, 307 (citing the Belgian ‘Act amending the Act of 28 May 2002 on euthanasia, sanctioning euthanasia for minors 2014’). Emphasis added to reflect the difference with the position for non-minors under the Belgian law. Additionally, consent from the child’s legal representatives is required.

⁴⁹⁴ *ibid*, 306

⁴⁹⁵ Raus (n 493). See, also, Kristof Van Assche, Kasper Raus, Bert Vanderhaegen and Sigrid Sterckx, ‘“Capacity for Discernment” and Euthanasia on Minors in Belgium’ (2019) 27 *Medical Law Review* 2.

⁴⁹⁶ As MacDonald J observed recently in *University Hospitals Plymouth NHS Trust v B (A Minor)* [2019] EWHC 1670 (Fam):

[12] ...unlike the position with competent adults a refusal by a minor recognized by law as having the capacity to authorise treatment (whether given by a child over the age of 16 or a younger Gillick competent child) is not binding on the doctors if another person with capacity to consent to treatment does so. In effect, this means that any person with parental responsibility can authorize the imposition of medical treatment on an unwilling child, as can the court.

requests by mature minors⁴⁹⁷) and Victoria (where the eligibility for ‘competent mature minors’ was considered).⁴⁹⁸ There is, then, no evidence of ‘slippery slopes’ in permissive jurisdictions. This is consistent with Justice Smith’s finding that the evidence from permissive jurisdictions ‘serve[d] to allay fears’ of a slippery slope.⁴⁹⁹

5. Conclusion

Justice Smith’s trial judgment in *Carter* is, and remains, a highwater mark when it comes to collating, analysing and applying the evidence relating to assisted dying in the context of human rights disputes. Nevertheless, the English courts have been quick to reject the utility of the judgment, citing apparent differences in the rights, analyses and evidence in issue. This chapter has demonstrated that, contrary to the claims of the English courts, the rights and analyses at the centre of the *Carter* proceedings overlap considerably with Article 8 of the ECHR and the proportionality assessment undertaken with respect to same. As for the evidence, it is inevitable that a decision which is over 10 times the length and which relied on evidence from over 50 leading experts including, crucially, their cross-examination, would cite different evidence to that relied upon by an English court hamstrung by the usual rule precluding cross-examination of witnesses in judicial review proceedings.⁵⁰⁰ Nevertheless, when regard is had to the evidence before Justice Smith *vis-à-vis* that which was before the English courts considering s 2 of the Suicide Act 1961 following *Carter*, it is clear that the evidence before Justice Smith was a far more detailed version of that which was before the English courts. Accordingly, the judgment in *Carter* is of significant utility to English courts considering the compatibility of s 2 of the Suicide Act 1961 with the ECHR, especially Articles 2, 3 and 8. However, the trial judgment in *Carter* was delivered 7 years ago, and caution must necessarily attend reliance upon data and conclusions that are dated.

Having established the relevance and utility of *Carter*, this chapter examined the evidence before, and conclusions of, Justice Smith in respect of the three ‘legitimate aims’ of the blanket ban in England and Wales outlined in Chapter Four: protecting individuals vulnerable to undue influence; protecting the doctor/patient relationship; and, protecting the sanctity of life. In respect of each aim, Justice Smith determined that the evidence did

⁴⁹⁷ Bill C-14, s 9.1(1) < <https://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent> > accessed 22 May 2019.

⁴⁹⁸ Legislative Council, Legal and Social Issues Committee, Inquiry into end of life choices (n 482), 276.

⁴⁹⁹ *Carter* (13) [1241], [1366], [1367].

⁵⁰⁰ Indeed, Omid T unsuccessfully applied to the High Court to cross-examine experts in his judicial review of the ban’s compatibility with the ECHR: *Omid T* (n 85).

not support a *blanket* ban on assisted dying. Rather, a more fairly balanced approach was possible, in which certain individuals could access assistance in dying, while safeguards could minimise the risks. Given, however, the length of time that had passed since the delivery of Justice Smith's judgment, it was necessary to consider what impact, if any, subsequent empirical evidence had had on the trial judge's findings.

An examination of data collated by regulatory bodies in permissive jurisdictions, in particular Belgium, the Netherlands, Oregon and Canada, together with the results of research conducted after *Carter*, confirmed the findings of the trial judge. In particular, in the jurisdictions surveyed (which reflected a cross section of assisted dying systems), individuals in their seventies, with terminal cancer continue to be the highest proportion of individuals to access assistance in dying. Further, rates of non-compliance with safeguards are consistently low across the jurisdictions surveyed, with cases of non-compliance (where information is available) tending to involve complex cases where opinions can and do reasonably differ as to the appropriate course of action. It is notable, also, that there is evidence that some doctors in England and Wales administer increasingly high doses of pain relief with the intention of bringing about the patient's death (i.e. euthanasia) and it is undeniable that individuals are assisted to die in England and Wales.⁵⁰¹ Legalising assisted dying would provide greater transparency in respect of such practices which, in turn, would minimise the risk to vulnerable individuals. As for the doctor/patient relationship, subsequent research has confirmed the findings of Justice Smith that while assisted dying inevitably impacts upon the doctor/patient relationship, it is not *per se* negative and can, in fact, be positive, by allowing patients to discuss their end-of-life care openly with their treating physicians. Finally, while of paramount importance, the principle of the sanctity of life can and does give way to other competing principles including self-determination and autonomy in other end-of-life contexts (i.e. withdrawal and refusal of life-sustaining treatment) and legalising assisted dying in specific circumstances so as to enable individuals to exercise their autonomy and self-determination is completely compatible with, and does not undermine, the existing approach to sanctity of life concerns in end-of-life care. There is also no evidence of slippery slopes materialising in permissive jurisdictions.

The findings of Justice Smith, together with subsequent data available from permissive jurisdictions, not only confirm the conclusion reached in the preceding chapter that the

⁵⁰¹ Seale (2006) and (2009) (n 376).

blanket ban on assisted suicide in England and Wales is incompatible with Article 8 of the ECHR, but also demonstrate that permissive schemes do not lead to the risks which the blanket ban is said to be necessary to protect against. In those circumstances, and recalling that a ‘guaranteed-to-function’ alternative is not a valid legal requirement before a measure can be found to violate Article 8 of the ECHR, the evidence strongly suggests that there *is* an alternative which does not pose the risks prophesied by the State and which is, then, ‘guaranteed-to-function’. Certainly, such schemes achieve a better balance between the competing rights and will better protect individuals vulnerable to undue influence, than the current *de facto* system in England and Wales of permitting benevolent assistance of loved ones who are terminally ill or elderly or are suffering intolerably as a result of a medical condition.

CHAPTER SIX

DIFFERENTIAL TREATMENT OF END-OF-LIFE PRACTICES: DISCRIMINATION UNDER ARTICLE 14 OF THE ECHR?

1. Introduction

As the preceding chapters have shown, there is a strong argument that the blanket ban on assisted suicide in England and Wales is incompatible with the rights in the ECHR to: life (Article 2); freedom from torture or inhuman or degrading treatment (Article 3); and, private life (Article 8). Having considered those substantive rights, it remains to be determined whether the blanket ban on assisted suicide is discriminatory, in violation of Article 14. This is an argument that has been litigated before both the domestic courts and the ECtHR but none of those courts concluded that the ban violated any of the substantive rights in the ECHR. More recently, Paul Lamb (who was a party to the *Nicklinson* proceedings) has written to the Justice Secretary arguing that the ban is discriminatory.⁵⁰² In light of the conclusions reached in earlier chapters, this chapter will consider whether the ban is, in fact, discriminatory. In so doing, this chapter will examine not only whether the ban has a disproportionate impact on some individuals as a result of their medical condition/physical disability, but also whether the ban fails to treat like cases alike. The latter examination turns on what acts constitute ‘suicide’ for the purposes of the Suicide Act 1961. If it is the case that certain permissible end-of-life practices such as the withdrawal/refusal of life-sustaining treatment constitute ‘suicide’ as that term is employed in s 2 of the Suicide Act 1961, the law fails to treat like cases alike, since the ban is only applied to *some* forms of assisted suicide.

2. Discrimination

2.1. General principles

Article 14 of the ECHR provides:

The enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

⁵⁰² Leigh Day, ‘Paul Lamb to bring new legal case for the right to die’ (7 May 2019) <<https://www.leighday.co.uk/News/2019/May-2019/Paul-Lamb-to-bring-new-legal-case-for-the-right-to>> accessed 11 June 2019.

Article 14 has no standalone effect; it ‘complements the other substantive provisions of the Convention and the Protocols thereto.’⁵⁰³ While the application of Article 14 does not ‘presuppose a breach of the [substantive] provisions ... there can be no room for its application unless the facts at issue fall within the ambit of one or more of them.’⁵⁰⁴ The preceding chapters have established that the blanket ban on assisted suicide engages the right to life (Article 2), the right to freedom from torture or inhuman or degrading treatment (Article 3) and the right to private life (Article 8), and Article 14 thus applies. Under Article 14:

[A] difference in treatment between persons in analogous or relevantly similar positions is discriminatory if it has no objective and reasonable justification, that is if it does not pursue a legitimate aim or if there is not a reasonable relationship of proportionality between the means employed and the aim sought to be realised.⁵⁰⁵

The State has a margin of appreciation in ‘assessing whether and to what extent differences in otherwise similar situations justify a different treatment.’⁵⁰⁶ The ECtHR has also held that ‘a general policy or measure that has disproportionately prejudicial effects on a particular group may be considered discriminatory notwithstanding that it is not specifically aimed at that group.’⁵⁰⁷ Additionally, Article 14 requires that States ‘treat differently persons whose situations are significantly different.’⁵⁰⁸ The list of prohibited grounds of discrimination in Article 14 is not exhaustive and has been held to include a person’s disability and medical condition.⁵⁰⁹

2.2. Disproportionately prejudicial effect

In *Pretty v United Kingdom*, the ECtHR considered the applicant’s complaint that she had been discriminated against in the enjoyment of the right to choose the manner and timing of her death (as protected by Article 8) ‘in that the domestic law permit[ed] able-bodied persons to commit suicide yet prevent[ed] an incapacitated person from receiving assistance in committing suicide.’⁵¹⁰ While the ECtHR framed Ms Pretty’s argument as one

⁵⁰³ See, for instance, *Molla Sali v Greece* App no 20452/14 (ECtHR, 19 December 2008) [123].

⁵⁰⁴ *ibid.*

⁵⁰⁵ *Molla Sali* (n 503) [88].

⁵⁰⁶ *ibid.*

⁵⁰⁷ *D.H. v Czech Republic* App no 57325/00 (ECtHR, 13 November 2007) [175].

⁵⁰⁸ *ibid.*

⁵⁰⁹ See, for instance, *Stec and Ors v United Kingdom* App nos 65731/01 and 65900/01 (ECtHR, 12 April 2006) [50]; *I.B v Greece* App no 552/10 (ECtHR, 3 October 2013) [73]; *Glor v Switzerland* App no 13444/04 (ECtHR, 30 April 2009) [53]. See, also, *Burnip v Birmingham City Council* [2012] EWCA Civ 629 in which the Court of Appeal confirmed that disability was a prohibited basis of discrimination for the purposes of Article 14.

⁵¹⁰ *Pretty v United Kingdom* (n 7) [87].

based on a failure to treat materially different cases differently, this seems to misconceptualise Ms Pretty's case. As the ECtHR noted, Ms Pretty's argument was that 'She was prevented from exercising a right enjoyed by others who could end their lives without assistance because they were not prevented by any disability from doing so. She was therefore treated *substantively differently* and less favourably than those others.'⁵¹¹ It appears from both the House of Lords' reasons and the judgment of the ECtHR that Ms Pretty's case with respect to discrimination was, in fact, based on the contention that an objectively neutral law (i.e. one that applied to everyone) had a disproportionately prejudicial effect on individuals who wanted to die by suicide but were unable to do so because of their medical condition and/or physical disability and was, thus, discriminatory. The House of Lords rejected Ms Pretty's Article 14 claim since '[t]he law confers no right to commit suicide' and, consequently, the argument that the ban prevented the physically disabled, but not the able bodied, from exercising a right to commit suicide failed. Further, the ban prevented *all* individuals from accessing assistance in dying by suicide; there was no differential treatment. In contrast, Justice Smith in *Carter* held that the analogous ban in Canada was discriminatory because it had 'a more burdensome effect on persons with physical disabilities than on others' and the ban thus created a distinction based on physical disability.⁵¹² To use the nomenclature of Article 14 of the ECHR, Justice Smith determined that an apparently neutral law (a ban that applied to everyone) put persons having a physical disability at a particular disadvantage compared with other persons without a physical disability and that amounted to discrimination on the basis of a person's disability. The same argument can be applied to s 2 of the Suicide Act 1961 in the context of Article 14 of the ECHR. The ban, which is ostensibly neutral insofar as it applies to everyone, imposes a disproportionate burden on individuals like Ms Pretty who, due to their medical condition (a protected characteristic for the purposes of Article 14), are physically incapable of dying by suicide without assistance. People without medical conditions that compromise their physical ability are not similarly affected. The latter are able to take their own lives without assistance and can, thus, exercise their right to choose the manner and timing of their deaths in a way that individuals who are physically disabled cannot because of the ban. While the ban applies to both able bodied and physically disabled individuals, the:

⁵¹¹ *ibid* [85] (emphasis added).

⁵¹² *Carter* (n 13) [1077].

[M]eans of suicide available to non-disabled persons ... are much less onerous than self-imposed starvation and dehydration [being the means of suicide available to individuals like Tony Nicklinson], and it is only physically disabled persons who are restricted to that single, difficult course of action.⁵¹³

There is, then, a strong argument that the ban is discriminatory because it has a disproportionately prejudicial impact on individuals like Tony Nicklinson and Paul Lamb and Noel Conway who, because of their medical condition and/or physical disability, are unable to suicide without assistance. It is notable that the Supreme Court, in rejecting Mr Conway's leave for appeal, observed that once he becomes dependent on continuous ventilation he could bring about his death by refusing to consent to its continued administration. As the Supreme Court said 'withdrawal would usually lead to his death within a few minutes, although it can take a few hours or in rare cases days.'⁵¹⁴ But, as Justice Smith held in *Carter*, the fact that the only means of suicide available to individuals like Mr Conway is the withdrawal of life-sustaining treatment provides evidence of the differential treatment the ban imposes on such individuals and that difference is based on their medical condition and/or disability which is a prohibited basis of discrimination under Article 14.

The same arguments are equally applicable to the prohibition on euthanasia. For individuals who are physically incapable of taking the final step necessary to suicide (for instance, swallowing a lethal dose of medication), permitting assisted suicide will not redress the disproportionately prejudicial effect that the offence of murder has on them. For such individuals to bring about their deaths they are restricted to self-imposed starvation and dehydration or the refusal of life-saving antibiotics in the event of an infection. Individuals without such disabilities are not similarly restricted.

There is also evidence that the ban has a disproportionately adverse impact on individuals like Omid T who, as a result of their medical condition and likely deterioration and death, are forced to take their lives prematurely. Individuals who do not have a medical condition that will result in a deterioration to such a state that their quality of life is severely diminished or will cause a prolonged, painful and undignified death are not similarly compelled to take their lives prematurely. Likewise, for individuals like Diane Pretty, Omid T and Noel Conway, the criminalisation of assistance constitutes inhuman or

⁵¹³ *ibid* [1076].

⁵¹⁴ *Conway* (Supreme Court) (n 8) [3].

degrading treatment in violation of Article 3 of the ECHR. Again, the ban has a disproportionately adverse impact on those individuals who, because of their medical condition, would die by suicide with assistance but are precluded from lawfully doing so.

There is, then, a strong argument that the blanket ban on assisted suicide in England and Wales is discriminatory as it has a disproportionately prejudicial effect on individuals who are physically incapable of dying by suicide without assistance. That argument is similarly applicable to the prohibition on euthanasia which has a disproportionately prejudicial effect on individuals like Tony Nicklinson who are physically incapable of suiciding (i.e. they cannot do the final act necessary to suicide, such as swallowing a lethal dose of medication). Insofar as this form of discrimination can be justified, it must have an ‘objective and reasonable justification’. Discrimination will not meet that threshold ‘if it does not pursue a “legitimate aim” or if there is not a “reasonable relationship of proportionality” between the means employed and the aim sought to be realised’.⁵¹⁵ The conclusions in Chapters Four and Five concerning the ban’s legitimate aim(s) and proportionately are germane and, as demonstrated in those chapters, the *blanket* ban on assisted suicide is not proportionate to the justifications proffered by the State. As discussed in Chapter Four, the same conclusion applies to the prohibition on euthanasia. A blanket prohibition in cases of individuals who are suffering intolerably as a result of a terminal or life-limiting condition or who are suffering as a result of geriatric syndromes is not proportionate to any of the aims proposed for the ban on assisted suicide. There is, then, a strong argument that the disproportionately adverse impact of the ban on assisted suicide and euthanasia on individuals like Diane Pretty, Tony Nicklinson, Noel Conway and Omid T on the basis of their medical condition and/or physical disability is unjustified. The ban on assisted suicide and euthanasia thus violates Article 14, taken in conjunction with Articles 2, 3 and 8 of the ECHR.

There is, however, another basis upon which it could be argued that the ban on assisted suicide is discriminatory: the failure to treat like cases alike. As the ensuing analysis reveals, the meaning of ‘suicide’ for the purposes of the Suicide Act 1961 and, in particular, the legal principles of intention and causation applicable to same, cover certain instances of withdrawal/refusal of life-sustaining treatment. While English law permits those forms of assisted suicide, it prohibits absolutely other forms of assisted suicide and the basis for that differential treatment is the individual’s medical condition. If the individual is terminally ill

⁵¹⁵ See, for instance, *Fabris v France* (2013) 57 EHRR 19 [56].

and receiving life-sustaining treatment, they can die by suicide with assistance by refusing or seeking the withdrawal of that treatment. If the individual is not receiving life-sustaining treatment, they cannot avail themselves of an assisted death. For the same reasons given in Chapters Four and Five and above, the justification(s) for this discrimination (insofar as it can be justified) are neither objective nor reasonable; insofar as they are legitimate, a *blanket* ban is disproportionate and the differential treatment is discriminatory.

3. The *legal* definition of ‘suicide’ in England and Wales

Suicide has been the subject of legal, philosophical, medical, sociological and religious debate for millennia and ‘The subject ... is now in pretty much the same state as when it began.’⁵¹⁶ Common amongst these disparate fields of study is the absence of an agreed definition of suicide. Of the innumerable definitions presently pervading the academic and medical literature, Margaret Battin has observed that:

It can be argued that terminological differences often serve to mark views about the morality of self-killing in various circumstances or for various reasons and that the wide range of terms used in cases of voluntary, knowing causation of one’s own death serves this purpose...⁵¹⁷

Definitions serve many and varied purposes and ‘a definition for the purposes of law may and sometimes should differ from one for scientific, ethical or other purposes.’⁵¹⁸ Thus, for example, what constitutes suicide in the medical field may not constitute suicide for the purposes of the Suicide Act 1961. A potential explanation for the absence of a definition of ‘suicide’ in the Suicide Act 1961 (and, indeed, the lack of an examination of what suicide means for the purposes of the Act by either the courts or Parliament) is the assumption that ‘suicide’ has a ‘plain’ or ‘ordinary’ meaning.⁵¹⁹ Such an assumption, however, ignores the fact that there is no single, uniform (and uncontroversial) understanding of ‘suicide’ such as would justify the title ‘plain’ or ‘ordinary’ meaning. Indeed, ‘the word [suicide] ... is peculiar’; the Latin word, *suicidium*, from which the English ‘suicide’ derives, is not ‘classical Latin’ and ‘could only have meant “the killing of

⁵¹⁶ Glanville Williams, *The Sanctity of Life and the Criminal Law* (Faber & Faber Limited 1958), 224.

