ASSISTANCE IN DYING:
A RIGHTS ANALYSIS IN CONTEXT

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor of Philosophy by:

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June 2006

The difference to the whole will be no greater than betwixt my being in a chamber and in the open air. The one change is of more importance to me than the other; but not more so to the universe.

David Hume, Of Suicide, 1784.

Any man's death diminishes me, because I am involved in mankind...

John Donne, Devotions upon Emergent Occasions, 1624.

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PART I: INTRODUCTORY

1. INTRODUCTION

A. Opening remarks

The topic of study for this thesis has been described by Lord Mustill as, 'at present, the most intellectually demanding, the most ethically challenging, and the most important for its contingent effects as well as for its immediate practical impact, of all the points on the line where law, medicine, belief and reason intersect'.[1] No doubt there will be some who think his Lordship guilty of ever such slight hyperbole; but I for one would want to thoroughly agree with the sentiment of his remarks. The question we are dealing with here is a difficult and significant one, one which cuts across many disciplines and has important ramifications for society at large.

This thesis is about the right to be assisted in dying—that is, the right of one person to have help from another to put into effect a desire to die which cannot be realised without such help. It is a topic, of course, on which many have written before. There are, quite literally, dozens of books which deal with this area in one way or another. Early classics by Glanville Williams[2] and A.B. Downing[3] set the agenda (Downing, in his preface, asks 'Is it a human right for an individual to be allowed to choose for himself the merciful release of death?'); in more recent years there have been book-length treatments by, to name just a few of the more well-known commentators, Ronald Dworkin,[4] Margaret Otlowski[5] and John Keown.[6] To be sure, the literature will continue to burgeon in the future. It is daunting to wonder whether one can add anything at all to the debate.

Having said this, however, for some time now I have had the feeling that much of the existing writing addresses the subject from the wrong angle. In recent times, the landscape of the assisted dying debate has crucially altered. As with many other areas of the law, we have seen the debate shift towards the language of rights. Yet commentators on the whole have tended to pay scant attention to this fact. In spite of Downing's prefacing question, none of the essays in his collection so much as approach a rights analysis of the issue, at least as I understand such analyses. This is hardly surprising, given that the book was written more than three decades ago at a time when, not only had the assisted dying debate not swung to the language of rights, but rights discourse in general was still very much in its infancy. What is surprising, however, is that the more recent considerations of the subject should take such little notice of the change in the debate. Apart from Dworkin, who in fairness has from the off approached the issue from a rights perspective, none of

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[1] Foreword to J. Keown, *Euthanasia, Ethics and Public Policy: an Argument against Legalisation* (Cambridge: CUP, 2002).

[2] G. Williams, *The Sanctity of Life and the Criminal Law* (London: Faber and Faber, 1958).

[3] A.B. Downing (ed.) *Euthanasia and the Right to Death: the Case for Voluntary Euthanasia* (London: Peter Owen, 1969).

[4] R. Dworkin, *Life's Dominion: an Argument about Abortion and Euthanasia* (London: HarperCollins, 1993).

[5] M. Otlowski, *Voluntary Euthanasia and the Common Law* (Oxford: Clarendon, 1997).

[6] J. Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge: CUP, 1995); J. Keown, *Euthanasia, Ethics and Public Policy: an Argument against Legalisation* (Cambridge, CUP, 2002).

the authors I have mentioned (and many more I have not) give more than perfunctory consideration to assistance in dying as a question of fundamental rights.

There are, of course, good reasons for this, particularly if we are thinking of the position of commentators in the UK. For a country still very much bewitched by, and beholden to, the common law tradition, rights can seem a curious and (a word I often hear used, especially by practising lawyers) 'trendy' development, and rights discourse an other-worldly language spoken by a few specialists who are more concerned with Strasbourg than the Strand. Even in the post-Human Rights Act age we seem hesitant and ill at ease framing our legal concerns in the language of rights.[7] This is not necessarily a bad thing: rights (as we shall see) can be appealed to too quickly; to translate all of our petitions and disputes into 'rightsspeak' would be both inappropriate and arrogant. On the other hand, we have to ask whether or not the common law is always the best way of analysing our legal and ethical problems.

