

Legalising assisted dying: unintended consequences and slippery slopes

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Suicide Act 1961

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

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

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

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

Assisted Dying Bill 2021

1 Assisted dying

- (1) Subject to **the consent of the High Court (Family Division)** pursuant to subsection (2), **a person who is terminally ill** may request and lawfully be provided with assistance to end his or her own life.
- (2) Subsection (1) applies only if the High Court (Family Division), by order, confirms that it is satisfied that the person—
 - (a) has a **voluntary, clear, settled and informed wish** to end his or her own life;
 - (b) has made a declaration to that effect in accordance with section 3; and
 - (c) on the day the declaration is made—
 - (i) **is aged 18** or over;
 - (ii) **has capacity to make the decision to end his or her own life**; and
 - (iii) has been **ordinarily resident** in England and Wales for not less than one year.

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

- Netherlands, Belgium, Luxembourg
- Canada
- California, Colorado, District of Columbia, Hawaii, Montana, Maine, New Jersey, Oregon, Vermont, Washington, Montana.
- Victoria, Western Australia, South Australia, Tasmania, Queensland, New South Wales, New Zealand
- Spain, Portugal, Colombia, Germany, Jersey ...
- For many (most?) patients, legalised assisted dying represents 'an insurance policy against future suffering', and may never be used.

The poison's still in the fridge, but perhaps I don't want it after all

In July, sick with cancer, Jo Beecham talked in this newspaper about stashing life-ending drugs in her fridge, in case she wanted to hasten her end. But as the disease wore on, and she received better palliative care, she had second thoughts

● [My cancer plan: poison in the fridge](#)

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Sun 26 Oct 2014 18.00 GMT



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Jo Beecham with her nurse, Annie Lister. Photograph: Jackie Kyrum Beecham

When Jo Beecham was diagnosed with cancer three years ago, her first instinct was to control the moment of her death, to bypass the worst of the pain. In fear, she bought some life-ending drugs, and in July this year, she gave [an account in these pages](#) of the challenges of living with poison hidden behind the bags of salad in the fridge. That was about the time that [Lord Falconer's bill](#) to legalise [assisted dying](#) received its second reading in the House of Lords.

To medicalise or not medicalise assisted dying?

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

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

Right to conscientiously object to participation.

Good reasons to involve doctors:

1. Necessary knowledge and skill to diagnose and confirm medical eligibility criteria.
2. Skills to end lives effectively and painlessly.
3. Evidence from Belgium that the integration of assisted dying and palliative care ensures continuity of care.
4. Broader purpose of legitimation.
5. Easier for relatives/loved ones?

And good reasons *not* to involve doctors:

1. Neutralise arguments grounded in the impact of legalisation upon medical profession?
2. Involvement in assisted dying is not easy for doctors.
3. Support for legalisation is generally lower among doctors than the general public.
4. Doctors find involvement in AD especially difficult when the patient's suffering is psychosocial or mental (easier if the patient is dying from cancer).
5. Advance decisions are difficult (and rare).

Doctor's professional organisations?

- Following polls of their members, the Royal College of Physicians (RCP) and the British Medical Association have now formally adopted a position of neutrality.
- The Royal College of General Practitioners (RCGP) and the Association for Palliative Medicine of Great Britain and Ireland (APM) continue to oppose a change in the law on assisted dying.
- In the RCP survey:
 - 43% thought the RCP should be opposed to a change in the law
 - 32% thought the RCP should be in favour of a change in the law
 - 25% thought the RCP should be neutral.
- In the RCGP survey:
 - 47% thought the RCGP should be opposed to a change in the law
 - 40% thought the RCGP should be in favour of a change in the law
 - 11% thought the RCGP should be neutral.

Robotics and assisted dying

- Would there be advantages in using robots to replace doctors' role in administering AD?
- What role could robots play in providing therapeutic services that help to address the needs of patients seeking AD?
- Is determining eligibility for AD a decision that would always have to be made by a person?

Vulnerable or not vulnerable?

- House of Lords Select Committee on Assisted Dying: ‘We were also concerned that **vulnerable people**—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death’.
- Lady Hale (in *R (Nicklinson and Another) v Ministry of Justice* [2014] UKSC 38): ‘The only legitimate aim which has been advanced for this interference is the protection of **vulnerable people**, those who feel that their lives are worthless or that they are a burden to others and therefore that they ought to end their own lives even though they do not really want to.’
- Rob Marris MP (House of Commons, 11 Sep 2015): ‘coercion of the **vulnerable** is the most difficult issue, for me and many people in the House and outside’

Evidence from Europe/US?

Requests come more frequently from those who:

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

‘I offer a new conception of vulnerability, one that demonstrates how **rich, educated, white males ... are just as, if not more, vulnerable** to threats posed by PAS/VAE’

Erik Krag, ‘Rich, White, and Vulnerable: Rethinking Oppressive Socialization in the Euthanasia Debate’ (2014) 39 *Journal of Medicine & Philosophy* 406–429.



Interest in assisted dying more generally:

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

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

Reason for interest in assisted dying:

- It is not objectively inadequate pain control
- But subjective judgement about what makes life worth living, and desire for control.
- If it's a person's *values* rather than their symptoms that prompt a request for an assisted death > what can palliative care do?
- In AD, patients exercise control by submitting themselves to a process in which *doctors* control whether they are allowed to access it.

Excluding the vulnerable?