⁵¹⁷ Margaret P Battin (ed), *The Ethics of Suicide: Historical Sources* (OUP 2015), 7-8 (emphasis added).

⁵¹⁸ Michael D Bayles, ‘Definitions in law’ in James Fetzer, David Shatz and George Schlesinger (eds), *Definitions and Definability: Philosophical Perspectives* (Springer 1991), 253.

⁵¹⁹ This being the ‘cardinal rule’ of statutory interpretation: Daniel Greenberg (ed) *Craies on Legislation* (11th edn, Sweet & Maxwell 2017), ch 17.

a pig”⁵²⁰ More importantly, it ignores the fact that, as the ensuing discussion will demonstrate, there is a common law definition of suicide.

3.1. The common law prohibition on suicide

‘Contexts are crucial’ when distilling legal meaning and the prohibition on assisted suicide is rooted in the common law’s criminalisation of suicide.⁵²¹ While ‘no exact date exists for the creation of the first antisuicide legal norms ... [f]airly certain, however, is the fact that suicide was not considered to be a felony until the fourteenth century.’⁵²² Thereafter, suicide was classified as *felo de se*, the punishments for which included the forfeiture of property, the denial of a Christian burial, burying at a crossroads, and the driving of a stake through the body.⁵²³ As to the origins of the phrase *felo de se*, *felo* referred to ‘a class of crimes involving a breach of trust between a person and his lord’ and ‘felo-de-se or felon of self was derived from *felo* when self-murder came to be viewed as a felony.’⁵²⁴ The reclassification of suicide as a felony (i.e. *felo de se*) is frequently attributed to a desire to render the royal coffers the recipient of the suicide’s goods as opposed to the suicide’s lord: ‘every felon forfeited his goods to the King, [thus] it only had to be decided that suicide was a felony to divert forfeiture from the suicide’s immediate lord to the royal coffers.’⁵²⁵ A finding, then, that a deceased was guilty of *felo de se* had significant legal and ecclesiastical consequences for the deceased and their family.

As to the substance of the offence, *felo de se* was said to constitute self-murder, thus incorporating the *mens rea* requirement for murder.⁵²⁶ Writing in the 18th century, Blackstone observed that the law:

⁵²⁰ Sir John Barry, ‘Suicide and the Law’ (1965) 5 *Melbourne University Law Review* 1, 1; Miriam T Griffin, ‘Suicide’ in Simon Hornblower, Antony Spawforth, and Esther Eidinow (eds), *The Oxford Companion to Classical Civilisation* (2nd edn, OUP 2014).

⁵²¹ Bayles (n 518), 253.

⁵²² Dennis E Hoffman and Vincent J Webb, ‘Suicide as Murder at Common Law: Another Chapter in the Falsification of Consensus Theory’ (1981) 19 *Criminology* 372, 373. While Bracton observed in the 13th century that ‘suicide was not a felony per se, if committed by a criminal it indicated confession to the crime and should lead to forfeiture of goods’ (J Neeleman, ‘Suicide as a crime in the UK: legal history, international comparisons and present implications’ (1996) 94 *Acta psychiatrica Scandinavica* 252, 252). See, also, W Norwood East, ‘Suicide from a Medico-Legal Aspect’ *BMJ* (8 August 1931) 241.

⁵²³ See, for instance, Terri Snyder, ‘What historians talk about when they talk about suicide: the view from early modern British North America’ (2007) 5 *History Compass* 658; Barry (n 520).

⁵²⁴ Hoffman and Webb (n 522), 374.

⁵²⁵ Williams (n 516), 227. It is not clear whether forfeiture covered both land as well as personal chattels. ‘[I]n general, it seems to have been limited to chattels’ (Barry (n 520), 2). See, also, Hoffman and Webb (n 522), 375-76; Neeleman (n 522), 253; and, Michael MacDonald, ‘The Medicalisation of Suicide in England: Laymen, Physicians, and Cultural Change, 1500-1870’ (1989) 67 *The Milbank Quarterly* 69, 70.

⁵²⁶ *Hales v Petit* (1565) 75 ER 399.

[R]anked *felo de se* [which he described as self-murder] among the highest crimes, making it a particularly peculiar species of felony, a felony committed on one's self ... A *felo de se* therefore is he that deliberately puts an end to his own life, or commits any unlawful malicious act, the consequence of which is his own death...⁵²⁷

Similarly, Hale's 'The History of the Pleas of the Crown' (first published in 1736) provided that 'felo de se or suicide is, where a man of age of discretion, and *compos mentis*, voluntarily kills himself by stabbing, poison, or any other way.'⁵²⁸ And, in 1866, Plunkett's 'Australian Magistrate' provided as a statement of offence for suicide that the deceased 'did unlawfully take a certain quantity of a certain deadly poison [*or destructive things*] called –, with intent then and thereby feloniously to kill and murder himself.'⁵²⁹ By at least the 18th century, then, there was a common law definition of suicide (or, rather, *felo de se*) which required that the deceased brought about their death while of sound mind and with the intent of bringing about that consequence.

Assisting or encouraging another to die by suicide (including by way of suicide pacts) was also unlawful. The state of the law was put in the following terms in the 1823 decision of *Rex v Dyson*:

If a man encourages another to murder himself and is present abetting him while he does so, such person is guilty of murder as a principal. If two encourage each other to murder themselves together, and one does so, but the other fails in the attempt upon himself, he is a principal in the murder of the other. But if it be uncertain whether the deceased really killed himself or whether he came to his death by accident before the moment when he meant to destroy himself, it will not be murder in either.⁵³⁰

Those encouraging and/or assisting were, then, guilty of the murder of the person who had suicided and individuals who survived a suicide pact were either guilty of:

- Murder in the second degree (if each member of the pact was responsible for taking his/her own life) *and* attempted murder of themselves; or,

⁵²⁷ Joseph Chitty (ed), *Commentaries on the Laws of England*, vol 4 (Walker 1826), 189.

⁵²⁸ Matthew Hale, *The History of the Pleas of the Crown*, vol 1 (E. Rider Little-Britain 1800) Chap XXXI, 411.

⁵²⁹ John Hubert Plunkett 'Australian Magistrate' [1866] *Australian Colonial Law Monographs* 1, 63. Words in square brackets in original.

⁵³⁰ *Rex v Dyson* (1823) Russ. & Ry 523, 930.

- Murder as a principal in the first degree (if the survivor killed the other person) *and* attempted murder of themselves.⁵³¹

While the law relating to suicide remained relatively unchanged between the 16th and 17th centuries, from the late 18th century significant amendments were made to the various laws penalising suicide. Specifically, the Right to Burial Act (1823) and the Internments (*felo de se*) Act (1882) formally recognised the right to a religious burial for a person who had died by suicide and the Abolition of Forfeiture Acts (1870) abolished forfeiture for penal offences (including *felo de se*).⁵³² These amendments, which ameliorated (somewhat) the ecclesiastical and legal consequences of a finding of *felo de se*, arose out of ‘social, political, and cultural changes’ (including, importantly, changes to inheritance laws⁵³³) which led to the secularisation of suicide and the associated cessation of the punishment of suicide by coroners and their juries.⁵³⁴ One of the primary ways in which this ‘palliation’ of the criminalisation of suicide was achieved was through the increasing number of *non compos mentis* findings by the coroner or their jury.⁵³⁵ A person who was determined to be *non compos mentis* when they died could not be said to have formed the requisite intention and could thus not be found to have died by *felo de se*. Thus, ‘By the end of the eighteenth century, a suicide was rarely pronounced sane.’⁵³⁶

Notwithstanding these legal changes, ‘suicide was still considered *felo-de-se*’ in England and Wales and attempted suicide continued to be an offence until suicide was decriminalised by the Suicide Act in 1961.⁵³⁷ Despite the decriminalisation of suicide, assisting and/or encouraging suicide remained (and remains) an offence. Indeed, when the Suicide Act was being read in the House of Lords, debate surrounded the potential illogicality of criminalising the aiding and abetting (as the offence was then phrased) of an act which, by virtue of that Act, was no longer itself an offence.⁵³⁸ Nevertheless, s 2 of the Suicide Act 1961 passed reading, thus criminalising the aiding, abetting, counselling or procuring of another’s suicide. While pursuant to s 2(1) ‘complicity in another’s suicide or

⁵³¹ Barry (n 520), 4.

⁵³² Hoffman and Webb (n 522), 379.

⁵³³ *ibid*, 379-80.

⁵³⁴ MacDonald (n 525), 74.

⁵³⁵ *ibid*, 75. See, also, Hoffman and Webb (n 522), 378.

⁵³⁶ Hoffman and Webb (n 522), 378. Non compos mentis verdicts accounted for 8.4 per cent of suicide verdicts in the 1660s, 15.8 per cent in the 1680s, almost 80 per cent in the 1750s and 97 per cent in 1780-1800 (MacDonald (n 525), 75, Figure 2).

⁵³⁷ *R v Mann* [1914] 2 KB 107. See, also, Neeleman (n 525), 252-257.

⁵³⁸ See, for instance, HL Deb (n 287), cols 246-76, 265 (Lord Denning).

attempted suicide [is] still an offence', it no longer constitutes murder; rather, it is a distinct indictable offence punishable by a maximum of 14 years' imprisonment.⁵³⁹ Significantly, for instant purposes, Parliament did not consider it necessary to define 'suicide' for the purposes of s 2 of the Suicide Act 1961 and, unless expressly stated otherwise, Parliament must be presumed to have intended for the phrase to bear the same meaning throughout the Act.⁵⁴⁰ 'Suicide' as used in s 2 of the Suicide Act 1961 must, then, have the same meaning as 'suicide' in s 1 which decriminalised the act. The definition of suicide for the purposes of s 2 is, then, the same as that which pertained while suicide was an offence under the common law and which, it is submitted, persists in large part in respect of suicide conclusions in the coronial context.

The question of whether a death was by way of suicide has, at least since the advent of the offence of *felo de se*, been a matter for the coroner. The office of coroner was established in 1194 and, consistent with the practice today 'The coroner was primarily responsible for making inquiries into all cases in which death was due to a cause other than a natural one, notably cases in which a question of criminal responsibility occurred (e.g. suicides, homicides and other types of violent death).'⁵⁴¹

The decriminalisation of suicide and the criminalisation of the offence of assisted suicide in s 2(1) of the Suicide Act 1961 did not alter that position; coroners remain mandated to investigate a death where, *inter alia*, there is reason to suspect that 'the deceased died a violent or unnatural death' (which includes suicide).⁵⁴² A material fact in any trial under s 2(1) of the Suicide Act 1961 will be whether the individual died by suicide (leaving aside for now the fact that the offence in s 2(1) covers attempted suicide) and, in the absence of any indication by Parliament that 'suicide' for the purposes of the Suicide Act 1961 has a meaning distinct from that employed in the Coroners and Justice Act 2009 ('CJA') (for instance, by providing a definition in either Act), 'suicide' must have the same meaning both in the coronial context and under s 2 of the Suicide Act 1961. Were it otherwise, a person may be found guilty of an offence under the Suicide Act in circumstances where

⁵³⁹ Criminal Law Revision Committee, Second Report (Suicide), Cmnd 1187 (HMSO 1960), 3.

⁵⁴⁰ Karl N Llewellyn, 'Remarks on the theory of appellate decision and the rules or canons about how statutes are to be construed' (1949) 3 *Vanderbilt Law Review* 395, 404.

⁵⁴¹ Hoffman and Webb (n 522), 377.

⁵⁴² Coroners and Justice Act 2009, ss 1 and 1(2)(a).

the deceased was not found to have died by suicide by a coroner/jury. There is nothing to suggest that Parliament intended the potential for such a legal absurdity.⁵⁴³

Indeed, Parliament has taken steps to avoid precisely that situation by requiring coroners to suspend an investigation into a person's death where a prosecuting authority so requests because a person may be charged with a 'homicide offence' (which includes assisting or encouraging suicide under s 2 of the Suicide Act 1961) or where the coroner becomes aware that a person has been charged with such an offence in respect of the deceased.⁵⁴⁴ If 'suicide' had a distinct meaning under the Suicide Act 1961 to that employed by the CJA, there would be no need to suspend an investigation given that the coroner's finding would have no impact on the criminal proceedings. If, as is submitted, suicide *does* have the same meaning in both Acts, it is of course necessary that an inquest be suspended where proceedings may or have been brought under the Suicide Act 1961 to avoid the absurd situation in which a person is convicted of an offence under the Suicide Act while the deceased is found not to have died by suicide by the coroner or *vice versa*. This interrelationship between coronial proceedings involving suicide and proceedings under s 2 of the Suicide Act 1961 is confirmed by the decision of *Ex Parte Luca*.⁵⁴⁵ That case concerned the applicability of the common law year and a day rule in coronial proceedings concerning suicide. Having determined that the rule, which applied when suicide was a crime, must still apply where a person was charged under s 2 of the Suicide Act 1961, the Court agreed with the submission that, while 'suicide' may have ceased to be a crime, it remained a creature which the common law recognised, including the year and a day rule. The Court also accepted the submission that 'A verdict of suicide ... should not be recorded now that suicide is no longer criminal when it could not have been recorded when it was.' The significance of the decision to the instant inquiry rests in the Court's examination of the common law rules applicable to criminal proceedings under the Suicide Act 1961 in deciding what rules were applicable in coronial proceedings involving a potential suicide. If 'suicide' meant different things for the purposes of the Suicide Act *vis-à-vis* the CJA, common law rules applicable to the former would not be applicable to coronial proceedings and the High Court reached the opposite conclusion thereby confirming the ongoing interplay between criminal and coronial proceedings involving suicide.

⁵⁴³ See, for instance, *Commissioners for Her Majesty's Revenue and Customs v DCC Holdings (UK) Limited* [2011] 1 WLR 44, [2010] UKSC 58.

⁵⁴⁴ Coroners and Justice Act 2009, Schedule 1, ss 1(2) and 2(2).

⁵⁴⁵ *R v Inner West London Coroner; Ex parte Luca* [1989] QB 249.

Given this overlap between the coronial jurisprudence and the Suicide Act 1961, and considering the wealth of case law regarding the meaning of suicide in the former, in contrast with the lack of analogous case law under the Suicide Act 1961, the ensuing section will examine how (if at all) the coronial jurisprudence has developed the common law definition of suicide proffered by Blackstone ('self-murder') and Hale ('voluntarily kill[ing] [one]self') with a view to distilling the present definition of 'suicide' for the purposes of the Suicide Act 1961 (and, incidentally, the CJA).

3.2. 'Suicide' and the CJA: the meaning of 'suicide'

The CJA and the Coroners (Inquest) Rules 2013 ('the Rules') (which deal with, *inter alia*, the reaching of conclusions⁵⁴⁶ of suicide by coroners and/or their juries) do not define 'suicide'. Case law concerning conclusions of suicide reveal that there are two elements which must be proven to the requisite standard of proof for a conclusion of suicide to be returned:

1. That the deceased intended their own death; and,
2. That they did an act with that intention which caused their death.⁵⁴⁷

As was the case at the time of Blackstone and Hale, intention remains the central aspect of a suicide conclusion. Thus, in *Ex Parte Thomas* the Court of Appeal held that 'in order to arrive at a verdict of suicide there must be evidence that the deceased intended the consequences of the act.'⁵⁴⁸ Similarly, in *Ex Parte Walker*, Leggatt J observed that the 'facts [must] point irresistibly to the existence of a suicidal intent' to support a suicide conclusion.⁵⁴⁹ Consistent with this case law, a Guidance document (which, though not legally binding, is nonetheless insightful⁵⁵⁰) produced by the Chief Coroner provides that:

[C]oroners should make express reference in each case of possible suicide to the two elements which need to be proved: (i) [the deceased] took his/her own life;

⁵⁴⁶ Since the enactment of the Coroners and Justice Act 2009 'verdicts' have been replaced with 'conclusions' (although courts still frequently use 'verdict').

⁵⁴⁷ See, for instance, *R (On the application of Lagos) v HM Coroner for the City of London* [2013] 3 WLUK 332, [2013] EWHC 423 (Admin).

⁵⁴⁸ *R v Cardiff City Coroner; Ex parte Thomas* [1970] 1 WLR 1475, 1478. See, also, *Re Davis* [1968] 1 QB 72 in which Sellers LJ opined that '[s]uicide is not to be presumed. It must be affirmatively proved to justify the finding. Suicide requires an intention' (82) (emphasis added).

⁵⁴⁹ *R v Northamptonshire Coroner; Ex parte Walker* (1989) 153 JP 289.

⁵⁵⁰ *R (On the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2019] 1 All ER 561, [2018] EWHC 1955 (Admin).

and (ii) [the deceased] intended to do so (or, put together, ‘he/she intentionally took his/her own life’) ... Suicide must never be presumed...⁵⁵¹

Likewise, the seminal text on coronial law and practice – *Jervis on Coroners* – provides that a conclusion of suicide ‘must always be based upon some evidence that the deceased intended to take his own life.’⁵⁵² Courts have also consistently reiterated that suicide cannot be presumed but, rather, must be ‘strictly proved’. Debate attends the standard of proof that applies to conclusions of suicide. The Divisional High Court in the recent decision of *Maughan*⁵⁵³ considered this issue at length and determined that the standard of proof is the civil standard, namely the balance of probabilities. This finding was confirmed by the Court of Appeal.⁵⁵⁴ Contrary case law including, for instance, *Lagos*⁵⁵⁵ which found that the standard was the criminal standard of beyond reasonable doubt, was held to be erroneous. There is much force in the Divisional High Court’s reasons in *Maughan*. In particular, as the Court emphasised, since coroners no longer play a role in the criminal justice system,⁵⁵⁶ and given the differences in the nature and purpose of coronial proceedings compared with criminal and civil proceedings, especially the lack of parties in the former, their inquisitorial nature and the fact that ‘[t]he function of an inquest is to seek out and record as many of the facts concerning the death as public interest requires’⁵⁵⁷ without determining culpability/liability, there is ‘no justification in principle for ... requiring proof to any higher standard than the balance of probabilities.’ This conclusion derives further support from

⁵⁵¹ Chief Coroner, ‘Guidance No. 17: Conclusions: Short-Form and Narrative’ (2013) [62] <<https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-17-conclusions.pdf>> accessed 30 July 2019 (citations omitted and emphasis added).

⁵⁵² Paul Matthew, *Jervis on Coroners* (13th edn, Sweet & Maxwell 2014), 13-67.

⁵⁵³ *Maughan* (n 550).

⁵⁵⁴ *Maughan v Her Majesty’s Senior Coroner for Oxfordshire* [2019] EWCA Civ 809, [2019] 3 All ER 567 [747].

⁵⁵⁵ *Lagos* (n 547).