It is widely acknowledged that the application of common law principles to cases of assistance in dying has led to the law in this area becoming 'morally and intellectually misshapen'.[8] It is not hard to see why. A common law analysis of assistance in dying, by concentrating on the conduct of the person doing the assisting, runs into all sorts of difficulties to do with intention and foresight, causation, and the (non-)distinction between life-ending actions and omissions. By contrast, a rights analysis, with its focus on the person wishing to be assisted, largely avoids these problems.[9] If there is a fundamental right to be assisted in dying in certain circumstances, such a right ought to be respected, regardless of what we can say about the assister's conduct, unless there are countervailing concerns for the rights of others. And yet, it is the common law problems that have preoccupied the majority of commentators and distracted them from the turn the assisted dying debate has taken towards rights.

Of course, some will be reading these opening paragraphs and thinking that the picture they paint looks a little dated in light of recent developments. There are likely to be few people who are unfamiliar with the tragic plight of Diane Pretty. She was the woman who in 2001-2002 challenged the UK prohibition on assisted suicide as incompatible with certain fundamental rights guaranteed under the European Convention on Human Rights.[10] Mrs Pretty suffered from the

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[7] Indeed, some would go so far as having the Human Rights Act repealed: B. Carlin, 'Rip up Human Rights Act, says Cameron' *The Daily Telegraph*, 26 June 2006.

[8] *Airedale NHS Trust v Bland* [1993] AC 789, p.887.

[9] As we shall see, a rights analysis cannot avoid the common law problems altogether, particularly where the argument is made that a right to assistance in dying ought to be recognised because of its equivalence to the already recognised right to withdraw life-sustaining medical treatment. Insofar as I have to address the common law problems, they are dealt with in Chapter 5 under the heading 'The right to equality/not to be discriminated against'. For good surveys of the philosophical and legal issues which lie at the heart of the common law problems, see H. Biggs, *Euthanasia, Death with Dignity and the Law* (Oxford: Hart, 2001), especially ch 2; and B. Steinbeck and A. Norcross, *Killing and Letting Die* (2nd Ed.) (New York: Fordham University Press, 1994).

[10] *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] EWHC Admin 788; *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61; [2002] 1 AC 800; *Pretty v United*

progressive degenerative condition known as motor neurone disease. Although this disease meant that during her final months she was physically capable of very little—she was essentially paralysed from the neck down—mentally she was fully alert and her capacity to make decisions was unimpaired. Mrs Pretty wished to take steps to bring her life to an end, because she was frightened and distressed by the prospect of the cruel final stages of the disease, which she knew could see her die as a result of suffocation caused by failure of the muscles that control breathing. Mrs Pretty's physical incapacity meant she was unable to end her life herself. She thus wished to enlist the help of her husband. He himself was willing to offer the assistance she required, but was prevented from doing so by section 2(1) of the Suicide Act 1961. This states that:

> A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to a term not exceeding fourteen years.

Under section 2(4) of the Suicide Act, proceedings may only be instituted for the offence under section 2(1) by or with the consent of the Director of Public Prosecutions (DPP). Mrs Pretty thus sought to secure her husband's immunity from prosecution by asking the DPP to give an undertaking that, were her husband to assist her, the DPP would refuse to grant his consent to Mr Pretty's prosecution. This the DPP refused to do, stating that 'successive Directors—and Attorneys General—have explained that they will not grant immunities that condone, require, or purport to authorise or permit future commission of any criminal offence, no matter how exceptional the circumstances'.[11]

Mrs Pretty, in judicial review proceedings in the Administrative Court, challenged the DPP's decision, arguing that it contravened her rights under Articles 2, 3, 8, 9 and 14 of the Convention. Her contention, which was framed in the form of two alternative submissions, suggested that either: (i) section 2(1) should, as required by section 3(1) of the Human Rights Act 1998, be interpreted compatibly with her Convention rights, thus obliging the DPP to give the requested undertaking; or (ii) if such interpretation was not possible, section 2(1) should be declared incompatible with the Convention, as permitted by section 4(2) of the HRA 1998.

On 18 October 2001, the Court delivered judgment dismissing Mrs Pretty's application. As to the first of her submissions, the Court found that, regardless of the strengths of the human rights arguments advanced, section 2(1) could not be interpreted so as to compel the DPP to grant the requested undertaking, since the DPP's powers did not extend to allowing him to grant what would amount to, in effect, a pre-offence pardon. Under section 2(4), the DPP has no power to

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Kingdom [2002] ECHR 427 (App. No. 2346/02). The substantive arguments raised by the *Pretty* case are considered in detail in chapters 5 and 6.