- Requirement that patient requests AD and doctor must not offer it
eg *Voluntary Assisted Dying Act 2017 (Victoria) section 8*
 - (1) A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person –
 - a) initiate discussion with that person that is in substance about voluntary assisted dying; or
 - b) in substance, suggest voluntary assisted dying to that person.
- Exclusionary?
- Do under-privileged people actually make less use of AD because they would have to *ask* for it?

‘Because patients who already know about the law are likely to be more educated, waiting for patients to initiate a request for AID might create access gaps for patients from less privileged backgrounds.’

M Buchbinder, ‘Aid-in-dying laws and the physician’s duty to inform’ (2017) 43 *Journal of Medical Ethics* 666-669.

Excluding people with mental disabilities?

- Does this amount to denying a group access to a service because of their disability?
- Does it contribute to stigmatisation, marginalisation and the removal of agency?
- Is it in keeping with a history of treating disabled people as if they are all incompetent and easily coerced?
- Does respect for disabled people mean that we need to allow them the same choices as everyone else?
- Cf suicide prevention

Truchon v AG (Canada) and AG (Quebec) 2019 QCCS 3792

Justice Baudoin:

Vulnerability (tied to various external factors including the social determinants of health) **should not be understood or assessed on the basis of a person's belonging to a defined group**, but rather on a **case-by-case basis**... In other words, it is not the person's identification with a group characterized as vulnerable—such as persons with disabilities, Indigenous persons or veterans—that should bring about the need to protect a person who requests medical assistance in dying but, rather, that person's individual capacity to understand and consent in a free and informed manner to such a procedure, based on his or her specific characteristics.

Social determinants of health

- What if it is the absence of adequate support services that make a person's suffering intolerable?
- Of course, the right answer is to provide the support services which the person needs.
- Should the inadequacy of social care services be a bar to the legalisation of assisted dying?
- Are we confident that someone who requests assisted dying in the UK would first receive a comprehensive care assessment and package of support services in order to see if their quality of life can be improved?

Vulnerability and other life-ending decisions

- Why are we less concerned about the vulnerability of patients who refuse life-prolonging treatment?
- If we think we can tell whether someone who is refusing life-prolonging medical treatment is able to make that decision, why can't we make the same judgement in the case of assisted dying?

Re B (Adult: Refusal of Treatment) [2002] EWHC 429

Dame Elizabeth Butler-Sloss P

There is a serious danger, exemplified in this case, of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient.

I do not consider that either the lack of experience in a spinal rehabilitation unit and thereafter in the community or the unusual situation of being in an ICU for a year has had the effect of eroding Ms B's mental capacity to any degree whatsoever.

I am therefore entirely satisfied that Ms B is competent to make all relevant decisions about her medical treatment including the decision whether to seek to withdraw from artificial ventilation . . . I also find that the Claimant has been treated unlawfully by the Trust since August.

Slippery Slopes:

- Rather than saying: “you can’t have access to AD because **I think it is always morally wrong**”, opponents say: “if you have access to AD, there is a danger that **someone else** who is vulnerable will be pressured into opting for AD”.
- Deflect attention from case at top of slope?
- More likely to be effective than argument that assisted dying would be morally wrong for everyone.
- Using non-vulnerable patients as a means to an end?
- Regulation preferable?

Strategic secularisation?

- Religious arguments against AD are downplayed, in favour of arguments about how it would work in practice, ie that it would be difficult to protect the vulnerable.
- Cf abortion, anti-abortion campaigners have increasingly argued that abortion is bad for *women* in order to appeal to people who do not share their beliefs about the embryo/fetus.

Pressure on the status quo in the UK?

- Discrimination (Swiss option only if have sufficient financial and social resources)?
- Must die abroad, can't die at home.
- Must die when still fit enough to travel.
- Few safeguards (assisted suicide is a crime in Switzerland only if the motive is selfish)
- Increasing volume of cases which are not prosecuted.
- What if Switzerland closed the 'safety valve'?
- UK is increasingly an outlier on AD.
- Demographic changes?



House of Commons
Health and Social Care
Committee

Assisted Dying/ Assisted Suicide

Second Report of Session 2023–24

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 20 February 2024*

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Public dialogue

Current project

Exploring public views on assisted dying

A public engagement project to explore people's views on
assisted dying in England.



Assisted Dying for Terminally Ill Adults (Scotland) Bill

[AS INTRODUCED]

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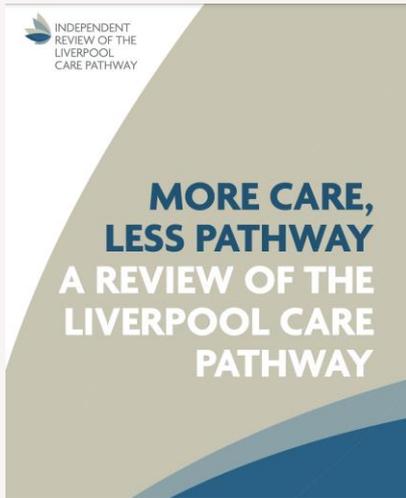
STATES OF JERSEY



ASSISTED DYING

**Lodged au Greffe on 22nd March 2024
by the Council of Ministers
Earliest date for debate: 21st May 2024**

STATES GREFFE



Importance of talking openly about death, dying and the wish to die

- Dying is (or should be) core NHS business.
- Dr Paul Perkins, Chief Medical Director at Sue Ryder (HSC Select Committee Report, para 267):
 - I am constantly surprised that as a society it is okay for us to have to sell second-hand cardigans to be able to look after seriously ill people. If people thought that you had to sell second-hand cardigans for their cancer surgery, I don't think that would be acceptable ...