⁵⁵⁶ *Maughan* (n 550) [34]:

Until 1977, it was the duty of a coroner's jury in any case where they found that the deceased had died through murder, manslaughter or infanticide, to state in the verdict the name of the person or persons considered to have committed the offence or to have been accessories to it. In such a case the record of the verdict (then known as the ‘inquisition’) would have the same effect as a bill of indictment committing the person or persons named to trial at what were originally the Courts of Assize and later the Crown Court. This power to commit originated before there were police forces or a fully established judicial system in England and Wales. It resembled, and was functionally equivalent to, that of the Grand Jury in criminal cases. The power was abolished by the Criminal Law Act 1977, section 56, which provided:

‘At a coroner’s inquest touching the death of a person who came by his death by murder, manslaughter or infanticide, the purpose of the proceedings shall not include the finding of any person guilty of the murder, manslaughter or infanticide; and accordingly a coroner’s inquisition shall in no case charge a person with any of those offences.’

⁵⁵⁷ *R v South London Coroner; Ex parte Thompson* (1982) 126 SJ 625 (Lord Lane LCJ) cited in *Maughan* (n 550) [37].

the fact that in ‘civil proceedings the standard of proof of criminal conduct remains the ordinary civil standard’ and especially since suicide is no longer an offence.⁵⁵⁸

The preceding analysis of the coronial case law reveals that there is a common law definition of ‘suicide’ which applies to the CJA (and the Rules) and which involves the doing of an act for the purposes of bringing about one’s death with the intention of bringing about that consequence. Such a definition is consistent with that expounded by Blackstone and Hale in the 18th century with respect to the common law offence of suicide (i.e. *felo de se*). Consistent with the presumption against the implied repeal of the common law, had Parliament intended for a different meaning to be given to ‘suicide’ as it appears in the Suicide Act 1961, the term would have been defined in that Act (whether at the time of enactment or as part of subsequent amendments, including when s 2(1) was amended in 2009). This is because ‘[s]tatutes are not presumed to make any alteration in the common law further or otherwise than the Act does expressly declare’.⁵⁵⁹ As Lord Steyn observed in *Pierson*:

For at least a century it has been ‘thought to be in the highest degree improbable that Parliament would depart from the general system of law without expressing its intention with irresistible clearness...’ The idea is even older. In 1855 Sir John Romilly observed that ‘...the general words of the Act are not to be so construed as to alter the previous policy of the law, unless no sense or meaning can be applied to those words consistently with the intention of preserving the existing policy untouched...’⁵⁶⁰

The absence of any definition of ‘suicide’ in the Suicide Act 1961 indicates that Parliament did not intend to depart from or alter the common law meaning. That the standard of proof in coronial proceedings involving a potential suicide is the civil standard does not alter the fact that ‘suicide’ for the purposes of both coronial proceedings and proceedings

⁵⁵⁸ *Maughan* (n 550) [40].

⁵⁵⁹ *Arthur v Bokenham* (1708) 11 Mod. 148, cited in Daniel Greenberg (ed), *Craies on Legislation: A Practitioners Guide to the Nature, Process, Effect and Interpretation of Legislation* (10th edn, Sweet & Maxwell 2016) 14.1.7. Similarly:

It is thought to be in the highest degree improbable that Parliament would depart from the general system of law without expressing its intention with irresistible clearness, and [to] give any such effect to general words merely because this would be their widest, usual, natural or literal meaning would be to place upon them a construction other than that which Parliament must be supposed to have intended.

(Peter Benson Maxwell, *On the Interpretation of Statutes* (12th edn, Sweet and Maxwell 1969), 116).

⁵⁶⁰ *R v Secretary of State for the Home Department; Ex parte Pierson* [1998] AC 539, 587, [1997] UKHL 37 (citations omitted).

under the Suicide Act 1961 has a common law meaning. Applying a lower evidentiary threshold in coronial proceedings to that applied in criminal proceedings under s 2 of the Suicide Act 1961 does not alter the interrelationship between the two jurisdictions. Both employ the same definition of ‘suicide’, it is simply the case that the existence of the elements of that definition must be proved to different standards depending on the jurisdiction, which is entirely consistent with the different function of each jurisdiction.

In sum, there is a common law definition of ‘suicide’ which applies to *both* the CJA and the Suicide Act 1961; ‘suicide’ as used in those Acts means the doing of an act for the purposes of bringing about one’s death and with the intention of bringing about that consequence. It is necessary to examine the content of that definition to determine what assisted dying practices properly fall within the remit of the Suicide Act 1961. More specifically, it is necessary to ascertain the:

- Nature of the intention required to be demonstrated on the part of the suicide; and,
- Degree of causation required (if any) between the act done by the suicide and their death.

Only once an examination of those issues has been completed will it be possible to determine which assisted dying practices are covered by the Suicide Act 1961. This, in turn, will facilitate an examination of whether the ban is discriminatory in violation of Article 14 of the ECHR. For the reasons given above, in particular the commonality of the meaning of ‘suicide’ between the coronial and criminal jurisdictions and the dearth of relevant case law examining what is meant by ‘suicide’ under the Suicide Act 1961, the appropriate starting point for an examination of these issues is the relevant coronial case law.

2.2.1. *Suicide and intention*

The law distinguishes between acting with intent and intentionally acting; the latter pertains to the act itself (for instance, stepping in front of a moving train) whereas the former concerns the outcome of the act (for instance, serious bodily injury or death).⁵⁶¹ It is possible, then, to act intentionally without intending the consequences. For instance, a person stepping in front of a moving train to save a child only to be killed, or a person

⁵⁶¹ See, for instance, Glenys Williams, *Intention and Causation in Medical Non-Killing: The Impact of Criminal Law Concepts on Euthanasia and Assisted Suicide* (Routledge-Cavendish 2007), 22-23; R A Duff, *Intention, Agency and Criminal Liability* (Wiley-Blackwell 1990); R A Duff, ‘Intention, Responsibility and Double Effect’ (1982) 32 *The Philosophical Quarterly* 126.

running across tracks to reach a different platform who is struck by a passing train. While they were both acting intentionally, neither could not be said to have acted with intent (at least insofar as their deaths are concerned). As will be discussed, these hypothetical scenarios also illustrate the fact that it is acting with intent (that is, intending the consequences of the act) which is the chief focus of the definition of ‘suicide’.

The various conceptualisations of intent contained in the relevant coronial jurisprudence consistently equate ‘intention’ with acting with intent:

- ‘the deceased intended his own death; and ... he did an act with that intention’;⁵⁶²
- ‘the deceased intended the consequences of the act’;⁵⁶³
- the ‘deceased intended to take his own life’.⁵⁶⁴

These formulations suggest a requirement of direct intention (i.e. acting with the purpose of bringing about one’s death) to support a conclusion of suicide. Unless there is evidence that the deceased acted for the purpose of bringing about their death, a suicide conclusion will not be open to the coroner/jury. But, s 2 of the Suicide Act 1961 is a criminal offence and, recalling that ‘contexts are crucial’ when distilling meaning, it is necessary to examine whether intention for the purpose of ‘suicide’ in s 2 only encompasses direct intention or extends to foreseeable consequences as is the case in criminal law more generally.

3.2.1.1. Criminal law conceptualisations of intention in England and Wales

Notwithstanding the oft-cited claim that ‘intent’ is ‘an ordinary English word’,⁵⁶⁵ courts have repeatedly examined the content and scope of ‘intention’, primarily in respect of the *mens rea* of murder. In the seminal decision of *Woollin*, the House of Lords confirmed that intention includes both direct intention and oblique/indirect intention.⁵⁶⁶ While debate continues as to whether *Woollin* applies only to murder cases, the prevailing view is that it applies to criminal law more generally.⁵⁶⁷ Whereas direct intention refers to the purpose of

⁵⁶² *Lagos* (n 547) [35].

⁵⁶³ *Thomas* (n 548), 1478.

⁵⁶⁴ *Matthew* (n 552), 13-67.

⁵⁶⁵ *R v Moloney* [1985] AC 905. See, also, Judicial Colleges, ‘Crown Court Compendium: Part I Jury and Trial Management and Summing Up’ (June 2018), 8-1 <<https://www.judiciary.uk/wp-content/uploads/2018/06/crown-court-compendium-pt1-jury-and-trial-management-and-summing-up-june-2018-1.pdf>> accessed 31 July 2019.

⁵⁶⁶ *R v Woollin* [1998] 4 All ER 103.

⁵⁶⁷ See, for instance, Findlay Stark, ‘It’s only words: On meaning and mens rea’ (2013) 72 *Cambridge Law Journal* 155; Gerard Coffey, ‘Codifying the meaning of “intention” in criminal law’ (2009) 73 *Journal of Criminal Law* 394; Itzhak Kugler, *Direct and Oblique Intention in the Criminal Law: An Inquiry into Degrees of Blameworthiness* (Routledge 2002); Glanville Williams, ‘Oblique Intention’ (1987) 46 *Cambridge Law Journal* 417. For arguments

the defendant's behaviour, indirect intention incorporates the issue of foresight and *may* (but not *must*) be found if the jury is satisfied that 'the consequence was a virtual certainty (barring some unforeseen intervention) as a result of the defendant's actions and that the defendant appreciated that such was the case.'⁵⁶⁸ Lord Kerr summarised the development, and present state, of the law on intention in the following terms:

In a trilogy of cases, *R v Moloney* [1985] AC 905; *R v Hancock* [1986] AC 455; and *R v Woollin* [1999] 1 AC 82 the House of Lords held that intention is not restricted to consequences that are wanted or desired, but includes consequences which a defendant might not want to ensue, but which the jury find (a) are the virtually certain result of the defendant's actions (barring some unforeseen intervention); and (b) are consequences which the defendant appreciated were virtually certain to occur. Before such an oblique intention could form the basis of a jury's verdict, of course, precise directions to this effect would have to be given.⁵⁶⁹

Consistent with Lord Kerr's conceptualisation, the Law Commission described the current state of intention in criminal law as follows:

At common law, someone must be taken to have intended something if they acted in order to bring it about. In that respect, 'intention' is partly defined by the common law. However, in unusual cases, typically murder cases, that definition has proven to be too narrow. It excludes from murder those cases that should be murder given [the defendant's] especially high level of culpability.

Accordingly, the following rule has been developed at common law. The jury *may* – but not *must* – find that the defendant ('D') intended the result if D thought it would be a certain consequence (barring some extraordinary intervention) of his or her actions, whether he or she desired it or not.⁵⁷⁰

against generalising *Woollin* (n 566) see, for instance, Victor Tadros, 'The system of the criminal law' (2002) 22 *Legal Studies* 448.

⁵⁶⁸ *R v Allen* [2005] EWCA Crim 1344; Crown Court Compendium (n 565), [6].

⁵⁶⁹ *R v Gnango* [2012] 1 AC 827, [2011] UKSC 59 [125].

⁵⁷⁰ Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No 304, 28 November 2006), 3.12-13 (emphasis in original).

Pursuant to s 8 of the Criminal Justice Act 1967:

A court or jury, in determining whether a person has committed an offence,—

(a) shall not be bound in law to infer that he intended or foresaw a result of his actions by reason only of its being a natural and probable consequence of those actions; but

It is, then, possible to be found to have acted with intent without having desired the consequences. As Glanville Williams observed, ‘Judges reject the proposition that the legal concept of intention in relation to the consequences of action necessarily involves desire of the consequence.’⁵⁷¹ For example, in *Hyam* the accused was convicted of the murder of two children who died because of a fire which started after she poured petrol through the letterbox of their house and set it alight. The accused wanted to scare the woman who lived there (her former lover’s new partner) but did not intend to harm anyone. Regardless, she was found guilty of murder based on indirect intention.⁵⁷² It must be noted that indirect intention is an ‘extremely rare’ occurrence and the construct was:

[D]esigned to help the prosecution fill a gap in the rare circumstances in which a defendant does an act which caused death without the purpose of killing or causing serious injury, but in circumstances where death or serious bodily harm had been a virtual certainty ... as a result of the defendant’s action and the defendant had appreciated that such was the case.⁵⁷³

Thus, in *Moloney*, the House of Lords allowed the appeal and substituted a verdict of manslaughter on the basis that the evidence, which was to the effect that the appellant, who was heavily inebriated, did not know he was aiming the gun at his step-father, could not have appreciated that the virtually certain consequence of his conduct was that his step-father would be shot and either killed or very seriously injured.⁵⁷⁴

The descriptions of intention in the coronial case law extracted above suggest that indirect intention is not sufficient to found a suicide conclusion; what is required is evidence of direct intention, that is, evidence that the deceased did an act for the purposes of bring about their death. This is hardly surprising. If indirect intention was sufficient to support a conclusion of suicide, a person fleeing from a violent attack who leaps from a window on the fourth floor and subsequently dies could be said to have had the requisite intention (i.e. indirect intention) for a suicide verdict. Yet, their purpose (i.e. direct intention) was the antithesis of death; they were actively trying to avoid it. Similarly, the good Samaritan who runs onto train tracks to help someone and is struck and killed by a passing train, the

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- (b) shall decide whether he did intend or foresee that result by reference to all the evidence, drawing such inferences from the evidence as appear proper in the circumstances.

⁵⁷¹ *Williams* (n 516), 417.

⁵⁷² *Hyam v DPP* [1975] AC 55.

⁵⁷³ *R v MD* [2004] EWCA Crim 1391 at [29].

⁵⁷⁴ *R v Moloney* (n 565).

impending presence of which had been made known to waiting passengers, certainly did not act with the purpose of bringing about their death, though they may be said to have had indirect intention given the virtual certainty of being struck by the oncoming train.

The principle of indirect intention plainly does not fit with the common law definition of suicide as an act done *for the purpose* of bringing about one's death (and which brings about their death). It should also be borne in mind that, following the decriminalisation of suicide in 1961, there is no ascribing of guilt when considering whether a person has died by suicide⁵⁷⁵ and the common law definition ought to reflect this. As such, the lacuna in those 'extremely rare' criminal cases which indirect intention is designed to potentially fill do not arise in the context of suicide. There is no compelling justification for stretching the *mens rea* of the common law definition of suicide beyond direct intention.

Case law concerning suicide conclusions confirms that intention may be inferred from the evidence, but it is an inference of *direct* intention to bring about death (as opposed to death being a virtually certain consequence). As the Court in *Hopper* noted:

It must not be taken that ... the Lord Chief Justice was ruling out verdicts of suicide in any case where there was an absence of positive evidence of intent or where the only evidence of intent and deliberation is to be inferred from the circumstances. It was conceded by counsel that if a man is found dead in his car with a pipe connecting the exhaust of the car into the interior of the car, it would be perfectly proper for a coroner to conclude that there was no possible explanation other than suicide...⁵⁷⁶

Consistent with this observation, the Court in *John*⁵⁷⁷ held that 'Where the act causing death was clearly deliberate the possibility of accident may be excluded and the circumstances may give rise to an irresistible inference of suicide even in the absence of a suicide note or a compelling antecedent history.'⁵⁷⁸ While this may suggest that a virtually certain consequence of death would be enough to meet the *mens rea* of suicide, the statement must be considered in light of the trial judge's self-direction (with which the Court took no issue)

⁵⁷⁵ Beyond the offence under s 2 of the Suicide Act 1961 which has its own specific *mens rea*: the defendant's act was intended to encourage or assist suicide or an attempt at suicide. Arguably, indirect intention would be sufficient to meet this element of a s 2 offence though this analysis is beyond the scope of the current inquiry.

⁵⁷⁶ *R v Her Majesty's Coroner for Essex; Ex parte Hopper* (Queen's Bench, 13 May 1988).

⁵⁷⁷ *R v HM Coroner for Newbury; Ex parte John* (1992) 156 JP 456.

⁵⁷⁸ *ibid*

that 'I have to be satisfied that the deceased knew the probable consequence of his act and that he did that act voluntarily and that *he intended such consequences to follow*.'⁵⁷⁹ Plainly, the 'irresistible inference' is that of direct intention, as opposed to virtually certain consequences, not least since in criminal law proceedings evidence of indirect intention does not inexorably lead to a finding that the defendant had the requisite *mens rea*. Rather, it is evidence from which the jury can infer intention. To suggest, then, that evidence of indirect intention could lead to an 'irresistible inference' of suicide in coronial proceedings would represent a fundamental alteration to (and expansion of) the criminal law conceptualisation of intention and, in the absence of reasons confirming such a reading, the judgment in *John* must be taken to be referring to direct intention and an 'irresistible inference' thereof.

The direct intention to bring about death was inferred in *Glover* in which the deceased knowingly ingested 25 Distalgesic tablets (12 times the normal dose) within a short timeframe⁵⁸⁰ and in *John* where the deceased died because of hanging.⁵⁸¹ In both cases, there was no direct evidence of suicidal intent (for example, a note or expressions of suicidal ideation in the immediate lead up to their deaths). In both cases, the intention that was inferred was the purpose of bringing about their death (i.e. direct intention). Both of the deceased persons were found to have done an act (ingesting a significant amount of Distalgesic tablets and hanging themselves) for the purpose of bringing about their death based on all of the evidence, even though there was no direct evidence of intention.

In contrast, in *Sreedharan*⁵⁸² the deceased had previously attempted suicide, had expressed suicidal ideation, was under a great deal of pressure and took an overdose of drugs prescribed to him by his GP in circumstances where it was accepted that the deceased likely knew the consequence could be fatal. While, ostensibly, such facts supported a suicide conclusion, the conclusion reached by the jury was unlawful killing based on the deceased's doctor's gross negligence in prescribing the relevant medication (the doctor, who had treated the deceased for some time, had provided the prescription at the request of the deceased's mother without examining the deceased). Significantly, a suicide conclusion was not left to the jury. As *Sreedharan* demonstrates, the evidence may

⁵⁷⁹ *John* (n 577) (emphasis added).

⁵⁸⁰ *R v HM Coroner for Devon; Ex parte Glover* (1985) 149 JP 208.

⁵⁸¹ *John* (n 577).

⁵⁸² *Sreedharan v HM Coroner for the County of Greater Manchester (Manchester City District)* [2013] 3 WLUK 663, [2013] EWCA Civ 181.

conclusively demonstrate that the deceased did an act or acts which caused their death but if there is insufficient evidence that the deceased did that act for the purpose of bringing about their death, a suicide conclusion is highly unlikely. If the *mens rea* of a suicide conclusion could be met by evidence of indirect intention, it is likely that a conclusion of suicide would at the least have been left to the jury in *Sreedharan*. *Lagos* is also illuminating in this respect.⁵⁸³ The deceased, who had a history of depression (with suicidal ideation) and anxiety, climbed onto a barrier which, given its height, would have ‘taken some effort’ and was subsequently found on the concrete floor below (a distance of some 30 to 40 feet).⁵⁸⁴ While the evidence ‘indicated that she impelled herself from the bar and fell backwards, resulting in her death’, a conclusion of suicide was not left to the jury as it was considered that ‘an accident could not be ruled out.’ Thus, it is not enough that the deceased did the act which directly ‘caused’ their death (for example, taking an overdose of prescription medication or impelling herself 30 to 40 feet onto concrete) and that it could be inferred from the evidence that death was a virtually certain consequence of that act and that was appreciated by the deceased (i.e. indirect intention). *Sreedharan* and *Lagos* demonstrate that the evidence must support a finding of direct intention for a conclusion of suicide to be open.