[11] DPP's written response to Mrs Pretty's request dated 8 August 2001.

disapply, or not to enforce section 2(1), only to exercise a discretion, after consideration of known evidence relating to an offence already committed, whether in the particular circumstances it would or would not be in the public interest to pursue prosecution. The pretended power of suspending primary legislation without the consent of Parliament was unlawful, and this had been so since 1668 when the Bill of Rights was passed. To have granted the requested undertaking would have meant the DPP acting beyond his office, and this, the Court thought, no argument could justify.

With regard to the second submission, that section 2(1) should be declared incompatible with Mrs Pretty's Convention rights, although the Court recognised that, from Mrs Pretty's point of view, this would be a much less satisfactory outcome—declarations of incompatibility not affecting the validity, continuing operation or enforcement of provisions; nor binding parties in the proceedings in which they are made (HRA, section 4(6))—in order to do fairness to the arguments advanced by her, the Court went on to examine in turn whether section 2(1) was incompatible with each of the Convention rights that Mrs Pretty had invoked. In each case, after considering the scope of the right, the Court concluded it was not.

The Court's findings on the interpretation of the various rights almost immediately ran into criticism in the days following the judgment. One commentator remarked that the judges had relied on an interpretation of the Convention rights which was 'the narrowest, most conservative and illiberal...possible', one which would 'retard the human rights cause for decades'.[12] In spite of this, however, on 29 November 2001, the House of Lords, after just six weeks of considering an appeal by Mrs Pretty, unanimously affirmed these findings, and appeared to prefer *them*, above the arguments relating to the role of the DPP, as the principal justification for dismissing Mrs Pretty's case. Subsequently, the House of Lords' assessment of Mrs Pretty's rights was validated almost in its entirety by the European Court of Human Rights (hereinafter the ECtHR), which also ruled that Mrs Pretty had not had her Convention rights violated.

Clearly then, the debate has moved on; and it is true that the thoughts that I have expressed, about the focus of many commentators on the common law problems, are really more the thoughts which prompted me to think about this thesis in the first place, at the end of the 1990s, before the *Pretty* case arose. At this time there really was a dearth of domestic writers looking at assisted dying from a rights perspective, and I could not understand why this was so. Across the Atlantic, academics had been musing on the subject of a constitutional right to assisted dying since the late 1980s.[13] Then, in 1993, we saw the powerful rights arguments mounted in the Canadian case of *Rodriguez*[14] and, later, the US Supreme Court cases of *Washington v*

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[12] A.C. Grayling, 'A Good Death' *The Guardian* (Saturday Review), 27 October 2001.

[13] See, e.g. T.J Marzen *et al*, 'Suicide: a Constitutional Right?' (1985) 24 *Duqesne Law Review* 1; J. Bopp, Jr., 'Is Assisted Suicide Constitutionally Protected' (1987) 3 *Issues in Law and Medicine* 113; Anon., 'Physician-Assisted Suicide and the Right to Die with Assistance' (1992) 105 *Harvard Law Review* 2021.

[14] *Rodriguez v British Columbia (AG)* [1993] 3 SCR 519.

Glucksberg[15] and *Vacco v Quill.*[16] The Human Rights Bill was going through Parliament; we knew that rights were being 'brought home'. To my mind, a challenge to the laws governing assisted dying under the European Convention looked, if not inevitable, then at least highly probable. There were a few others who seemed to be of the same opinion, for example Andrew Grubb[17] and Michael Freeman.[18] But it is true to say that, at this time, the vast majority of commentators were still writing about assisted dying as a matter best analysed via the traditional framework.

Undoubtedly, *Pretty* has been a watershed. Since 2002, articles discussing assistance in dying from a rights perspective have started to appear in the journals with more and more regularity.[19] Yet there remains work to be done. For I have yet to come across a rights analysis which ties itself to the broader debate on assistance in dying: one which attempts to place the right in context, which examines not only the legal right but also the moral right upon which the legal right must rest, and the underlying justifications for this moral right, taking into account also the social, cultural and historical backdrop to the debate.[20] These are the considerations which give this thesis its shape, a shape which is perhaps a little odd but which I hope is nevertheless as uncomplicated as possible, whilst at the same time being able to accommodate the complexity of the arguments, both legal and non-legal.