That the common law definition of suicide incorporates direct intention alone is reflected in *Stroud’s* definition of ‘suicide’ which provides that ‘To “commit suicide” is for a person voluntarily to do an act ... *for the purpose of destroying his own life*, being conscious of that probable consequence, and having at the time sufficient mind to will the destruction of life.’⁵⁸⁵ This definition also highlights the fact that, as discussed above, the intention aspect of suicide is concerned with acting with intent, as opposed to acting intentionally. That is not to say that acting intentionally is an irrelevant consideration; as *Stroud’s* definition demonstrates, the deceased must have been found to have been acting intentionally (or ‘voluntarily’). Indeed, as the Court of Appeal opined in *Thomas* ‘[s]uicide is voluntarily doing an act for the purpose of destroying one’s own life while one is conscious of what one is doing’.⁵⁸⁶ Where the evidence is insufficient to support a conclusion that the deceased acted intentionally, the coroner or jury should enter an open conclusion or, if the

⁵⁸³ *Lagos* (n 547). See, also, the consistent outcome in *R v City of London Coroner, Ex parte Barber* [1975] 1 WLR 1310. But, it should be noted that following *Maughan* (n 550), *Lagos* is not authoritative, at least insofar as the standard of proof is concerned.

⁵⁸⁴ *Lagos* (n 547).

⁵⁸⁵ Daniel Greenberg (ed), *Stroud’s Judicial Dictionary of words and Phrases* (9th edn, Sweet & Maxwell 2016), ‘Suicide’ (emphasis added).

⁵⁸⁶ *Thomas* (n 548), 1478.

evidence permits, a conclusion of accidental death.⁵⁸⁷ Thus, while the repeated references to intention in the context of suicide conclusions pertain to acting with intent (which refers to direct intention alone), to return a conclusion of suicide, the coroner or the jury must also be satisfied on the balance of probabilities that the deceased also acted intentionally.

A related issue that requires (brief) consideration is the extent to which the deceased must have been ‘competent’ to justify a conclusion of suicide.

3.2.1.2. *Suicide, intention and competence*

The significance of a finding that the suicide was *non compos mentis* was largely lost upon the decriminalisation of suicide in 1961. Nonetheless, the ‘trend’ of buffering a suicide verdict by reference to the deceased’s state of mind has persisted. While the latest iteration of the Rules omitted the optional phrase ‘whilst the balance of his mind was disturbed’ from the proposed form for a suicide conclusion, that has not precluded coroners/juries from returning a short-form conclusion of ‘suicide whilst the balance of [his/her] mind was disturbed’ (provided there is evidence to that effect).⁵⁸⁸ As to the origins of the phrase ‘whilst the balance of his mind was disturbed’:

A Departmental Committee on Coroners (1936) recommended ... that the verdict of *felo de se* be abolished, and that there should be no reference in the verdict to the deceased’s state of mind, but that the verdict should simply be that the deceased died by his own hand. But pending any such reform it became the common practice to adopt the form of words ... ‘while the balance of his mind was disturbed’.⁵⁸⁹

Importantly, a finding that the deceased died by suicide ‘whilst the balance of his [or her] mind was disturbed’ does not ‘negative the intention to take his or her own life’.⁵⁹⁰ That is because ‘The verdict of suicide in an inquest is not specifically related to the deceased’s

⁵⁸⁷ *Barber* (n 583), 1313 (Lord Widgery CJ): ‘Suicide must be proved by evidence, and if it is not proved by evidence, it is the duty of the coroner not to find suicide, but to find an open verdict.’ Similarly, in *Hopper* (n 576) Parker LJ held that a verdict of suicide could not be returned because the coroner could not adequately have ‘excluded the possibility that the death had been caused by some unexplained accident.’

⁵⁸⁸ Matthew (n 552), 13-71. Although the Chief Coroner’s Guidance suggests that ‘there is usually no longer any need to add the words “whilst the balance of his mind was disturbed”’ (Chief Coroner’s Guidance (n 551), [63]).

⁵⁸⁹ J W Cecil Turner, *Kenny’s Outlines of Criminal Law* (18th edn, Cambridge University Press 1962), 176.

⁵⁹⁰ Matthew (n 552), 13-71.

state of mind, but purely to the evidence that he or she intended to kill himself or herself, *and this verdict will stand irrespective of the state of his mind.*⁵⁹¹

Thus, the fact that the deceased had been diagnosed with a mental illness which may have increased the potential for their suicide prior to their death does not *ipso facto* preclude the coroner or jury from returning a conclusion of suicide, provided the evidence is sufficient to prove on the balance of probabilities that the deceased had the requisite intention at the relevant time.⁵⁹²

3.2.1.3. *Suicide and intention: conclusions*

An examination of the relevant jurisprudence reveals that intention remains ‘the essential ingredient’⁵⁹³ of the common law definition of ‘suicide’. Coronial case law confirms that only evidence of direct intention will meet the *mens rea* element of suicide; there is no scope for indirect intention in respect of the definition of ‘suicide’. Thus, to constitute ‘suicide’ either for the purposes of a suicide conclusion under the CJA or to reach a verdict in respect of an allegation of assisting or encouraging suicide under s 2 of the Suicide Act 1961, the coroner or jury must be satisfied to the requisite standard of proof that the deceased acted to bring about their death and did so with the purpose of causing their death (direct intention).

Having considered the scope of intention, the next section will examine the role (if any) causation plays in the definition of suicide for the purposes of the Suicide Act 1961.

3.2.2. *Suicide and causation*

Much of the debate (in the legal sphere and elsewhere) regarding what acts constitute ‘suicide’ has turned on the question of causation. Indeed, one of the four factors Lord Bingham cited in *Bland* as reason for why withdrawal of treatment did not constitute suicide was that ‘it was not the discontinuance of artificial feeding but the patient’s condition and its underlying cause which caused his death.’⁵⁹⁴ But, is a patient who refuses life-sustaining treatment knowing that without it they will die and who does so with the intention of bringing about their death, any different to a person who, acting with the

⁵⁹¹ Sir Montague Levine and James Pyke, *Levine on Coroners’ Courts* (Sweet & Maxwell 2009), 35-07 (emphasis added).

⁵⁹² Thus, verdicts of suicide were returned in the following cases notwithstanding the fact that the deceased had been diagnosed as schizophrenic: *R (On the application of Scott) v HM Coroner for Inner West London* [2001] 2 WLUK 320, [2001] EWHC Admin 105; *R (On the application of the Commissioner of Police for the Metropolis) v Coroner Southern District of Greater London* [2003] 6 WLUK 782, [2003] EWHC 1829 (Admin).

⁵⁹³ Levine and Pyke (n 591), 30-26.

⁵⁹⁴ *Bland* (n 31), 814.

requisite intention, places themselves in the path of an oncoming train? In both cases, the individual acts so as to put themselves in the face of near-certain death. In both cases, have they not done an act causative of death? The ensuing discussion examines these questions with a view to distilling the ‘causation’ required for a finding of ‘suicide’ as that term is used both in the Suicide Act 1961 and the CJA.

3.2.2.1. *Causation in suicide conclusions*

As outlined above, in addition to the requisite *mens rea*, the common law definition of suicide also encompasses an *actus reus*: the doing of an act which causes death. In contrast with criminal jurisprudence which, as will be discussed below, (artificially) delineates between acts and omissions in the context of withdrawal/refusal of life-sustaining treatment, there is nothing in the relevant coronial case law to suggest that an ‘act’ in the context of the *actus reus* of suicide should not be accorded its ordinary meaning. Per the Oxford English Dictionary, ‘act’ includes to ‘bring about’, ‘to put in motion’ and to ‘produce an effect’⁵⁹⁵ which plainly encompasses the giving of instructions to withdraw treatment, a refusal of treatment. Indeed, on this definition, an advance directive authorising palliative sedation could constitute an ‘act’. In each instance, the individual is taking action – an express instruction or the refusal of consent – to bring about/produce an outcome/effect, or to put in motion a chain of events that will lead to the intended outcome, namely the withdrawal/non-administration of life-sustaining treatment or the administration of palliative sedation. Given that a doctor cannot administer treatment without the informed consent of a (capacitous) patient, a request to withdraw treatment or the refusal of consent thereto will inexorably lead to the treatment’s withdrawal or non-administration. If the doctor does not comply, they will be guilty of trespass to the person.⁵⁹⁶ In terms of palliative sedation, the doctor treating the patient (who is likely to be incapacitous at the time of its administration) is obliged to act in the patient’s best interests. Relevant to an assessment of those interests will be the previously expressed wishes of the patient, including their advance directive. A decision not to administer palliative sedation despite an advance directive would, then, occur only in very rare circumstances in which such treatment is contrary to the patient’s best interests. An advance directive could, thus, also satisfy the *actus reus* requirement of suicide. The ensuing analysis will consider the way in which coronial jurisprudence has articulated the causative

⁵⁹⁵ Oxford English Dictionary Online (OUP 2019), ‘Act’
<<https://www.oed.com/view/Entry/1889?rkey=Gk7oSu&result=5#cid>> accessed 31 July 2019.

⁵⁹⁶ See, *Re B* (n 33).

relationship that must exist between the relevant ‘act’ and the person’s death for the act to satisfy the *actus reus* of suicide.

Judicial enunciations of the *actus reus* of a suicide conclusion have variously required that the deceased:

- did ‘an act for the purpose of destroying one’s own life’;⁵⁹⁷
- committed ‘an act of self-destruction’;⁵⁹⁸
- ‘wilfully and intentionally destroys himself’;⁵⁹⁹
- ‘took his own life’;⁶⁰⁰
- ‘killed himself’;⁶⁰¹
- ‘has taken his own life’;⁶⁰²
- ‘did an act ... which caused his death.’⁶⁰³

These formulations indicate that the deceased’s act must cause their death for the *actus reus* element to be met. As will be discussed, the coronial case law concerning causation in the context of suicide conclusions largely mirrors the approach taken to causation in the criminal law context. There is a spectrum or chain of causation, ranging from a traditional ‘but for’ conceptualisation (i.e. but for the deceased’s act, death would not have occurred) to a broader, ‘common sense’ approach which considers the centrality of the deceased’s act to the outcome (i.e. the ‘significant’/’substantial’ and ‘operating’ cause). Notwithstanding those similarities, given the nature of coronial proceedings, it is possible (indeed, likely) that factors which may be considered too remote in the chain of causation to support a finding of culpability in criminal proceedings, may well be central to a coronial conclusion.

An inquest:

[I]s a fact-finding investigation and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the

⁵⁹⁷ *Thomas* (n 548), 1478.

⁵⁹⁸ *Clyft v Schwarbe* (1846) 3 CB 437 at [472]. See, also, *Reeves v Commissioner of Police of the Metropolis* [2000] 1 AC 360.

⁵⁹⁹ *Advocate-General of Bengal v Ranees Surnomoyee* [1864] UKPC 14.

⁶⁰⁰ Chief Coroner’s Guidance (n 551), [44].

⁶⁰¹ *R v HM Coroner for Derby and South Derbyshire; Ex parte Hart* (2000) 164 JP 429 [65].

⁶⁰² *Chambers v HM Coroner for Preston and West Lancashire* [2015] 1 WLUK 166, [2015] EWHC 31 (Admin) [18].

⁶⁰³ *Lagos* (n 547) [35] (emphasis added).

other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish the facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.⁶⁰⁴

A distinction is drawn between the medical cause of death and by what means (formerly 'how') the deceased met their death. The question of how/by what means has been described as a 'question directed to the immediate physical means of death'.⁶⁰⁵ As the Chief Coroner's Guidance provides:

[T]he coroner (or the jury if there is one) must, in addition to finding the 'medical cause of death' ...make two key decisions: (1) findings of fact as to 'how' the deceased came by his or her death ... and (2) the conclusion as to the death ... These two decisions are separate but they must be closely related.⁶⁰⁶

It is possible for several circumstances to have coalesced to lead to the medical cause of death, with each being directly relevant to the coronial conclusion.⁶⁰⁷ This is particularly so in the context of deaths which raise issues under Article 2 of the ECHR (generally, when the deceased was under the control of the State, for instance the death of a prisoner). In Article 2 inquests 'the Coroner [is] required to examine not merely how [the deceased] met his death in the sense of the immediate cause of death, but also the circumstances in which he came by his death, in the sense of *factors that may have contributed to his death*.'⁶⁰⁸

That is not to say, however, that non-Article 2 inquests are limited to an examination of the 'last chain of causation'; rather, it is 'for the coroner to decide on the particular facts of a case at what point "the chain of causation becomes too remote to form part of his

⁶⁰⁴ *Thompson* (n 557) (cited with approval in *McKerr v Armagh Coroner* [1990] 1 All ER 865, 868).

⁶⁰⁵ *Lagos* (n 547) [15].

⁶⁰⁶ Chief Coroner's Guidance (n 551) [17].

⁶⁰⁷ See, for instance, *R (Longfield Care Homes) v HM Coroner for Blackburn* [2004] EWHC 2467 (Admin).

⁶⁰⁸ *R (on the application of Pounder) v HM Coroner for the North and South Districts of Durham and Darlington* [2009] 3 All ER 150, [2009] EWHC 76 (Admin) [22] (emphasis added).

investigation.”⁶⁰⁹ Indeed ‘[i]t has long been recognised that the scope of inquiry at an inquest can extend wider than is strictly required for the production of the verdict’.⁶¹⁰

The obligation to explore the means by which the deceased met their death – including, in Article 2 inquests, the circumstances surrounding the death – and the absence of any obligation to find criminal or civil liability has the potential to significantly broaden the causative chain relevant to a suicide conclusion beyond that which would apply in the case of, for instance, a medical negligence claim or a murder trial.⁶¹¹ As coroners (and juries) have an obligation to record ‘as many of the facts concerning the death as [the] public interest requires’ an inquest considering a suicide conclusion will consider a number of links in the chain of causation including those which would perhaps be deemed too remote to satisfy the *actus reus* in a murder trial (i.e. an act which merely ‘sets the scene’⁶¹² and is, thus, not an ‘operating’ or ‘substantial’ cause such as would lead to a finding a guilt).⁶¹³

Thus, in *Sreedharan* (discussed above in respect of intention), while the evidence at least ostensibly supported a suicide conclusion, suicide was not left to the jury. Instead, the jury reached the conclusion of unlawful killing based on the deceased’s doctor’s gross negligence in prescribing the relevant medication. Leaving aside duty of care considerations, it is unlikely that the doctor’s prescription of the relevant medication would be sufficient to meet the ‘significant and operating cause’ test of causation in criminal law, not least since Mr Sreedharan knowingly taking too many tablets (assuming such an act could properly be said to be a free, voluntary, deliberate informed act) would likely constitute a *novus actus interveniens* such as to break the chain of causation between the doctor’s prescribing of the tablets and Mr Sreedharan’s death.⁶¹⁴ Thus, even where the deceased did the act which directly ‘caused’ their death (for example, taking an overdose of prescription medication) a suicide conclusion may not be left to the jury because, *inter*

⁶⁰⁹ R (*On the application of Butler*) v HM Coroner for the Black Country District [2010] EWHC 43 (Admin) [62] citing the Court of Appeal (Civil Division) decision in R v Inner West London Coroner; *Ex parte Dallaglio* [1994] 4 All ER 139.

⁶¹⁰ *Lagos* (n 547), [50].

⁶¹¹ Coroners and Justice Act 2009, s 5(3). See, also, *McDonnell v HM Assistant Coroner for West London* [2016] 12 WLUK 123, [2016] EWHC 3078 (Admin) citing R (*Hurst*) v Inner North London Coroner [2007] 2 AC 189 [7]-[8]

⁶¹² See, for instance, R v Smith [1959] 2 WLR. 623, [1959] 2 QB 35, 43.

⁶¹³ *Thompson* (n 557).

⁶¹⁴ See, for instance, cases in which a person has provided a syringe loaded with narcotics to another who has injected themselves and subsequently died from a drug overdose such as R v Kennedy (*No 2*) [2007] 3 WLR 612, [2007] UKHL 38.

alia, the broad approach to causation, when coupled with the lack of evidence of intention, supports a different conclusion entirely (as in, for example, *Sreedharan*).

The preceding demonstrates the following in terms of the *actus reus* of suicide in the coronial context:

- Given that an inquest is a fact-finding exercise and not a method of apportioning guilt, there is no justification for applying in the coronial context the artificial distinction between acts and omissions developed in *Bland* to avoid doctors being culpable of murder following the withdrawal of life-sustaining treatment at a patient's request or based on the patient's best interests. As such, 'act' has its ordinary meaning, namely the taking of action to bring about a result, which would include the withdrawal of consent to life-sustaining treatment or, potentially, an advanced directive for palliative sedation;
- Causation is broader than a simple 'but for' analysis and, given the nature of inquests, requires an examination of the immediate cause of death, the circumstances in which the deceased came by their death and, in inquests which raise concerns under Article 2 of the ECHR, an examination of the factors that may have contributed to their death;
- While there is considerable overlap between the concepts of causation in the coronial context compared with criminal law proceedings, the fact-finding focus of an inquest means that, in some instances, a broader approach to causation will be taken such that an act will be found to have played a causal role in a person's death in circumstances where it may not constitute a 'substantial' and 'operating' cause in criminal proceedings.

Recalling that s 2 of the Suicide Act 1961 is a criminal offence, and bearing in mind the different focus of a coronial inquest in contrast to a criminal trial, it is necessary to examine the approach to causation in criminal law proceedings.

3.2.2.2. Criminal law conceptualisations of causation

The offence of assisting or encouraging suicide in s 2 of the Suicide Act 1961 is a 'conduct crime'; it requires only that the accused did an act 'capable of encouraging or assisting the suicide' (or attempted suicide) of another with the requisite intention. So long as the act is 'capable' of encouraging or assisting (and the requisite *mens rea* is demonstrated), the offence will be made out; there is no need to prove that the accused's acts *actually*

encouraged or assisted another's suicide (or attempt thereat). Causation, therefore, is irrelevant for the purposes of the offence of assisting or encouraging suicide. The conduct of the accused, however, is significantly different to the conduct of the deceased, the latter of which is the focus of this chapter. The common law definition of suicide reflects the fact that, were suicide still an offence, it would be a 'result crime': it requires proof that the deceased did an act for the purpose of bringing about their death *and* that act did in fact bring about their death. That suicide has a causative aspect is unsurprising given its historical relationship with murder, the latter of which is perhaps the common law's most well-known result crime.

3.2.2.2.1. Acts versus omissions

In considering the criminal law's approach to causation, it is necessary to address the distinction between acts and omissions as it has a direct bearing on the *actus reus* of suicide. A sharp distinction is drawn between acts and omissions and that distinction is deeply embedded within the criminal law.⁶¹⁵ Yet, debate has surrounded, and continues to attend, the classification of acts and omissions, with academics proposing a range of potentials from a focus on bodily movements, to an examination of control.⁶¹⁶ A considerable amount of attention has been directed to the act/omission distinction in respect of medical treatment (in particular, withdrawal of life-sustaining treatment). Outside of that context, the courts have tended to characterise omissions as the failure to act. For instance, people have been found guilty of manslaughter because of a failure (i.e. an omission) to obtain medical assistance for a person in respect of whom they had assumed a duty of care.⁶¹⁷ In contrast, in the medical treatment context, the concept of omissions has been stretched such that, following the seminal decision of the House of Lords in *Bland*, doctors are taken not to have acted (i.e. they are said to have omitted to act) when they actively withdraw a patient's life-sustaining treatment.⁶¹⁸ In such circumstances, doctors are said to be omitting to treat the patient and, where death ensues, it is said to arise as a result of the patient's underlying illness or condition.⁶¹⁹

⁶¹⁵ See, for instance, Tracey Elliott and David Omerod, 'Acts and omissions – A distinction without a difference?' (2008) 39 *Cambrian Law Review* 40, 41.

⁶¹⁶ See, for instance, *ibid*, 41-42.

⁶¹⁷ See, for instance, *R v Evans (Gemma)* [2009] 1 WLR 1999, [2009] EWCA Crim 650.

⁶¹⁸ *Bland* (n 31).

⁶¹⁹ See, for instance, *Bland* (n 31), 866 and Royal College of Physicians, 'Clinically-assisted nutrition and hydration (CANH) and adults who lack the capacity to consent: Guidance for decision-making in England and Wales' (2018), 43 <<https://www.bma.org.uk/advice/employment/ethics/mental-capacity/clinically-assisted-nutrition-and-hydration/clinically-assisted-nutrition-and-hydration-canh-guidance>> accessed 31 July 2019.

The counterintuitive nature of this approach to omissions is most apparent when one considers its practical application to situations such as the withdrawal of artificial ventilation. While the steps taken by the doctor will vary based on how dependent the individual is on ventilation, the doctor responsible for withdrawal will need to *do* a number of things:

- If the patient is highly dependent on ventilation, they will become very breathless or distressed within minutes of it being stopped. As a result, the treating doctor will need to administer medication (typically opioids and benzodiazepines) designed to alleviate this distress (typically in the form of sedation) prior to the withdrawal of the ventilation;
- Even if the patient is not highly dependent on ventilation but, nevertheless, requires it to survive, there will come a point at which the withdrawal of that ventilation will cause breathlessness and/or distress which the doctor will need to pre-empt through the administration of appropriate medication;
- The doctor will need to physically withdraw ventilation. What this entails will differ depending on the nature of the ventilation but there is no question that it will require an act or acts on the part of the doctor.⁶²⁰

Plainly, withdrawal of ventilation requires several acts on the part of the doctor. Nevertheless, following *Bland*, the behaviour of a doctor who administers medication to ameliorate distress and suffering and actively withdraws the patient's ventilation is said to be an 'omission'.

Similar conceptual difficulties arise in the context of the withdrawal of artificial nutrition and hydration. In cases where such treatment⁶²¹ is the only life-sustaining treatment the patient is receiving and the patient is not terminally ill (i.e. where the patient is in a persistent vegetative state or a minimally conscious state as a result of a catastrophic brain injury), its removal will cause the patient's death, typically through multi-organ failure stemming from starvation/dehydration or bronchopneumonia. As that decline could be accompanied with pain and discomfort for the patient, doctors overseeing the withdrawal of artificial nutrition and hydration administer medication to ameliorate distress and

⁶²⁰ See, for instance, Association for Palliative Medicine of Great Britain and Ireland, 'Withdrawal of assisted ventilation at the request of a patient with motor neurone disease: Guidance for professionals' (2015) <<https://apmonline.org/wp-content/uploads/2015/02/APM-Guidance-on-Withdrawal-of-Assisted-Ventilation-Consultation-1st-May-2015.pdf>> accessed 31 July 2019.

⁶²¹ It is well established in medical law in England and Wales that artificial nutrition and hydration constitutes treatment (see, for instance, *Bland* (n 31)).

pain.⁶²² In both the instances of withdrawal of treatment just described, the treating physicians are *doing* things including actively administering medication to ameliorate the consequences of their *acts* (i.e. the *withdrawal* of artificial ventilation, nutrition and/or hydration) which are themselves intimately connected to the patient's cause of death.

The tenuousness of the distinction between acts and omissions in the medical treatment context is perhaps best exemplified when one considers the alleged difference between the 'malicious' interloper and the beneficent doctor described by Lord Goff in *Bland*:

[T]he doctor's conduct is to be differentiated from that of, for example, an interloper who maliciously switches off a life support machine because, although the interloper may perform exactly the same act as the doctor who discontinues life support, his doing so constitutes interference with the life-prolonging treatment then being administered by the doctor. Accordingly, whereas the doctor, in discontinuing life support, is simply allowing his patient to die of his pre-existing condition, the interloper is actively intervening to stop the doctor from prolonging the patient's life, and such conduct cannot possibly be categorised as an omission.⁶²³

There does not appear to be any difference in the *act* undertaken by the interloper compared with the doctor. Indeed, as Lord Goff recognised, they 'perform exactly the same *act*' (emphasis added). In both instances, the individual withdrawing the treatment is said to be allowing the patient's underlying condition to 'run its course' (noting, of course, that death after withdrawal of artificial nutrition and hydration quite often results from starvation/dehydration as opposed to the underlying clinical condition of the patient). It appears that the differential classification of their treatment as an act (for the interloper) as opposed to an omission (for the doctor), stems from their different intentions: whereas the interloper's purpose is to bring about the patient's death,⁶²⁴ the doctor's intention is to comply with the patient's request or, where the patient is in a persistent vegetative or minimally conscious state, to withdraw treatment that is no longer in their best interests. But, while intention can affect the legal consequences of an act, it cannot transform what

⁶²² See, for instance, Jenny Kitinger and Celia Kitinger, 'Deaths after feeding-tube withdrawal from patients in vegetative and minimally conscious states: A qualitative study of family experience' (2018) 32 *Palliative Medicine* 1180.

⁶²³ *Bland* (n 31), 866.

⁶²⁴ Of course, there is a strong argument that a doctor who withdraws life-sustaining treatment has indirect intention of the patient's death insofar as it is a virtually certain consequence. But if the doctor's conduct is classified as an omission, the *actus reus* for murder is absent and the presence of the requisite *mens rea* is inconsequential.

is plainly an act into an omission: an act is an act whether the individual undertook it with malicious intent or benevolently. Whether that act should carry liability is an entirely separate question. There is nothing in Lord Goff's reasons to suggest that were the interloper's intention to withdraw treatment which they did not consider to be in their loved one's best interests (i.e. a purely benevolent intention), that would convert the act of withdrawing the life-sustaining treatment into an omission (at best, it would transform the conduct into a 'mercy killing' which, under current English law, is still murder). If withdrawal constitutes an act regardless of the interloper's intention, it should likewise constitute an act when undertaken by a doctor. While these shortcomings in Lord Goff's reasons strongly point against their application to the situation of concern in this chapter, if the reasons do apply they provide direct support for the contention that a patient who requests the withdrawal of, or refuses, life-sustaining treatment does an act since in such circumstances, the patient is in an analogous position to that of the interloper; the patient's request or refusal 'constitutes interference with the life-prolonging treatment then being administered by the doctor. Accordingly ... the [patient] is actively intervening to stop the doctor from prolonging [their] life.' It is also arguable that a patient who requests palliative sedation in an advance directive is similarly acting as they are likewise intervening in the doctor's prolongation of their life.

Having observed the inherent limitations of the act/omission distinction in the context of life-sustaining treatment, there is a further, perhaps more persuasive reason for its non-application to a patient's decision to cease, or their refusal of, life-sustaining treatment or their request for palliative sedation. In these cases, there is no question of culpability or liability on the part of the patient; the purpose is not to ascribe blame for a particular act (or, for that matter, omission). There is, then, no obvious need to perpetuate the tenuous distinction between acts and omissions in the context of medical treatment and a patient's request for the withdrawal/refusal of life-sustaining treatment and an advance directive for palliative sedation should be considered an act for the purposes of the common law definition of suicide.

The act of requesting the removal of life-sustaining treatment, refusing such treatment and an advance directive for palliative sedation is sufficient to satisfy the *actus reus* of suicide even though the doctor is the individual who does (or does not do) the act that, as will be discussed below, is a substantial and operating cause of the patient's death. This is because, as referred to above, a doctor is compelled to act upon a capacitous patient's instruction to withdraw life-sustaining treatment and cannot administer treatment to a capacitous

patient who has refused it, even if the doctor considers such treatment to be in the patient's best interests.⁶²⁵ The doctor's conduct is, then, a relatively certain consequence of the patient's instruction.⁶²⁶ While culpability is not relevant for instant purposes, if it were, the doctor would arguably be an innocent agent and the patient would be the principal perpetrator, provided the doctor did not have the requisite *mens rea* and was simply acting, as required by law (conscientious objection aside), in accordance with the patient's express wishes.⁶²⁷ Given that criminal law already accommodates the potential that a doctor who does an act that will likely lead to death can do it without the intention to cause death (i.e. the doctrine of double effect),⁶²⁸ it is not a stretch to assume that a doctor acting upon the instructions of a capacitous patient which will likely lead to their death can do so without the attendant *mens rea* such that they are acting as innocent agents for the patient, who is the principal and to whom the act (and its legal consequences) are attributed.

Accordingly, insofar as the common law definition of suicide requires that the deceased *did an act* for the purposes of bringing about their death, an express request to end, or the refusal of further, life-sustaining treatment will satisfy the *actus reus* requirement as will an advance directive for palliative sedation. Indeed, the Supreme Court expressly acknowledged this fact in the reasons rejecting Noel Conway's appeal, wherein the Court stated that 'Mr Conway could bring about his own death in another way, by refusing consent to the continuation of his NIV [non-invasive ventilation].'⁶²⁹ Of course, a further, critical, question remains as to whether that act is causative of the patient's death. But, insofar as the immediate concern is whether a patient in these cases can be said to be doing an act, it is clear that they are. As noted above, the conduct of the patient in such instances parallels that of Lord Goff's interloper who intervenes to prevent the doctor from continuing to prolong their life. And, as Lord Goff expressly acknowledged, there can be no question that in such instances, the interloper/patient is acting.

Having established, then, that a patient's request to withdraw/refusal of life-sustaining treatment and an advance directive for palliative sedation constitutes an act for the purposes of ascertaining whether the *actus reus* of suicide has been met in the criminal law

⁶²⁵ *Re B* (n 33).

⁶²⁶ It is no less certain than death following an overdose or, indeed, death following the impelling of oneself off a three-storey building.

⁶²⁷ See, for instance, *Re Michael* (1840) 9 C & P 356.

⁶²⁸ See, for instance, *Nicklinson* (n 7) [18] (Lord Neuberger): 'a doctor commits no offence when treating a patient in a way which hastens death, if the purpose of the treatment is to relieve pain and suffering (the so-called "double effect")'.

⁶²⁹ *Conway* (Supreme Court) (n 8) [3]

context, the next question is whether such an act can be said to have caused the patient's death. That requires an examination of the criminal law's approach to causation.

3.2.2.3. *Acts causative of death*

In the criminal law context, causation is a matter of common sense, not philosophical analysis.⁶³⁰ It is, for the most part, a question of fact for the jury, though it is decided in accordance with legal principles.⁶³¹ The starting point is 'but for' or 'factual' causation, otherwise known as *sine qua non*. The test for factual/but for causation requires the jury to consider whether, but for the actions of the relevant individual, the relevant harm would have occurred in the same manner and at the same time that they did. A 'simple approach' to but for causation is to eliminate the individual's conduct from the narrative and ask whether the result would have occurred anyway.⁶³² If the answer is in the affirmative, the conduct of the individual did not factually cause the outcome. The focus is on the specific results at the specific time. The fact that a patient is terminally ill and likely to die from complications stemming from that illness (for instance, chronic infection or pneumonia) at an indeterminate point in the not-too-distant future does not absolve the individual who kills them by stabbing them. Thus, in *Dyson*,⁶³³ the victim was terminally ill with meningitis at the time the defendant injured him. Those injuries were found to have caused the victim's death since he died sooner than he would have from the meningitis. Thus, but for the defendant's actions, the victim would not have died at the time and in the manner that he did.

The but for test is, however, only the starting point of the examination of causation in criminal proceedings.⁶³⁴ 'There are many acts that are *sine qua non* of an event but are not either in law or common sense, the cause of it.'⁶³⁵ The individual's conduct need not be the sole cause of the result. What is required is that the conduct in question was an 'operating' and 'substantial' cause of the event.⁶³⁶ Much jurisprudence has been dedicated to ascertaining what 'operating' and 'substantial' means. To be 'substantial', the act in question must be more than a 'de minimis or minimal' cause.⁶³⁷ As for an 'operating' cause, the chain of causation between the act (or omission) and the event must not have been

⁶³⁰ *Kennedy* (n 614) [15].

⁶³¹ *R v Cheshire* [1991] 1 WLR 844.

⁶³² David Omerod and Karl Laird (eds), *Smith and Hogan's Criminal Law* (14th edn, Oxford University Press 2015), 64.

⁶³³ *R v Dyson* [1908] 2 KB 454 (CA).

⁶³⁴ *R v Hughes* [2013] 2 AC 337, [2013] UKSC 5 [22].

⁶³⁵ Omerod and Laird (n 632), 64.

⁶³⁶ See, for instance, *R v Malcherek* [1981] 1 WLR 690; *R v Mellor* [1996] 2 WLUK 122.

⁶³⁷ See, for instance, *Hughes* (n 634) [22].

broken by a *novus actus interveniens* such as a free, voluntary and informed act of a third party or, indeed, the victim.⁶³⁸ When examining whether an act of a third party or the victim has broken the chain of causation, the court (or, more specifically, the jury) asks whether, having regard to the whole of the individual's character (including their religious beliefs⁶³⁹), the intervening act was 'the natural result of what the alleged assailant said and did, in the sense that it was something that could reasonably have been foreseen as the consequences of what he was saying or doing'.⁶⁴⁰ Thus, a decision of a victim who is an adherent of the Jehovah's Witness faith not to receive a life-saving blood transfusion did not constitute a *novus actus interveniens* as it was reasonably foreseeable that an individual such as the victim (i.e. a person of the same faith) would not accept a blood transfusion.⁶⁴¹ Similarly, acts undertaken by victims to escape violence (for example, jumping out of a window, escaping from a moving car, or running into traffic to escape an assault) are not only reasonably foreseeable but they also cannot be said to be free, voluntary or informed such as to break the chain of causation.⁶⁴²

Relevantly, for instant purposes, it is possible for an individual to be guilty of a person's death even though the immediate cause of the victim's death was suicide, provided their suicide was a reasonably foreseeable consequence of the defendant's conduct. In the Court of Appeal decision of *Wallace*,⁶⁴³ the Court held that there was no legal impediment (as opposed to evidentiary limitations) to the defendant being found guilty of murder even though the victim's cause of death was lawful euthanasia in Belgium.⁶⁴⁴ The victim had been grievously injured after the defendant threw sulphuric acid onto his face and body. At the first trial, the trial judge determined not to leave the charge of murder to the jury on the basis that the acts of the doctors in Belgium in euthanising the victim constituted a *novus actus interveniens* thus breaking the chain of causation. In contrast, the Court of Appeal determined that the question of murder could be left to the jury on the basis that they 'may

⁶³⁸ See, for instance, *Kennedy* (n 614); *Cheshire* (n 631); *R v Roberts* (1971) 56 Cr App R 95 (CA); *R v Wallace* (2018) 2 Cr App R 22, [2018] EWCA Crim 690.

⁶³⁹ *R v Blaue* [1975] 1 WLR 1411.

⁶⁴⁰ *R v Roberts* (n 638), 102.

⁶⁴¹ *Blaue* (n 639); *Pitts* (1842) C & M 284; *R v Curley* (1909) 2 Cr App R 96.

⁶⁴² See, for instance, *Pitts* (n 641); *Curley* (n 641); *R v Roberts* (n 638); *R v Lewis* [2010] 1 WLUK 410, [2010] EWCA Crim 151; *R v Williams and Davis* [1992] 1 WLR 380; *R v M* [1999] 11 WLUK 937, [2000] Crim LR 372.

⁶⁴³ *R v Wallace* (n 638).

⁶⁴⁴ Following the appeal, Berlinah Wallace was retried. While she was acquitted of murder, she was convicted of the offence of applying a corrosive fluid with intent contrary to section 29 of the Offences Against the Persons Act 1861 and sentenced to 12 years' imprisonment: *R v Berlinah Wallace* (Crown Court Bristol, 23 May 2018) <<https://www.judiciary.uk/wp-content/uploads/2018/05/r-v-wallace-sentencing.pdf>> accessed 31 July 2019.

conclude on the very special facts of this case, that there was nothing that could decently be described as voluntary either in the suffering or in the decision by [the victim] to end his life, given the truly terrible situation he was in' as a result of the defendant's acts.⁶⁴⁵ As the Court of Appeal observed:

It would, as the prosecution say, seem an odd result, if a defendant who paralysed one victim but not another in identical circumstances (so the second could take their own life, but the first could only do so through the intervention of a third party) would be legally responsible for the death of the second victim but not the first. In the event we consider that the jury could conclude on the facts as they were here that the acts of [the victim] and the doctors were not sensibly divisible; that the doctors' (lawful) conduct in carrying out with their hands what he could not carry out with his own was but one link in the chain of events instigated by the defendant and, notwithstanding the intervening act of [the victim] and/or the doctors, the defendant's conduct could fairly be said to have made a significant contribution to [the victim's] death...⁶⁴⁶

The decision in *Wallace* serves to reinforce two important aspects of causation in English criminal law. The first is that, like causation in the coronial context, in the vast majority of cases there will be a chain of causation and the defendant's conduct will be one of a number of 'causes'. In such cases, the defendant's culpability will depend, *inter alia*, on whether their acts (or 'omissions') were a substantial and operating cause of the victim's death. The second is that a decision by the victim to bring about their death by suicide does not, *ipso facto*, break the chain of causation provided it can be demonstrated that the victim's decision was not a *novus actus interveniens* and, relatedly, that the defendant's conduct remained a substantial and operating cause of the victim's death.

The decision of *Dear*⁶⁴⁷ is illuminating in this respect. In that case, the defendant slashed the victim's face with a Stanley knife. The victim refused to seek medical treatment and, with the assistance of another man, managed to stem the bleeding. Nevertheless, several days after the attack, the victim was found deceased in his apartment. The immediate cause of death was exsanguination, with the autopsy revealing that a major artery in the victim's face had been cut. It was accepted that that injury had been inflicted by the defendant. A note was located in the victim's flat which suggested that he intended suicide. It was,

⁶⁴⁵ *Wallace* (n 638) [76].

⁶⁴⁶ *ibid* [85]. (emphasis in original)

⁶⁴⁷ *R v Dear* [1996] 3 WLUK 208, [1996] Crim LR 595.

however, not clear whether the victim had intentionally reopened his wounds or if the injury to the artery had inadvertently reopened (for instance, through an accidental bump). The defendant was convicted of the applicant's murder. Significantly for instant purposes, the Court of Appeal confirmed that even if the victim had reopened his wounds with suicidal intent, 'the jury were entitled to find that the defendant's conduct made an operative and significant contribution to the death'.⁶⁴⁸

Finally, several cases have confirmed that a decision by doctors to withdraw life-sustaining treatment of patients in persistent vegetative states where continued treatment is no longer in their best interests, may be the immediate cause of death but it does not break the chain of causation between the defendant's acts and the victim's death. In such cases, the defendant's unlawful conduct remains a substantial and operating cause at the time of the patient's death.⁶⁴⁹ It is only when it can properly be said that the defendant's conduct is 'merely the setting in which another cause operates' that the chain of causation may be said to have been broken (for instance, in the case of grossly negligent medical treatment).⁶⁵⁰

The preceding analysis has demonstrated that causation in criminal law contexts is a fact-based assessment, which goes beyond a 'but for' examination of the defendant's unlawful conduct and considers whether it was an operating and substantial cause of the relevant harm. There is, then considerable overlap between the approaches to causation taken in the coronial proceedings compared with criminal proceedings. The key points to take from the discussion of the principles governing causation in criminal proceedings for the instant inquiry are:

- While the starting point is the but for test, the defendant's conduct need not be the sole cause of the relevant harm;
- If the defendant's conduct was an 'operating' and 'substantial' cause of the harm, it will satisfy the *actus reus* element of the offence;
- To be a 'substantial' cause, the conduct must 'play more than a minimal part' in the relevant harm.⁶⁵¹ To be an 'operating' cause, the chain of causation between

⁶⁴⁸ *ibid*, 595-96.