The rights analysis proper—by which I mean the analysis of the legal right—comes last, in chapters 5 and 6, which together make up Part III. Here, first I will briefly articulate the analytic right to assistance in dying, i.e. the type of right that the right to assistance in dying is or can be. Then I will examine from which positive human rights the contested right can most comfortably be derived; in other words, what are the substantive provisions within whose ambit the right to assistance in dying can best be said to fall. Via a detailed assessment of *Pretty*, but also the Canadian and American cases, as well as authority from other jurisdictions, I shall consider the merits and demerits of grounding the right to assistance in dying in the right to life; the right to be free from certain prohibited types of treatment; the right to freedom of conscience; the right to equality and not to be discriminated against; and the right to autonomy. Following this, in chapter 6, I shall consider on what grounds it might be possible for the state to interfere with the right; and this will involve looking at a variety of 'state interests' including the interest in upholding the

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[15] *Washington v Glucksberg* (1997) 138 L Ed 2d 772.

[16] *Vacco v Quill* (1997) 138 L Ed 2d 834.

[17] Writing a case commentary on *Rodriguez*, Professor Grubb had noted that the case 'illustrated how the European Court of Human Rights might approach a challenge to section 2 of the Suicide Act'. (1994) 2 Med L Rev 119, p.123; see also, I. Kennedy and A. Grubb, *Medical Law: Text with Materials* (2nd ed.) (London: Butterworths, 1994), p.1289.

[18] M. Freeman, 'Death, Dying, and the Human Rights Act 1998' (1999) 52 *Current Legal Problems* 218.

[19] D. Morris, 'Assisted Dying under the European Convention of Human Rights: a Critique' [2003] *EHRLR* 65; A. Pedain, 'The Human Rights Dimension of the Diane Pretty Case' (2003) 62 *CLJ* 181; B. Hale, 'A Pretty Pass: when is there a Right to Die?' (2003) 32 *CLWR* 1; J. Keown, 'European Court of Human Rights: Death in Strasbourg—Assisted Suicide, the Pretty Case, and the European Convention on Human Rights' (2003) 1 *IJCL* 722; M Freeman, 'Denying Death its Dominion: Thoughts on the Diane Pretty Case' (2002) 10 *Med L Rev* 245.

[20] Very few legal writers at all attempt to provide context to the assistance in dying debate; those that do, however, write firmly from the common law perspective.

sanctity of human life, the interest in preventing suicide, the interest in protecting dependants, the interest in preserving the integrity of the medical profession, the interest in not demeaning the disabled, and the interest in protecting the lives of those who do not want to die. Chapter 6 also considers the means by which the state may interfere with the right, i.e. it looks at the issue of proportionality.

Part II is where I consider the moral right, specifically the justifications for the moral right. James F. Childress, one of the founding fathers of modern bioethics, is surely right when he states that arguments for assisted dying 'invoke two major constellations of moral ideas: on the one hand, the values of personal autonomy (self-determination or self-rule); on the other hand, the disvalue of human suffering and the value of compassionate responses to that suffering.'[21] These are the two pillars which must bear the bulk of the justificatory burden. Taking the latter first, in chapter 3 I examine in detail not only the degree of suffering sometimes experienced by the terminally ill, but also the adequacy of society's current best response: the hospice and palliative care movement. In terms of linking the rights analysis to the broader debate, this chapter I think is crucial, for it allows me to explore areas which are often neglected by legal commentators but which are nonetheless integral to the question of whether or not we ought to recognise a right to assistance in dying. How can we possibly respond to those who assert that good palliative care can in the majority of cases obviate the need for more drastic measures, if we know little or nothing not only about what patients sometimes have to go through in the run up to death, but also how much the hospice movement can actually achieve, and realistically be expected to achieve?

The value of personal autonomy is discussed in chapter 4. However, in writing this chapter it seemed important to me not only to look at autonomy as a value in isolation, but also to try to say something about the relation it has to another important concept in the debate: the idea of dignity. Dignity would be important in any discussion of assisted dying, but it is especially important when considering the issue from a rights perspective; it is a commonplace to say that human rights derive from the dignity of each human being. Thus, chapter 3 starts from the question: what is a dignified death or a death with dignity? As we shall see, this is no simple matter to explain. The difficulty is that, dignity is not a concept that is easily pinned down: it means different things to different people; consequently, the notion of a dignified death is open to different interpretations. Yet, it is clear that some conceptions of dignity seem to be more defensible than others, and this means that so too are some conceptions of a dignified death. A conception of dignity which links the value of humanity to the fact that humans are autonomous seems to be among the more tenable of the differing conceptions; however, we also need to note that there may be other, perhaps equally, valid contenders, for example the idea that dignity relates to the fact that humans have certain fundamental interests; also, we shall consider the merits of the idea that

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[21] J.F. Childress, 'Religious Viewpoints' in L. Emanuel (ed.), *Regulating How We Die: the Ethical, Medical, and Legal Issues surrounding Physician-Assisted Suicide* (London: Harvard University Press, 1998), p.120.

dignity is a virtue. The question is, whether these conceptions of dignity and their consequent conceptions of death with dignity support the right to be assisted in dying.

Along with the present introduction, Part I is comprised of a chapter on the origins and evolution of the prohibition on assistance in dying; again, my thoughts were to give context to the discussion. However, historical attitudes to assisted dying are not only a matter of background importance. In rights analyses, tradition and consensus are always at the forefront of the judge's mind (or at least they should be). The fundamental rights that are protected by national constitutions and international conventions might be dynamic, fluid things which must be interpreted by each generation in light of present-day conditions, but rights cannot slip anchor from the past altogether. Particularly in the North American case law, it can be seen that judges regard the issue of whether the right to assisted dying can be firmly rooted in the past as key to determining whether such a right ought presently to be acknowledged; and in the ECtHR too, although this tribunal does not seem to attach quite as much importance to historical analysis, it is nevertheless clear that, in interpreting the terms of the European Convention on Human Rights, the ECtHR ought to bear in mind the Council of Europe's 'common heritage of political traditions [and] ideals...' (Preamble to the Convention.)

But then, as well as understanding the history of the debate, it is important to grasp also the reasons for the present state of play. With this in mind, the remainder of this introduction will look, first, at why the assisted dying debate has of late become so prominent; and secondly, why the debate has shifted towards the language of rights. I will also consider the drawbacks of a rights analysis of assisted dying. However, before I get on to these issues, let me round off these opening remarks by explaining the terminology used in this thesis.

It will probably be wondered why I insist on using the terms 'assisted dying' or 'assistance in dying', rather than something more familiar and less cumbersome like 'assisted suicide' or 'euthanasia'. The reason has already been hinted at: it is because, under a rights analysis we focus on the perspective of the person wishing to be assisted; yet terms like 'assisted suicide' and 'euthanasia' ineluctably lead us to concentrate on the conduct of the assister. In the case of the former, we are interested in the *extent* of the assister's participation—has he actually caused the death or has he done no more than act as an accessory at or before a death which is ultimately caused by the assistee?[22] As for the latter, it is the *mode* of conduct with which we are concerned—was it active or passive? For while active euthanasia (e.g. the giving of a lethal injection) is unacceptable and considered by UK courts to be no different from homicide, passive euthanasia (where that is taken to mean the withholding or withdrawing of life-sustaining treatment) may lawfully be practised, although it certainly would not be called euthanasia.[23] So, 'assisted dying' and 'assistance in dying' are terms that are primarily intended to signal a change

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[22] *AG v Able* [1984] QB 795.

[23] *Airedale NHS Trust v Bland* [1993] AC 789 (incompetent patient); *Re B (Adult: Refusal of Medical Treatment)* [2002] EWHC 429 (Fam), [2002] 2 All ER 449 (competent patient).

in emphasis. They are meant to highlight the fact that, in this thesis, the view taken is that there is little to be gained by making hair-splitting distinctions based on the assister's conduct, that is to say, there is little to be gained from making distinctions based on causation, intention, or actions and omissions.