⁶⁴⁹ See, for instance, *Malcherek* (n 636).

⁶⁵⁰ See, for instance, *R v Smith* [1959] 2 WLR 623; *R v Jordan* (1956) 40 Cr App R 152 (though the facts of this case have been repeatedly described as exceptional: *Malcherek* (n 636) 180).

⁶⁵¹ *Wallace* (n 638) [86(3)(a)].

the defendant's conduct and the harm must not have been broken by a *novus actus interveniens*;

- A victim's decision to bring about their death by suicide may not constitute a *novus actus interveniens* if the evidence is sufficient to demonstrate that the victim's suicide was a reasonably foreseeable consequence of the defendant's conduct.

3.2.3. Summary

The preceding sections have traced the origins and development of the common law definition of suicide for the purposes of ascertaining the meaning of 'suicide' as that term is used in the Suicide Act 1961. That examination has revealed that 'suicide' has a common law meaning which comprises two central elements: (1) the doing of an act (2) for the purposes of bringing about one's death. Given the longstanding interrelationship between the coronial and criminal jurisdictions, jurisprudence from each has been examined in order to distil the nature and scope of those two elements. That examination has resulted in the distillation of two principles central to the content and scope of the definition of 'suicide' for the purposes of the Suicide Act 1961. Those principles can be summarised as follows:

1. Intention: only direct intention will satisfy the *mens rea* of suicide. Where the patient acts for the purpose of bringing about their death, that will be evidence of intention.
2. Causation: the patient's act need not be the sole cause of their death. Provided it is an 'operating' and 'substantial' cause, that will satisfy the causation requirement.

3.3. 'Suicide' and withdrawal/refusal of treatment: a re-examination of the legal classification of assisted dying

Presently, where death occurs following withdrawal/refusal of treatment or palliative sedation, in the absence of evidence suggesting that the death was 'unnatural' (such as gross negligence), the likely coronial conclusion (if there were to be an inquest which is unlikely⁶⁵²) would be 'natural causes'. Historically, a death was considered 'unnatural' if it was attended by some form of violence. In the 1882 decision of *Hull*, the Court held that 'no doubt the main object of all such inquiries is to ascertain whether the death has been

⁶⁵² Given that the duty to investigate arises if the coroner has reason to suspect that:

- (a) the deceased died a violent or unnatural death,
- (b) the cause of death is unknown, or
- (c) the deceased died while in custody or otherwise in state detention.

(Coroners and Justice Act 2009, s 5(2)).

caused by any violence or criminal act.⁶⁵³ Today, when dealing with deaths arising from withdrawal/refusal of treatment or palliative sedation the following applies:

[W]here death is due to an event which is itself a response to an underlying cause, that underlying cause must be considered. If it is not in itself unnatural, for example cancer, or a heart condition, and the response was a natural consequence of the disease (for example, the usual and appropriate treatment, properly administered), the fact that a recognised complication of the response led to death does not make the death unnatural.⁶⁵⁴

While physician assisted suicide or euthanasia in response to a terminal or life-limiting illness could arguably be considered ‘an event which is itself a response to an underlying [natural] cause’ (in the same way that palliative sedation is such an event) and, if so, should lead to a conclusion of ‘natural causes’ rather than ‘suicide’, where the ‘event’ is an act undertaken by the deceased *with the intention* of bringing about their death and the act is a ‘substantial’ and ‘operating’ cause of the deceased’s death, the deceased can be said to have died by suicide (as that term is used in the Suicide Act 1961), rather than death by natural causes.

While such a contention may seem controversial by moral, ethical and/or philosophical standards, for the reasons outlined above, it makes more sense legally than the alternative act/omission distinction developed by the House of Lords in *Bland* (the validity of which troubled several Lords, especially Lord Mustill).⁶⁵⁵ A finding that withdrawal/refusal of treatment and palliative sedation can constitute suicide plainly raises significant issues in terms of the offence of assisting or encouraging suicide in s 2 of the Suicide Act 1961 since a doctor who acts in accordance with a patient’s autonomous right to cease or not initiate life-sustaining treatment or, indeed, their advance directive with respect to palliative sedation – or provides advice with respect to same – *could* be guilty of the offence of assisting or encouraging suicide under s 2 of the Suicide Act 1961.⁶⁵⁶ Such an outcome, which is problematic for a variety of reasons, is undesirable. It does, however, reveal the

⁶⁵³ *R v Hull* (1882) 9 QBD 689, 700.

⁶⁵⁴ *Matthew* (n 552) 5-73.

⁶⁵⁵ *Bland* (n 31), 866 (Lord Goff), 879, 881-82 (Lord Browne-Wilkinson) and 886-87 (Lord Mustill). See, also, discussion of this issue by Lord Neuberger in *Nicklinson* (n 7) [18].

⁶⁵⁶ In such cases, it is likely that the broader criminal law conceptualisation of intention – i.e. including oblique/indirect intention – would apply such that a doctor could be found to have the requisite *mens rea* of s 2 of the Suicide Act 1961 if assisting or encouraging the patient’s suicide is a virtually certain consequence of their conduct.

inherent limitations of s 2 of the Suicide Act 1961 which are, in turn, reflections of the differential treatment afforded to various end-of-life practices compared with assisted suicide. This chapter does not advocate a broadening of the meaning of suicide but, rather, emphasises the difficulties with the formulation of the current blanket ban, given the proper construction of ‘suicide’.

Of course, not all instances of withdrawal/refusal of treatment and/or requests for palliative sedation will constitute suicide. For such acts to be properly classified as such, there must be evidence that the deceased:

- Intended to take their life (i.e. acted with the purpose of bringing about their death); and,
- Did an act that was a substantial and operating cause of their death.

For the reasons given above, a capacitous patient’s instruction to withdraw life-sustaining treatment or the refusal of such treatment and an advance directive to administer palliative sedation constitutes an ‘act’. The key issues, as with any alleged instance of suicide whether in the coronial context or in criminal proceedings, are whether the deceased can be said to have intended to take their life *and* whether the act undertaken can properly be said to be a ‘substantial’ and ‘operating’ cause of their death.

3.3.1. Intention

It bears recalling that only direct intention will suffice. Where a patient requests that their life-sustaining treatment be ceased or refuses its administration for the purpose of bringing about their death, that will be evidence of direct intention. The fact that the patient does not desire to die and would prefer to live if they were able to rid themselves of their terminal or life-limiting condition does not alter the fact that their intention is to bring about their death and that is direct intention for instant purposes. Likewise, the fact that the patient wants to bring about their death because they are suffering immeasurably or because their deterioration and death is likely to be prolonged, painful or undignified, does not alter the fact that they intend to bring about their death. The patient in such circumstances is akin to the individual with motor neurone disease who is not presently dependent on ventilation and who, intending to bring about their death in order to avoid the inevitable decline, seeks the assistance of Dignitas in so doing. There is no doubt that the individual in the latter case intended to bring about their death, yet that intention may well have stemmed from the same concerns which led the patient with motor neurone

disease who was dependent on artificial ventilation to withdraw consent for that treatment or to refuse it. In both cases, the individual acts with the purpose of bringing about their death. In both cases the individual intends their death. Similarly, a patient who requests palliative sedation at a specific point of physical decline with the purpose of bringing about their death (whether, in fact, palliative sedation does achieve that outcome will be discussed below) has the requisite intention for suicide.

In contrast, a terminally ill patient who instructs a doctor to withdraw life-sustaining treatment or refuses to commence it because the treatment is causing them considerable pain or distress acts with the purpose of halting that treatment only. They do not act with the purpose of bringing about their death through the ending of that treatment. Even if death is a virtually certain consequence, their act (i.e. instructions to cease or refusal to consent to treatment) was intended to avoid the pain/distress associated with it. Putting an end to the treatment (or not commencing it) is the means of reducing pain/suffering which is the intended end. This can be compared with the patient who is suffering (physically or otherwise) because of their condition or illness and the only way *that is satisfactory to the patient* of putting an end to that suffering is death. In that case, the patient acts for the purpose of bringing about their death. A crude example of the distinction between the two patients is the individual with a mental health condition. That patient may experience unpleasant side-effects as a result of the medication taken to ameliorate the symptoms of their condition. As a result, they cease their treatment or refuse medication. They do so for the purpose of ending/avoiding the adverse side-effects ('Situation A'). If their untreated condition causes them unbearable suffering, they may do an act for the purpose of bringing about their death to put an end to their suffering ('Situation B'). The patient who ends/refuses life-sustaining treatment because that treatment is causing them unbearable suffering, is analogous to the individual in Situation A. The patient who ends/refuses life-sustaining treatment in order to bring about death because it is in death that their suffering will end is analogous to the individual in Situation B.

The distinction is also illustrated by the victim of a stabbing – a Jehovah's Witness – who refuses a life-saving blood transfusion. Their refusal may lead to their death, but they did not refuse the transfusion for the purpose of bringing about their death. Were they to survive, they would not consider their act a 'failure'. In contrast, a patient who seeks to end their suffering by bringing about their death would consider their continued existence a 'failure'. Likewise, the patient who ends/refuses treatment because the treatment is

causing them suffering would not consider their continued existence without treatment a ‘failure’.

Each of these instances presumes, of course, that the individual is *compos mentis* at the time the act leading to their death takes place. It is submitted that nothing changes if the patient is incapacitous at the time of their death but has made an advance directive specifying the withdrawal of life-sustaining treatment if they are in a persistent vegetative or minimally conscious state. In this case, the individual has done an act (instructing their treating physicians to withdraw/not administer life-sustaining treatment) for the purpose of bringing about their death. They thus have the requisite intention. Questions of whether you can legitimately attribute past intention to a patient in a persistent vegetative or minimally conscious state are beyond the scope of the instant inquiry.

Greater ambiguity attends advance directives concerning palliative sedation. Such treatment is provided to address a patient’s refractory symptoms when the patient’s death is likely within the coming hours or days. It entails keeping the patient in an unconscious state and is attended by the removal of artificial nutrition and hydration.⁶⁵⁷ There is debate as to whether palliative sedation causes death.⁶⁵⁸ It is administered when the terminally ill patient’s symptoms are not responding to existing treatment including pain relief and is intended to reduce suffering in the last hours/days of life by keeping a patient in a heavily sedated state so that they are (hopefully) unaware of the pain/distress.⁶⁵⁹ A person who requests palliative sedation in an advance directive is likely, then, to do so for the purpose of addressing refractory symptoms and not to bring about death. In that case, the requisite intent for suicide will be absent. That said, if the patient does request palliative sedation for the purpose of bringing about their death (leaving aside, for now, whether palliative sedation *causes* death), intent will be present.

3.3.2. *Causation*

As observed above, the physical aspect of suicide need not be the sole cause of death though it must be a ‘significant’ and ‘operating’ cause of death. It is, then, entirely possible to have multiple acts coalescing to lead to death and this will likely be the case in situations

⁶⁵⁷ See, for instance, Livia Anquinet, Judith Rietjens, CliveSeale, Jane Seymour, Luc Deliens and Agnesvan der Heide, ‘The Practice of Continuous Deep Sedation Until Death in Flanders (Belgium), The Netherlands, and the U.K.: A Comparative Study’ (2012) 44 *Journal of Pain and Symptom Management* 33, 34.

⁶⁵⁸ See, for instance, Rob George and Claud Regnard ‘Lethal drugs or dangerous prescribers?’ (2007) 21 *Palliative Medicine* 77.

⁶⁵⁹ See, for instance, Anquinet et al (n 657).

involving withdrawal/refusal of treatment and palliative sedation. In such circumstances, the underlying condition/illness is undoubtedly *a* cause of death but so too is the decision either to cease life-sustaining treatment, to refuse such treatment or, potentially, to be terminally sedated. Were it not for those decisions (i.e. acts), the individual could have continued living, perhaps only for a short period but living nonetheless. Thus, in the same way that a terminally ill person who ingests a lethal dose of analgesic will be considered to have died by suicide (notwithstanding the fact that their terminal illness would, ultimately, have led to their death), a terminally ill person who withdraws/refuses treatment similarly brings about their death, just via a different means. A hastened death is still a death brought about by an act of the deceased. Indeed, the Supreme Court recognised this when they observed that Noel Conway could bring about his death once he became dependent on 24-hour ventilation by refusing consent to the continuation of his ventilation.⁶⁶⁰ In refusing consent to the ongoing administration of ventilation, Noel Conway would be ‘bring[ing] about his own death’ which, however imminent as a result of complications arising from his condition, would not have occurred at that time and in that manner, were it not for his act. His act would, thus, satisfy the ‘but for’ test of causation *and* would be a ‘significant’ and ‘operating’ cause of his death. As discussed earlier, a person is guilty of murder if their unlawful act is a significant and operating cause of the victim’s death even if the victim has a terminal illness that would otherwise have been fatal at a later time.⁶⁶¹ Unless it can be shown that the deceased would have died in the same manner and at the same time, regardless of the accused’s unlawful act, the but for test will be satisfied and, unless there is evidence to demonstrate that the accused’s conduct was not a significant and operating cause of the victim’s death, the *actus reus* of murder will be satisfied.⁶⁶² The question, then, is whether the act of a patient who seeks the withdrawal of life-sustaining treatment, refuses to consent to its administration or a patient who provides an advance directive requesting palliative sedation can be said to be a ‘significant’ and ‘operating’ cause of death. Whether the patient’s act is a significant and operating cause is highly fact specific. If a patient is receiving life-sustaining treatment (such as artificial ventilation or artificial nutrition and hydration), their request for its removal or a refusal to consent to its administration will satisfy both the but for test (since, but for the patient’s act, their death would not have occurred at that time and in that manner) and the significant and operating

⁶⁶⁰ *Conway* (Supreme Court) (n 8) [3].

⁶⁶¹ See, for instance, *Dyson* (n 633).

⁶⁶² *ibid.*

cause test since it cannot be said that the removal/non-administration of life-sustaining ventilation/nutrition and hydration is a negligible cause nor will it be too remote to the patient's death. Beyond artificial ventilation/nutrition and hydration, whether a patient's request to cease or refusal of consent to treatment can be said to be a 'significant' and 'operating' cause of death will depend on the specific facts. It may be that the patient has advanced-stage kidney failure and is receiving daily dialysis which the patient decides to cease/refuses consent to its ongoing administration. In that instance, the patient's act satisfies both the *sine qua non* and the significant and operating cause requirements since, but for the patient's act, they would have continued receiving life-sustaining dialysis. While they may well have suffered a fatal myocardial infarction or subdural haemorrhage while receiving treatment, their death following the ceasing of dialysis was caused by their act of requesting its cessation/refusing to consent to its continued administration. The same applies to a person who is tetraplegic/quadruplegic and is receiving antibiotics to address a urinary tract infection which, if left untreated, will likely lead to sepsis (urosepsis) and death. The decision to cease the administration of antibiotics or the refusal of consent thereto is both *sine qua non* and a significant and operating cause of their death. It is impossible to canvass all of the potential fact variations and, more importantly, such an exercise is unnecessary for instant purposes. The preceding discussion has demonstrated that a request to withdraw/refusal of consent to life-sustaining treatment *may* satisfy the causal element of the common law definition of suicide.

As for palliative sedation, as noted above, significant doubt attends whether such treatment, when properly administered, causes death. It is generally accepted that good practice in respect of palliative sedation (or, as it is otherwise known, palliative/continuous deep sedation) involves the administration of *small* doses of opioids and sedatives, titrated according to the patient's specific symptoms which, given the body's ability to adjust to suitably small increases in dosage, should not hasten death.⁶⁶³ In most cases, then, palliative sedation should not cause death; it should be neither *sine qua non* the patient's death nor a 'significant' and 'operating' cause. Indeed, palliative sedation should be accompanied by the withdrawal of artificial nutrition and hydration which may well be the legal cause of death. Insofar as the withdrawal of that treatment forms part of the palliative sedation, it

⁶⁶³ See, for instance, Rob George and Claud Regnard (n 657), 77; Bassam Estfan, Fade Mahmoud, Philip Shaheen, Mellar Davis, Wael Lasheen, Nilo Rivera, Susan LeGrand, Ruth Lagman, Declan Walsh, Lisa Rybicki, 'Respiratory function during parenteral opioid titration for cancer pain' (2007) 21 *Palliative Medicine* 81.

may well be that the patient's sedation is a legal cause of death. But, as the preceding summary demonstrates, it is far from clear whether palliative sedation can be said to cause death and, even if it can, as discussed above, the patient will likely lack the requisite intention when making their advance directive for a request for palliative sedation to constitute suicide.

The preceding discussion of causation in the context of three forms of end-of-life treatment has demonstrated that, in some instances, the act of a patient will be the legal cause of their death. This is most likely in cases involving a request for the withdrawal of/refusal of consent to life-sustaining artificial ventilation or nutrition and hydration. In such cases, the patient's request for withdrawal or refusal of consent will be *sine qua non* and a significant and operating cause of their death. In the case of palliative sedation, there is significant debate as to whether such 'treatment', when properly administered, causes death. It may be that death occurs as a result of the concomitant withdrawal of nutrition and hydration or, considering best practice dictates that palliative sedation be administered in the last hours/days of a patient's life, it may be caused by complications stemming from the patient's underlying illness/condition. It is, thus, not possible to reach any generalised conclusions regarding whether palliative sedation satisfies the causation element of the common law definition of suicide. There may be cases in which it does, whether because the doctor administers exceedingly high doses of opioids/benzodiazepines leading to significant respiratory depression and, ultimately, death, or because of the attendant withdrawal of nutrition/hydration. But even if the causation requirement is met, as discussed above, the patient is unlikely to have had the requisite intention to satisfy the definition of suicide.

3.4. Assisted dying and suicide: some conclusions

The preceding analysis has revealed that there is a common law definition of 'suicide' which applies both to the coronial jurisdiction and in criminal proceedings involving the Suicide Act 1961. Having examined the relevant coronial and criminal jurisprudence, it is apparent that that definition comprises the following elements:

1. The direct intention to bring about one's death (i.e. acting for the purpose of causing one's death); *and*,
2. An 'act' on the part of the deceased which was a significant and operating cause of death.

Relevant to the second element of the definition of 'suicide', the artificial act/omission distinction developed in *Bland* which characterises a doctor's withdrawal/withholding of life-sustaining treatment as an omission does not apply to a patient's decision to cease, or their refusal of consent to, life-sustaining treatment. In such cases, as well as in cases involving an advance directive to administer palliative sedation, the patient has acted.

The elements of the common law definition of 'suicide' just outlined will be met when a patient requests the withdrawal of life-sustaining treatment or refuses such treatment and does so for the purpose of bringing about their death. In such cases, the patient's act (i.e. their request for withdrawal or their refusal of consent) will be both *sine qua non* and a significant and operating cause of their death since, but for their act, they would not have died in the manner that they did, at the time that they did. Further, in acting to bring about their death (as opposed to acting for the purpose of ending treatment that is causing them pain or distress), they had the requisite direct intent to satisfy the intention element of the common law definition of suicide. In contrast, in cases involving palliative sedation, the patient is unlikely to have had the requisite intention since palliative sedation is, when properly administered, used to ameliorate suffering/distress caused by a terminally ill patient's refractory symptoms and is, then, not intended to bring about death. Further, there is significant debate as to whether palliative sedation, when properly administered (i.e. appropriately titrated), causes death. Of course, there may be instances in which palliative sedation is administered for the purpose of bringing about a patient's death but, in general, an advance directive for palliative sedation will not satisfy the elements of the common law definition of suicide.