What this means, of course, is that when I talk of assistance in dying I should be understood as referring to a much broader range of activities than any of the traditional labels on their own are able to encompass. As well as covering assisted suicide and both active and passive euthanasia, I would also bring within the term the commonly practised, so-called 'double effect' cases. The classic example of this is where a dying patient is suffering from agonising pain which ordinary quantities of analgesic drugs fail to make bearable; in such cases, many doctors will give the minimum dose necessary to lessen the patient's pain, knowing that this dose is at the same time of a level that will prove fatal to the patient.[24] However, in all of these cases the crucial caveat is that the person being assisted must be competent and wanting to die. Another reason for using the term '*assistance* in dying' is that it is meant to imply help, and, generally speaking, something can only be of help if it furthers a purpose or objective on which the helper and the helped are agreed. If the person being helped positively does not want the 'help', then it becomes, rather, a hindrance, or even something worse. Similarly, if the person helped is not competent to determine whether he wants the 'help', we are then into the realm of paternalism. Thus, this thesis has nothing to say about cases of so-called 'involuntary euthanasia' (which are really just cases of out and out murder),[25] and little to say about cases of 'non-voluntary euthanasia', including those cases of passive non-voluntary euthanasia such as where life-sustaining treatment is withdrawn from patients in persistent vegetative states (PVS).[26] Not everyone is going to be satisfied by this—the scope of the thesis seeming somewhat limited—but, until the case for allowing assistance in dying has been brought into focus at its most compelling, i.e. where the person involved is competent and consenting, then the case for all other types of assistance in dying will continue to remain distinctly blurred, notwithstanding that some of these other types of assistance already occur quite lawfully, and on a regular basis.

B. Why now?

Scarcely a week, it seems, can go by without an article appearing in the journals either advocating or opposing assistance in dying. In the *British Medical Journal*, for instance, in the last

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[24] The legal authority for this practice derives from the guidance offered to the jury by Devlin J in the case of *R v Adams* [1957] Crim L Rev 365.

[25] The etymology of the word euthanasia is well known: it derives from the Greek *eu*, meaning 'good' or 'well', and *thanatos*, meaning 'death'. So, as Hazel Biggs notes, to talk of involuntary euthanasia is to accept a 'fallacious classification', since the term euthanasia should never properly be applied in such cases; insofar as the individual wishes to go on living, their death simply cannot be a 'good death': H. Biggs, *Euthanasia* (Oxford: Hart, 2001), p.12.

[26] Although I shall incidentally touch on such cases at various points, most notably in chapter 4 when I consider precautionary reasoning *vis-à-vis* those who are non-autonomous.

twelve months alone there have appeared over sixty original articles, reviews, or letters addressing the subject either directly or indirectly.[27] Similar coverage is to be found in the legal, philosophical, and sociological reviews; this is to say nothing of the constant stream of newspaper reports detailing the plights of individuals such as Diane Pretty and Terri Schiavo.[28] At the time of writing, a Bill put forward by the cross-bench peer and former human rights lawyer, Lord Joffe, has just been the subject of an impassioned debate in the House of Lords.[29] The Assisted Dying for the Terminally Ill Bill—which would have made it lawful for a physician, at the persistent and informed request of a competent, terminally ill individual who is suffering unbearably, to prescribe medication which the patient could then use to end his life—had already been before a Select Committee of the House of Lords,[30] and was on course to receive its Second Reading, when Lord Carlile of Berriew tabled an amendment to delay the Bill for a period of six months. As one writer has remarked, though assistance in dying is an issue which has always 'simmered', of late it appears to have become a controversy 'at a rolling boil'.[31] But why is this?

There are generally recognised to be several reasons for the current upsurge in attention which the subject is receiving.

The recoil from the medical model of death

First, something needs to be said about the nature of modern death. There is in our society a growing concern about the 'denaturalisation' of death and dying. Whereas death was once an intensely intimate, socio-familial experience—the dying person surrounded by relatives, friends and ritual—nowadays it is a very different affair. Nowadays, death is more likely than not to occur in a sterile hospital ward, with the dying individual attended to by unfamiliar doctors and nurses, ritual being replaced by medical routine. Hospitals are now not only the place of death for the majority of the population,[32] but also they are the environment in which an increasing proportion of the last year of life is spent. Data from surveys conducted in the UK show that, on average, individuals spend 38 days in hospitals or hospices in the year before their death; this figure represents 22 per cent of all occupied NHS bed days during that year.[33]

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[27] Electronic search of the *BMJ* archive was performed looking for 'hits' which contained the terms 'euthanasia', 'assisted suicide', or 'assisted dying' between June 2005 and June 2006.

[28] Terri Schiavo was the brain-damaged women who died in 2005 after a Florida state court ruled that the feeding tube by which she had been kept alive since 1990 should be removed. The case divided not only Mrs Schiavo's family—while her husband, Michael Schiavo, had petitioned for the removal of the tube, her parents, the Schindlers, had vigorously objected to the move at every stage—but the entire US nation, even prompting personal intervention from the US President. See D. Teather and R. Luscombe, 'Bush enters fray in right-to-die case dividing the US' *The Guardian*, March 21, 2005; Anon., 'Terri Schiavo dies' *The Guardian*, March 31, 2005.

[29] *Parliamentary Debates*, Lords, 12 May 2006, available at www.publications.paliament.uk.

[30] The Committee published a report of its findings on 4 April 2005, HL-86 (London: HMSO, 2005).

[31] N. Milton, 'Lessons from Rodriguez v British Columbia' (1995) 11 *Issues in Law & Medicine* 123, p.141.

[32] J. Ellershaw and C.Ward, 'Care of the Dying Patient: the Last Hours or Days of Life' (2003) 326 *BMJ* 30, stating that more than 66 per cent of UK deaths occur in hospitals.

[33] J.E. Seymour, *Critical Moments–Death and Dying in Intensive Care* (Buckingham: OUP, 2001), p.19.

This denaturalisation—or, as it is often called, the 'medicalisation' or 'technicalisation'—of the dying process has increasingly come under attack of late. Throughout the literature and research concerning the subject, the broad consensus that emerges is that of a critique of modern, hospitalised death, such being contrasted with, and represented as a threat to, idealised notions of the 'good death'. 'Hospitalized death', it has been written, 'is characterized by a loss of individual choice; fear; isolation from family, friends and professional carers; lack of knowledge about the dying state; and by a prolongation of the dying career'.[34] The dying person, commentators have noted, is often subjected to 'aggressive', 'dehumanizing', and 'depersonalized' treatment,[35] which leads to the loss of dignity of the individual and ultimately to the 'social status of the dying person [being] diminished'.[36]

Criticism of this sort perhaps first appears in the 1970s in the writings of people such as Philippe Ariès and Ivan Illich. In his now classic text *Limits to Medicine: Medical Nemesis*,[37] Illich noted that 'Society, acting through the medical system, decides when and after what indignities and mutilations [man] shall die. The medicalization of society has brought the epoch of natural death to an end'.[38] Illich—whose views of course are well-known as applying not just to death and dying but to all aspects of medicine—had drawn his conclusions after studying the earlier work of the renowned French historian Ariès. In his essays, which have since been collected and expanded into a single volume *The Hour of Our Death*,[39] Ariès had lamented the loss in the Western world of what he called a 'tame' death, and contrasted this to the 'dirty', 'wild', 'hidden' event of modern medicalised death. By a 'tame' death, Ariès had meant that sort of death, common throughout human history until very recently, which is characterised both by a 'familiar simplicity', and by a 'public aspect', a placing of the dying individual at the centre of a group of people. The sort of ending, Ariès thought, that is 'the oldest death there is'.

It is the sort of death, for example, to be found in Elisabeth Kübler-Ross's *On Death and Dying*, where she remembers the death in her childhood of a farmer that her family knew:

> He fell from a tree and was not expected to live. He asked simply to die at home, a wish that was granted without questioning. He called his daughters into his bedroom and spoke with each one of them alone for a few minutes. He arranged his affairs quietly, though he was in great pain, and distributed his belongings and his land, none of which was to be split until his wife should follow him in death. He also asked each of his children to share in the work, duties, and tasks that he had carried on until the time of the

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[34] D. Clark and J.E. Seymour, *Reflections on Palliative Care* (Buckingham: OUP, 1999), p.89.

[35] D.W. Moller, *On Death without Dignity: the Human Impact of Technological Dying* (New York: Baywood, 1990), pp.32-34.

[36] D.W. Moller, *Confronting Death: Values, Institutions, and Human Mortality* (Oxford: OUP, 1996), p.22.

[37] I. Illich, *Limits to Medicine – Medical Nemesis: the Expropriation of Health* (London: Marion Boyars, 1976).

[38] *ibid.*, p.207.

[39] P. Ariès, *The Hour of our Death* (trans. H. Weaver) (London: Allen Lane, 1981).