While these conclusions raise significant issues in terms of the culpability of medical professionals and others, that does not alter the legal reality that certain conduct which is presently considered to be a lawful manifestation of a patient's autonomy and self-determination (and protected as such) may, in fact, constitute suicide for the purposes of the Suicide Act 1961 and in terms of suicide conclusions in the coronial context. This has profound implications for, *inter alia*, the validity of the justifications for the blanket ban on assisted suicide in England and Wales discussed in Chapter Four; if patients who seek withdrawal of/refuse consent to life-sustaining treatment are dying by suicide and are, in fact, being assisted in doing so (albeit unwittingly given the current understanding of the legal status of such acts) by medical practitioners, then the justifications given for not permitting other patients to do the same lose some or all of their force. These conclusions

also raise issues concerning the proper classification of other conduct in the coronial context (including, for instance, starvation and/or other forms of what has previously been considered ‘self-neglect’). More pressingly, however, are the implications of these findings for Article 14 of the ECHR.

4. Differential treatment of ‘suicide’: implications for Article 14

As noted earlier, discrimination under Article 14 of the ECHR occurs when, *inter alia*, there is ‘a difference in treatment between persons in analogous or relevantly similar positions’ and there is ‘no objective and reasonable justification’.⁶⁶⁴ While the preceding distillation of the meaning of ‘suicide’ for the purposes of the Suicide Act 1961 has revealed that some end-of-life practices that are currently permitted by English law may, in fact, constitute ‘suicide’, that does not itself confirm that individuals who engage in those end-of-life practices are in an ‘analogous’ or ‘relevantly similar position’ to those like Noel Conway who would seek assistance in dying by suicide if legally permitted to do so. In terms of what makes a situation ‘analogous’ or ‘relevantly similar’, it is not necessary for the positions to be identical.⁶⁶⁵

The question, then, is whether Noel Conway at the time the Supreme Court dismissed his application for permission to appeal could be said to be in an analogous situation to Noel Conway who is dependent upon continuous ventilation? For the following reasons, the answer must be yes. As Lady Hale held in *AL (Serbia)*:

There are ... dangers in regarding differences between two people, which are inherent in a prohibited ground and cannot or should not be changed, as meaning that the situations are not analogous. For example, it would be no answer to a claim of sex discrimination to say that a man and a woman are not in an analogous situation because one can get pregnant and the other cannot. This is something that neither can be expected to change. If it is wrong to discriminate between them as individuals, it is wrong to focus on the personal characteristics which are inherent in their protected status to argue that their situations are not analogous...⁶⁶⁶

Recalling that a person’s medical condition and disability are prohibited grounds for differential treatment under Article 14, and given that a person’s receipt (or not) of life-

⁶⁶⁴ *Pretty v United Kingdom* (n 7) [88].

⁶⁶⁵ See, for instance, *R (Carson) v Secretary of State for Work and Pensions* [2006] 1 AC 173, [2005] UKHL 37 (Lady Hale).

⁶⁶⁶ *AL (Serbia) v Secretary of State for the Home Department* [2008] 1 WLR 1434, [2008] UKHL 42 [27].

sustaining treatment is inherent in those prohibited grounds and cannot be changed, it would be legally impermissible to suggest that the two versions of Mr Conway were not in analogous situations. This is all the more so when one considers the fact that the act of refusing continued ventilation would meet the criteria for ‘suicide’ just as would the act of ingesting a fatal dose of barbiturates. Both versions of Mr Conway are suffering intolerably, both have a terminal illness, both are competent, and both wish to exercise control over the manner and timing of their death, as is their right under Article 8 of the ECHR. They are in analogous situations, but the ban prohibits only one version of Mr Conway from exercising his right to control the manner and timing of his death through assisted suicide and there is no evidence that that is proportionate to the aims of protecting: individuals vulnerable to undue influence, the doctor/patient relationship, or the sanctity of life.⁶⁶⁷

The same reasoning precludes a finding that Diane Pretty and Tony Nicklinson are not in analogous situations: their conditions cannot be changed and the differences between them are inherent in the prohibited ground of medical condition or disability. There is, then, a strong argument that English law fails to treat equally individuals who are in analogous or relevantly similar situations. Given the findings in Chapters Four and Five, the justification for the ban is neither objective nor reasonable and, in those circumstances, the ban on assisted suicide in s 2 of the Suicide Act 1961 is discriminatory in violation of Article 14, taken in conjunction with Articles 2, 3 and 8 of the ECHR.

This conclusion is directly at odds with the decision of the United States Supreme Court in *Vacco*.⁶⁶⁸ In that case, the Supreme Court examined whether the prohibition in New York on assisting suicide violated the Equal Protection Clause of the Fourteenth Amendment. In finding that the prohibition did not violate the Equal Protection Clause, the Supreme Court overturned the Court of Appeal’s finding that ‘New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths’ because:

[T]hose in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal off such systems; but those who are similarly situated, except for the previous attachment of life-sustaining

⁶⁶⁷ See, Chapters Four and Five.

⁶⁶⁸ *Vacco* (n 93).

equipment, are not allowed to hasten death by self-administering prescribed drugs.⁶⁶⁹

The Court of Appeal, thus, determined that the two versions of Noel Conway referred to above were in analogous situations. Notably, the Court of Appeal concluded that '[t]he ending of life by [the withdrawal of life-support systems] is nothing more nor less than assisted suicide'⁶⁷⁰ and further held that this differential treatment was not rationally connected to any legitimate state interest.⁶⁷¹

Central to its decision to overturn the Court of Appeal's judgment, was the Supreme Court's rejection of the finding that ending or refusing life-sustaining treatment could constitute assisted suicide.⁶⁷² According to the Supreme Court, the distinction between assisted suicide and refusing life-sustaining treatment 'comport[ed] with fundamental legal principles of causation and intent.'⁶⁷³ But, as the preceding analysis has revealed, the legal principles of intention and causation in English criminal law that apply in cases of suicide (at least insofar as that term is employed in the Suicide Act 1961) can, and do, apply to certain instances of refusal of life-sustaining treatment. The Court of Appeal's findings in *Vacco* thus provide support for the findings reached in this chapter regarding the meaning of suicide and the application of Article 14, read together with Articles 2, 3 and 8 of the ECHR.

5. Conclusion

This chapter has considered the potential discriminatory effect of the ban on assisted suicide in England and Wales. Drawing on the findings in previous chapters, there is a strong argument that the ban is discriminatory because it imposes a disproportionate burden on individuals who are physically unable to die by suicide without assistance and because it differentiates between analogous cases of suicide on the basis of a prohibited ground (medical condition and/or disability) and there is no reasonable or objective justification for that differential treatment. Central to the claim that the ban discriminates between analogous cases is the conclusion that, in certain instances, refusal of life-sustaining treatment constitutes 'suicide' for the purposes of the Suicide Act 1961.

⁶⁶⁹ *ibid*, 798.

⁶⁷⁰ *Vacco* (n 93).

⁶⁷¹ *ibid*, 799.

⁶⁷² *Vacco* (n 93), 800.

⁶⁷³ *ibid*, 801.

In the absence of a definition in the Suicide Act 1961, tracing the history of the offence of *felo de se* revealed that there is a common law definition of suicide which has existed since at least the 18th century. This definition has evolved primarily through coronial jurisprudence and, having regard to that case law, it is apparent that 'suicide' as that term is employed in both the Suicide Act 1961 and the coronial context means the doing of an act for the purposes of bringing about one's death with the intention of bringing about that consequence. This, however, does not resolve the question of what acts constitute suicide for the purposes of s 2 of the Suicide Act 1961. To resolve that issue, it was necessary to determine the scope of the intention and causation elements of the definition. That examination revealed that, contrary to criminal law in England and Wales more generally, suicidal intention only encompasses direct intention. As for the causal aspect, what is required is that the act of the suicide was a significant and operating cause of death; it need not be sole causal factor. In sum, the common law definition of suicide comprises the following elements:

1. The direct intention to bring about one's death (i.e. acting for the purpose of causing one's death); *and*,
2. An 'act' on the part of the deceased which was a significant and operating cause of death.

It is, then, entirely possible that certain instances of withdrawal/refusal of treatment and/or palliative sedation constitute suicide as that term is employed in the Suicide Act 1961. Provided the individual does the act (for instance giving instructions regarding treatment) with the direct intention of bringing about their death, and that act is a significant and operating cause of their death, the individual will have died by suicide for the purposes of s 2 of the Suicide Act 1961.

As canvassed in this chapter, the ban imposes a disproportionate burden on individuals like Diane Pretty and Noel Conway who cannot control the manner and timing of their deaths without assistance. This conclusion is equally applicable to the prohibition on euthanasia which restricts individuals who are physically incapable of suiciding to a 'single, difficult course of action' in order to bring about their deaths, namely self-starvation and dehydration or the refusal of life-saving treatment such as antibiotics. The prohibition on euthanasia thus has a disproportionately prejudicial effect on individuals on the basis of their physical disability and is discriminatory in violation of Article 14, read in conjunction with Articles 2, 3 and 8 of the ECHR. The Suicide Act 1961 also differentiates between

analogous cases of suicide on the prohibited basis of an individual's medical condition and/or disability, thus violating Article 14, read in conjunction with Articles 2, 3 and 8 of the ECHR.

6. Rectifying the incompatibility

In order to address the discriminatory effect of the Suicide Act 1961, the State will need to legislate for a permissive assisted dying system in line with that proposed in Chapters Two, Three and Four. While the primary focus of this chapter was the Suicide Act 1961, the conclusions reached with respect to the ban's discriminatory effect are equally applicable to the prohibition on euthanasia. Consequently, if the State introduces a system which permits assisted suicide only, individuals who, as a result of their medical condition and/or physical disability, cannot suicide will continue to be disproportionately prejudiced by the prohibition on euthanasia in violation of Article 14 of the ECHR, read in conjunction with Articles 2, 3 and 8. Similarly, if the State restricts access to assisted dying by reference to an individual's life expectancy, this would also fail to redress the violation of Article 14 of the ECHR, read in conjunction with Articles 2, 3 and 8, since the ban on assisted suicide and the prohibition on euthanasia would continue to have a disproportionately prejudicial effect on individuals whose deaths are not within the specified timeframe, like Omid T. Further, restricting access to assisted dying based on a person's life expectancy would not remedy the law's failure to treat like cases alike. As the research in this chapter revealed, certain instances of refusal/withdrawal of life-sustaining treatment constitute 'suicide' for the purposes of the Suicide Act 1961, yet those acts are not prohibited. As Chapters Four and Five revealed, there is no objective or reasonable justification for allowing those acts of suicide, regardless of the individual's life expectancy, while prohibiting other forms of suicide because the individual's death is not predicted to occur within a specific timeframe. Should the State introduce a system of assisted dying that is predicated upon the individual's life expectancy, the law would continue to differentiate between analogous cases on the basis of individual's medical condition in violation of Article 14, read in conjunction with Articles 2, 3 and 8 of the ECHR. In sum, then, consistent with the conclusions reached in respect of Articles 2, 3 and 8, the State will need to introduce an assisted dying system that permits both assisted suicide and euthanasia and is based on a person's intolerable suffering stemming from a terminal or irremediable medical condition, rather than the individual's life expectancy. Such a system

would not only remedy the incompatibilities with Articles 2, 3 and 8 of the ECHR, but it would also address the discriminatory effect of English law as it presently stands.

CONCLUSION

The overarching objective of this thesis was to analyse the human rights implications of the blanket ban on assisted suicide in England and Wales. This was achieved through an examination of the ban's compatibility with the ECHR, specifically the right to life (Article 2), the right to freedom from torture or inhuman or degrading treatment (Article 3), the right to private life (Article 8) and the freedom to enjoy those substantive rights without discrimination (Article 14). The inclusion of Articles 2 and 3 took this analysis beyond the parameters established in the erstwhile domestic and ECtHR jurisprudence, and provided a more comprehensive analysis of the ban's impact on the rights of individuals in England and Wales than has previously been undertaken in either the case law or the academic literature. Further, while the right to choose the manner and timing of one's death (Article 8, ECHR) has been the focus of judicial review proceedings before the English courts, including the Supreme Court, that jurisprudence was critically examined in this thesis with a view to ascertaining whether the conclusion that the ban was compatible with Article 8 reached by both the High Court and the Court of Appeal in Noel Conway's judicial review proceedings was legally correct.

1. Overview of research findings

While English law differentiates between assisted suicide and euthanasia on the one hand and other end-of-life practices like the refusal/withdrawal of life-sustaining treatment on the other, as the analysis undertaken in Chapters One, Four and Six revealed, there is considerable overlap between those practices in terms of the principles underpinning them and, significantly, the legal status of the practices. A capacitous patient's autonomy, self-determination and dignity provide the foundation for the absolute respect afforded to their refusal of, or decision to cease, life-sustaining treatment, even where that decision will inevitably lead to their death. In such cases, while the sanctity of life is an important factor, it is outweighed by the patient's right to control what happens to their body, including whether it is kept alive. In stark contrast, a capacitous individual who has decided, in the exercise of their autonomy and self-determination, that their quality of life is significantly diminished as a result of a life-threatening or life-limiting medical condition, is prohibited from acting on that decision by ending their life with assistance. The same outcome may be sought in both cases – the ending of suffering which can only be achieved through the ending of life – and both individuals are exercising their rights to autonomy and self-

determination. Yet, English law respects absolutely the right of one of them to refuse life-sustaining treatment, while criminalising the other's exercise of their right to choose the manner and timing of their death. Central to that differential treatment is the weight attributed to competing interests such as the sanctity of life. While such interests are relevant to Article 8 of the ECHR, which is a qualified right, competing interests have no relevance to the State's general obligation to protect life in Article 2 and the State's negative obligation not to subject individuals within its jurisdiction to torture or inhuman or degrading treatment in Article 3 of the ECHR.

Chapter Two examined the compatibility of the ban with the right to life. While both the domestic courts and the ECtHR rejected Diane Pretty's argument that the right to life necessarily incorporated – and protected – the inverse right to die, no court considering the Suicide Act 1961 has examined whether the ban violates the *positive* obligation to protect life. It is incontrovertible that Article 2 confers a general obligation on the State to protect life. Central to this obligation is a responsibility to establish a legal system which deters threats to life. Evidence from England and Wales, which was reflected in the findings of the Canadian courts in *Carter*, confirms that the ban on assisted suicide compels some individuals to take their lives prematurely, before their physical condition deteriorates to the point at which they can no longer suicide without assistance. Plainly, the ban interferes with the right to life of such individuals and, in enacting and maintaining the ban in the face of a number of proposed amendments to allow assisted suicide in certain circumstances, the State has failed to put in place a system that deters such threats to those individuals. Indeed, it has enacted a system that is itself a threat to life for some individuals. The ban thus violates the right to life of some individuals and that is sufficient to support a finding that the ban is incompatible with Article 2 of the ECHR. There is no scope for a consideration of the reasons for the ban – Article 2 does not invite a balancing exercise, at least when it comes to the State's *general* obligation to protect.

The same applies in respect of Article 3 of the ECHR, which contains an absolute prohibition on torture or inhuman or degrading treatment. As with her Article 2 claim, the House of Lords and the ECtHR rejected Ms Pretty's claim that the ban violated Article 3 of the ECHR on the basis that there was no 'treatment' which the State could be said to be responsible for. The harm, it was said, arose as a result of Ms Pretty's medical condition and the State was in no way responsible for that. However, as discussed in Chapter Three, the State has an obligation not to subject individuals to treatment that causes suffering or exacerbates suffering that arises as a result of a medical condition. Through the Suicide

Act 1961, the State criminalises the provision of assistance to another who wishes to suicide. For some individuals who are thus precluded from lawfully accessing assistance in dying by suicide, the State can be said to have subjected them to treatment which, if not itself the source of suffering, exacerbates the suffering caused by the individual's medical condition. This line of argument derives support from the reasoning of President Hale and Lord Kerr (with whom Lord Wilson agreed) in the *Northern Ireland Abortion Case*, in which both concluded that the criminalisation of abortion in the case of rape, incest and fatal foetal abnormality, constituted treatment on the part of the State. As President Hale observed, in those cases, it is *the State* that is subjecting the individual to the 'agonising dilemma' of unlawfully procuring an abortion, travelling to England to access an abortion or continuing with the pregnancy. The same applies to the State in the context of the blanket ban on assisted suicide. It is the State that is subjecting the individual to the agonising dilemma: do they take their lives prematurely, while they are still physically capable of doing so without assistance? Or do they access assistance unlawfully, thereby subjecting those who provide such assistance to the risk of prosecution? Alternatively, do they travel to a permissive jurisdiction, again before they are physically incapable of travelling without assistance, and do they go alone or do loved ones accompany them, thereby exposing themselves to the possibility of prosecution? Or, do they face a potentially prolonged, painful and/or undignified death?

The analysis conducted in Chapter Three led to the conclusion that, in criminalising the provision of assistance and thereby forcing individuals like Noel Conway and Omid T to confront an 'agonising dilemma' ranging from a premature death to a protracted, painful and undignified death, the State has subjected such individuals to 'treatment' such as to engage Article 3 of the ECHR. As to whether that treatment reaches the minimum level of severity to constitute a violation of Article 3, it cannot reasonably be suggested that the treatment has been intentionally inflicted for the purpose of securing a particular aim, such as to constitute torture. There is, however, ample evidence that for Diane Pretty, Noel Conway and Omid T, and hundreds if not thousands more individuals like them, the ban – and, thus, the treatment – causes 'either actual bodily injury or intense physical and mental suffering' and 'arouse[s] ... feelings of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance'.⁶⁷⁴ In such cases, the blanket ban on assisted suicide constitutes inhuman or degrading

⁶⁷⁴ *Jallob* (n 198) [68]. See, also, *Ilascu* (n 211) [100]-[101].

treatment by the State in violation of its negative obligation under Article 3 of the ECHR not to inflict such treatment. The prohibition in Article 3 of the ECHR is absolute; the purpose of the treatment is irrelevant. Even if it was permissible to have regard to the reason for the infliction of the ill-treatment when considering whether the treatment violated Article 3, as the analysis undertaken in Chapters Four and Five revealed, a *blanket* ban on assisted suicide is disproportionate; a less restrictive measure would better balance the competing interests. Chapter Three also considered the possibility that the ban violated the State's positive obligation to protect. Lord Kerr's finding in the *Northern Ireland Abortion Case* that the risk that some girls and women would suffer harm in violation of Article 3 as a result of the ban on abortion was sufficient to engage the State's positive obligation to protect them against that harm materialising was similarly applicable to the ban on assisted suicide. There was evidence that the ban would constitute inhuman or degrading treatment for some individuals in a 'highly vulnerable class' of people in England and Wales and the risk of that harm materialising was sufficient to engage the State's positive obligation to protect. In failing to amend the Suicide Act 1961, the State violated its positive obligation under Article 3 of the ECHR. The same reasoning concerning the State's negative and positive obligations under Article 3 was applicable to the common law offence of murder, insofar as it precludes voluntary active euthanasia.

The focus of Chapter Four was the right to choose the manner and timing of one's death, an aspect of the right to private life protected by Article 8 of the ECHR. Following the ECtHR's finding in *Pretty*, it is clear that the blanket ban on assisted suicide interferes with the right of individuals like Noel Conway and Omid T to choose the manner and timing of their death. Central to the analysis undertaken in Chapter Four was accounting for the opposing outcomes reached by Lady Hale and Lord Kerr in *Nicklinson* and the High Court and Court of Appeal in *Conway*. The critical analysis of case law undertaken in this chapter revealed a fundamental error first made by then-President Neuberger in *Nicklinson* and perpetuated by the High Court and Court of Appeal in *Conway*, namely, that for a court to find that the ban was incompatible with Article 8 of the ECHR, the applicant challenging the ban had to provide evidence of a fully-formed, guaranteed-to-function alternative. Such a requirement is plainly erroneous; once an applicant has proven an interference by the State with their right to private life, the onus shifts to the State to prove that the interference is justified. It was incontrovertible that the ban interfered with Noel Conway's right to choose the manner and timing of his death. The onus then shifted to the State to prove that the interference was justified. Requiring Mr Conway to prove a guaranteed-to-

function alternative impermissibly shifted the onus back to him, and assumed a fact not found, namely that the ban *was* justified.

Further, in placing the requirement on Mr Conway to prove that a system of assisted suicide would function appropriately, the High Court and the Court of Appeal failed to have regard to the fact that the current system is not itself guaranteed-to-function; hundreds of people have died with assistance both in England and Wales and in permissive jurisdictions overseas. Indeed, the statistics of prosecutions under s 2 of the Suicide Act 1961, together with the sentencing remarks made in cases involving s 2 prosecutions, reveal that while there is a *de jure* ban on assisted suicide, there is a *de facto* system of permitted assisted suicide involving benevolent assistance of individuals with life-threatening or life-limiting conditions or elderly loved ones. Such a *de facto* system not only provides clear evidence of a ‘guarantee-to-function’ alternative to the blanket ban, it also reiterates the invalidity of the requirement placed on Noel Conway to prove that a less restrictive system would function appropriately before a finding of incompatibility could be made; it cannot be a requirement that a system which is not itself ‘guaranteed-to-function’ can only be declared incompatible with the ECHR if there is an alternative that is ‘guaranteed-to-function’.

As to whether the ban is proportionate to the aims pursued, while doubt attends the validity of the additional aims identified by the High Court in *Conway*, they were nevertheless considered in Chapter Four. In reaching the conclusion that a *blanket* ban is disproportionate to the aims pursued, regard was had to the medical system in England and Wales; medical professionals working with terminally ill patients are required to ensure that decisions made by such patients do not arise as a result of undue influence. This familiarity, coupled with the fact that prosecutions under s 2 of the Suicide Act 1961 are highly unlikely in cases of benevolent assistance provided to individuals with life-threatening or life-limiting conditions or elderly individuals, demonstrates that a less restrictive ban – one which reflects the *de facto* situation in England and Wales – strikes a better balance between the aim of protecting individuals vulnerable to undue influence and the rights of individuals like Noel Conway and Omid T than the blanket ban. Indeed, regulating a practice that is already taking place would provide better protection for individuals who were vulnerable to undue influence as such a system could ensure that appropriately qualified individuals, with experience in determining whether a patient is acting as a result of undue influence, provided the assistance. An appropriately regulated permissive system would better protect individuals vulnerable to undue influence than the

current system which entails an *ex post facto* assessment of vulnerability based on secondary sources and hearsay.

As for the doctor/patient relationship, there is evidence that a system which enables patients to have frank conversations with their doctors about their end-of-life care improves, rather than undermines, the doctor/patient relationship. Further, while the law has drawn artificial distinctions between acts/omissions to avoid medical professionals being culpable for criminal offences when they withdraw life-sustaining treatment or administer increasing doses of pain relief, regardless of the legal classification of such conduct, doctors treating terminally ill patients, and patients who are in persistent vegetative states/minimally conscious states, are regularly involved in treatment which leads to, or at the least contributes to, the patient's death. Doctors already play a pivotal role in patients' deaths and it is difficult to see how extending the category of patients who can access such assistance would so deleteriously affect the doctor/patient relationship as to warrant a *blanket* ban. Indeed, several medical bodies have recently polled their members to ascertain their position on assisted suicide, with the Royal College of Physicians changing its official stance with respect to assisted suicide from against to neutral which is further evidence of the fact that a *blanket* ban on assisted suicide is not necessary to protect the doctor/patient relationship.

As for the final aim, protecting the sanctity of life, English medical law recognises the importance of that principle but has repeatedly confirmed that a patient's sanctity of life is not absolute; a capacitous patient can exercise their autonomy and self-determination and refuse life-sustaining treatment, and a doctor must respect that decision, even if they do not agree with it. Likewise, an incapacitous patient cannot be kept alive simply for life's sake; ongoing treatment must be in their best interests and where it is not, it must be ceased, even when that will lead to death. It is difficult to see how a ban, which precludes capacitous individuals from exercising their autonomy and self-determination to avoid a potentially prolonged, painful and undignified death, protects the sanctity of life, unless that concept is given a meaning different to that employed elsewhere in medical law, namely the protection of life at all costs, regardless of the patient's best interests. Again, it is notable that the *de facto* situation in England and Wales reflects the approach taken elsewhere in medical law, namely that benevolent assistance of an individual who has a terminal, or life-limiting condition, or who is elderly and has limited quality of life, is permitted. This plainly reflects a balancing of the competing interests in favour of the

individual's autonomy, self-determination and dignity. The *blanket* ban is, then, disproportionate to the aim of protecting the sanctity of life.

As discussed above, the requirement that the applicant challenging the ban's compatibility with Article 8 of the ECHR prove that there is a viable, guaranteed-to-function, alternative, is legally dubious to say the least. However, as the research conducted in Chapter Five revealed, even if it were permissible to place such a requirement on applicants, the permissive systems in an increasing number of countries and States in America are all evidence of 'guaranteed-to-function' alternatives. 'Guaranteed-to-function' cannot be taken to mean completely without risk; any system based on human judgement is fallible. Rather, guaranteed-to-function, at least in terms of Article 8 of the ECHR, must refer to a system that sufficiently meets the concerns raised by the State. Chapter Five used the findings of Justice Smith in *Carter* as the foundation for an examination of whether permissive schemes pose an unacceptable risk to individuals vulnerable to undue influence, to the doctor/patient relationship and to the sanctity of life. Those findings were then considered in light of subsequent data collected by the regulatory bodies in several permissive jurisdictions. That analysis revealed that while no permissive system is faultless, rates of non-compliance with the legislative requirements are low, with many cases of further investigation by the regulatory bodies involving complex cases where opinions were varied as to the appropriate course of action. Certainly, there is no evidence of a 'slippery slope', or of a risk of vulnerable individuals being pressured into accessing assisted suicide. The majority of individuals accessing assistance in dying in permissive jurisdictions are elderly with terminal cancer. In those jurisdictions that collate further demographic data, the results reveal that the majority of persons who die with assistance are educated, have private health insurance and are receiving palliative care. Insofar as it is possible to objectively gauge a person's vulnerability to undue influence, such individuals are not likely to be considered at risk. Further, there was no evidence of deterioration in the doctor/patient relationship, indeed, there was frequently an improvement, with patients preferring a system in which they can have honest and frank conversations about their end of life care. And, finally, as to the sanctity of life, jurisdictions that allow assisted dying adopt an approach to the principle similar to that which exists elsewhere in English medical law, namely, that while it is of considerable importance, it can and does give way to other considerations such as the patient's autonomy, self-determination and dignity. Further, there is no evidence of slippery slopes in permissive jurisdictions.

Having determined that the *blanket* ban is incompatible with the right to life (Article 2, ECHR), the right to freedom from torture or inhuman or degrading conduct (Article 3) and the right to private life (Article 8), Chapter Six considered whether the ban was discriminatory. There are two potential bases for a finding that the ban is discriminatory. The first is that it imposes a disproportionate burden on individuals who are physically unable to die by suicide without assistance, and the second is that it differentiates between analogous cases of suicide on the basis of a prohibited ground (medical condition and/or disability) and there is no reasonable or objective justification for that differential treatment. As for the first basis, while the ban applies to both able bodied and physically disabled individuals, the means of suicide available to able bodied individuals are much less onerous than those available to individuals who, because of physical disability, can only bring about their death by self-starvation and dehydration. And, it is only physically disabled persons who are restricted to that single, difficult course of action. While there may be no ‘right to suicide’ in domestic law, there is a right to choose the manner and timing of one’s death and the blanket ban on assisted suicide imposes a disproportionate burden on individuals who, as a result of their physical disability, are unable to exercise that right. Similarly, the ban compels some individuals to take their lives prematurely, on the basis of their medical condition and future deterioration and subjects some individuals who do not take their lives prematurely to inhuman or degrading treatment or, at the least, exacerbates their suffering such as to reach the minimum level of severity under Article 3 of the ECHR. The ban, thus, places a disproportionate burden on individuals who, as a result of their medical condition, will be physically unable to die by suicide without assistance. Accordingly, the ban on assisted suicide is discriminatory in violation of Article 14, read in conjunction with Articles 2, 3 and 8 of the ECHR.

The same line of reasoning applies to the prohibition on euthanasia. Individuals who, as a result of their medical condition and/or physical disability, cannot suicide (even with assistance) are disproportionately prejudiced by the prohibition on euthanasia and are restricted to the ‘single, difficult course of action’ of self-starvation and dehydration or the refusal of life-saving treatment, such as antibiotics, in order to bring about their deaths. Individuals without physical disabilities are not so restricted and the prohibition on euthanasia is, thus, discriminatory as it has a disproportionately prejudicial effect on individuals on the basis of their medical condition and/or physical disability in violation of Article 14, read in conjunction with Articles 2, 3 and 8 of the ECHR.

As for the second basis of discrimination, Chapter Six examined whether the ban discriminates between analogous cases. This turned on the meaning of ‘suicide’ for the purposes of Suicide Act 1961. If ‘suicide’ covers instances of end-of-life practices which are lawful, such as the withdrawal of life-sustaining treatment, then the ban discriminates between analogous cases. Through critical examination of coronial and criminal case law, a common law definition of suicide was distilled. ‘Suicide’ as that term is used in the Suicide Act 1961 comprises the following elements:

1. The direct intention to bring about one’s death (i.e. acting for the purpose of causing one’s death); *and*,
2. An ‘act’ on the part of the deceased which was a significant and operating cause of death.

There are, then, instances of withdrawal/refusal of life-sustaining treatment which legally constitute ‘suicide’ and involve assistance from doctors but which are not, in practice, prohibited by the ban. While English law permits those forms of assisted suicide, it prohibits absolutely other forms of assisted suicide and the basis for that differential treatment is the individual’s medical condition. If the individual is terminally ill and receiving life-sustaining treatment, they can die by suicide with assistance by refusing or seeking the withdrawal of that treatment. If the individual is not receiving life-sustaining treatment, they cannot avail themselves of an assisted death. The justifications for this differential treatment are the same as those given for the interference with Article 8 of the ECHR. For reasons given in Chapters Four and Five, the justification(s) for the failure to treat like cases alike are neither objective nor reasonable; insofar as they are legitimate, a *blanket* ban is disproportionate and the differential treatment is discriminatory in violation of Article 14, read in conjunction with Article 8 of the ECHR.

2. Rectifying the incompatibility

The research conducted in Chapters Two to Six revealed that the ban is incompatible with the right to life (Article 2, ECHR), the right to freedom from torture or inhuman or degrading treatment (Article 3, ECHR), the right to private life (Article 8, ECHR) and the right to enjoy those substantive rights free from discrimination (Article 14, ECHR read in conjunction with Articles 2, 3 and 8). The power to make a declaration of incompatibility pursuant to s 4 of the HRA 1998 is discretionary – the courts are not compelled to make such a declaration. However, as both Lady Hale and Lord Kerr observed in *Nicklinson*,

there is little to be gained and much to lose in not issuing such a declaration as it is an especially useful method of communication with Parliament. Indeed, by signalling to Parliament that the Suicide Act 1961 violates not only the right to private life of individuals like Noel Conway and Omid T, but also the fundamental rights to life and freedom from torture or inhuman or degrading treatment, a declaration of incompatibility will undoubtedly affect any debate surrounding the amendment of the Suicide Act 1961. More significantly, perhaps, in a jurisdiction where a declaration of incompatibility does not affect the validity of the law, it is the best remedy for an individual who has had their rights violated. Such individuals deserve a declaration of incompatibility, considering the magnitude of the harm that is caused by the ban on assisted suicide.

The question, then, is what Parliament must do to rectify the incompatibilities. Again, it must be noted that Parliament can choose to do nothing in the face of a declaration of incompatibility. However, should Parliament decide to act to remedy the violations, there are several options available. In the context of Article 2, Parliament could simply repeal the ban, thereby decriminalising assistance. That would take the pressure off individuals who would otherwise be forced to take their lives prematurely were the ban still in place. This is the situation in Scotland, where assisting suicide is not a criminal offence and Switzerland, where there is no legislation regulating the provision of assistance. Such an approach is, however, not ideal as it does not offer the transparency and accountability that a regulated system of assistance would. It is recommended, then, that Parliament either amend the Suicide Act 1961 to provide for forms of assisted suicide, or repeal the Act and introduce legislation akin to Oregon's Death with Dignity Act or Victoria's Voluntary Assisted Dying Act.

As for the ban's incompatibility with Article 3 of the ECHR, it is not enough for Parliament to introduce legislation permitting assisted suicide. The same line of reasoning that led to the conclusion that the ban constitutes treatment, arguably applies to the offence of murder, which criminalises euthanasia. If that is correct, then Parliament will need to adopt legislation akin to that which exists in Canada (in particular Part VIII of the Criminal Code) and Victoria, both of which permit euthanasia in specific circumstances. As to the eligibility criteria, as suffering is highly subjective, a life-expectancy requirement of 6 months or less (as exists in the permissive US states), will not resolve the incompatibility, as individuals whose life-expectancy is more than six months may nevertheless experience suffering that reaches the minimum level of severity. An approach such as that initially proposed by the Supreme Court of Canada in *Carter*, namely assisted dying for individuals who, as a result

of a 'grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual', provides an ideal model.

As with the violation of Article 3 of the ECHR, the repeal of the Suicide Act 1961 and the introduction of legislation enabling assisted suicide would not be sufficient to address the incompatibility with Article 8 of the ECHR. The same reasoning that led to the conclusion that the *blanket* ban is disproportionate applies to the offence of murder, which criminalises euthanasia. For individuals like Tony Nicklinson who are physically incapable of doing the final act leading to their death (and, thus, cannot suicide), the prohibition on euthanasia violates their right to choose the manner and timing of their death. And, just as a *blanket* ban on assisted suicide is not necessary, so too is a blanket prohibition on euthanasia unnecessary. The same considerations regarding the medical profession's familiarity with obtaining informed consent, free from undue influence, and its approach to other end-of-life practices such as the withdrawal of life-sustaining treatment from both capacitous and incapacitous patients, demonstrates that a less restrictive ban on euthanasia would strike a better balance between the rights of individuals like Tony Nicklinson to bring about their death in the exercise of their autonomy and self-determination *vis-à-vis* the State's interests in protecting vulnerable individuals, the doctor/patient relationship and the sanctity of life.

By introducing a system of assisted dying that permits assisted suicide and voluntary active euthanasia for individuals who, as a result of a grievous and irremediable medical condition which causes suffering that is intolerable to the individual, Parliament would not only address the current violations of the rights to life (Article 2 of the ECHR), freedom from torture or inhuman or degrading treatment (Article 3 of the ECHR) and the right to choose the manner and timing of one's death (Article 8 of the ECHR), but such a system would also remove the discriminatory effect of the ban and address the current incompatibility with Article 14, read together with Articles 2, 3 and 8 of the ECHR.

Throughout this thesis, reference has been made to 'individuals' as opposed to 'adults'. While the overwhelming majority of permissive jurisdictions restrict access to 'adults' (defined as individuals aged 18 years or older), there is no justification for limiting an assisted dying regime in England and Wales to 'adults'. English law recognises the right of Gillick competent children to make decisions regarding their medical treatment, including the refusal of life-sustaining treatment, subject to parental consent and judicial oversight.⁶⁷⁵ Accordingly, Gillick competent children should be permitted to access assistance in dying

⁶⁷⁵ See, for instance, *B (A Minor)* (n 496).

if they are suffering intolerably as a result of a terminal or irremediable medical condition subject to the same conditions as those imposed on Gillick competent children in other medical situations (the (de)merits of such limitations are beyond the scope of this dissertation).

3. Implications of this research

The findings in this thesis fundamentally alter the narrative surrounding the blanket ban on assisted suicide in England and Wales and have implications for the ECtHR when examining state ban's on assisted suicide. Contrary to the findings of the ECtHR in *Pretty* and the High Court and Court of Appeal in *Conway*, the ban is incompatible with Article 8 of the ECHR. This finding alone has profound consequences for future challenges to the ban, two of which have been recently foreshadowed. But the research in this thesis broadened the inquiry beyond that previously conducted by either the domestic or ECtHR courts or in the academic literature. In so doing, this thesis has demonstrated that the ban also violates the fundamental rights to life and freedom from torture or inhuman or degrading treatment. These findings redirect the focus onto the individuals affected by the ban, as opposed to society's interest in regulating the way in which individuals die, and when that is the focus, it is patently clear that the ban causes immeasurable harm to a considerable number of individuals each year. Importantly, Article 3 confers an absolute right; it does not matter a whit what the purpose of the ban is. The fact that it causes one individual suffering that reaches the minimum level of severity is sufficient to ground a declaration of incompatibility. The fact that it causes hundreds of people such harm is ample justification for a repeal of the ban and the introduction of a system of assisted dying that permits both suicide and euthanasia for individuals who are suffering intolerably as a result of a grievous and irremediable medical condition. Similarly, the fact that Omid T was compelled to take his life prematurely is proof that the ban violated his right to life and confirms the finding that the ban is incompatible with Article 2 of the ECHR. When the focus is on the very real human cost of the ban, the justifications proffered by the State for maintaining it grow increasingly tenuous; it is not enough to make vague claims about protecting the vulnerable, or the doctor/patient relationship or the sanctity of life, when individuals are taking their lives or are suffering intolerably because of it. This is all the more so given the findings that the *blanket* ban is not proportionate to any of those aims.

The outcomes of the research conducted in this thesis are directly relevant to the way in which future judicial review applications concerning the Suicide Act 1961 are argued and

to the nature and scope of any future amendments to that Act and to the common law offence of murder. Even more importantly, however, these findings recognise the human cost of the ban. The accounts and suffering of individuals affected by the ban are not only acknowledged, but they provide the foundation for the findings. ‘There’s nothing certain in a [person’s] life except this: That [they] must lose it.’⁶⁷⁶ When a person’s death promises to be prolonged, painful or undignified or when their quality of life is so diminished by intolerable suffering arising from a grievous and irremediable medical condition, any legislation prohibiting them from exercising control over how they experience their death must be carefully scrutinised and its legal veracity confirmed. Such was the purpose of this thesis and, having conducted a rigorous examination of the legality of the Suicide Act 1961, in the context of the ECHR, it is clear that the justifications proffered for preventing hundreds if not thousands of individuals from exercising control over the manner and timing of their death are seriously wanting and the blanket ban on assisted suicide is incompatible with Articles 2, 3, 8 and 14 (read together with each of those substantive rights) of the ECHR.

⁶⁷⁶ Though this quote is frequently attributed to Aeschylus’s *Agamemnon*, doubt attends the validity of that ascription. See, for instance, Stransham-Ford (n 106) [1].

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