> accident. He asked his friends to visit him once more, to bid good-bye to them. Although I was a small child at the time, he did not exclude me or my siblings. We were allowed to share in the preparations of the family just as we were permitted to grieve with them until he died. When he did die, he was left in his own home, which he had built, and among his friends and neighbors who went to take a last look at him where he lay in the midst of flowers in the place he had lived in and had loved so.[40]

For those who would criticise the medical model of dying, this sort of death represents the ideal ending. However, as the ethicist Daniel Callahan has pointed out, we must be careful not to romanticise or be unrealistic about how previous generations died. We must 'pay attention to the pain that marked many earlier deaths, unrelieved by narcotics or analgesics. There were no respirators to relieve the suffocation induced by collapsing lungs, or drugs to control the erratic beat of a heart out of control, or antibiotics to stem gangrene or the torture of spreading bedsores'.[41] Modern medicine does—and must—make a difference to the way we think about death and dying.

Nevertheless, the desire to recoil from over-medicalisation of the dying process has had no slight influence on the assistance in dying debate. By becoming conscious of the idea that a medicalised death has not always been the paradigm way of dying, and by questioning the benefits to be had from ending one's life in this way, individuals have become far more inclined to put forward their own ideas of what they consider to be an acceptable form of death, with many people now taking the view that, in certain circumstances, without the sanctioning of third party assistance, it might be impossible to achieve a 'good death'. The argument, as it runs, is that with certain types of illnesses, in some cases, towards the end medicalisation is inevitable; thus the individual should have the choice to bow out before that point is reached.

Of course, there is a paradox here: how, it may be asked, can an assisted death ever be considered a more natural death? Moreover, if it is a doctor who assists, this is surely as medicalised a death as there can possibly be. This, I think, is to miss the point slightly. For the whole argument about medicalisation is not that modern medicine and those who practise it should have no part in the terminal stages of life, but rather, only that they should have a more limited role. Whatever the terminology used—'natural', 'tame', 'non-medical', 'good' death—the central idea that is trying to be captured is that of a death which is ultimately accepted and which once again can be thought of as a principally human affair, rather than just a technical problem which should be battled against at all costs. For many, the right to assistance in dying is crucial to the realisation of this idea, at least under some circumstances. However, fears about the overreach of medicine and the loss of long-held ideals regarding the 'proper' way of dying cannot

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[40] E. Kübler-Ross, *On Death and Dying* (London: Routledge, 1970), p.5.

[41] D. Callahan, *The Troubled Dream of Life: In search of a Peaceful Death* (London: Simon & Schuster, 1993), p.52.

on their own account for the volume of the present debate. There must be, and there are, certain other factors which call for consideration.

Individualism

First and foremost, we should consider the rise to dominance of a particular social and political ideology. For as well as arising negatively from the desire to avoid a medicalised death, the tendency of individuals to assert their own personal vision of what they consider an acceptable form of dying, also stems from, or is a manifestation of, society's increasing preoccupation with individualism, and consequently rights. In Western democracies, more and more we tend to define who we are by reference not to community standards, but instead by reference to the standards of the individual. Whereas personal identity has in the past been perceived as inherently social—a consequence of independent variables such as one's territorial location, ethnicity, language, religion, citizenship—it has of late become fashionable to suggest that personal identity rests in fact in the interests of separate human beings: individuals themselves—rather than linguistic groups, nations or states—are society's real building blocks.[42]

It is in this increasingly individualistic ideological climate that we must now place, and attempt to understand, the current debate. Professor Margaret Somerville has noted that, with more and more people applying a highly personalised approach to the issue, increased calls to recognise a right to assisted dying should hardly come as a surprise to us. However, she questions whether such untempered individualism might not be harmful. She writes that 'there seems to be either a total lack of consciousness, or possibly a denial, that extreme individualism can undermine the intangible infrastructure on which society rests, the communal societal fabric'.[43] Such concerns are not new. They echo the 'communitarianist' critique espoused in the 1980s (recently reinvigorated), that individualism was going too far and that, left unchecked, it would be responsible for the break up of civic life.[44] The communitarian perspective is not without merit: it highlights the dangers of exaggerated liberalism and causes individualists to hone their arguments better. But, in the context of the assistance in dying debate, such concerns seem somewhat out of place, given that, as has just been shown, a large part of the reason for the debate is that people feel that communal ideas of death have been usurped of late by the modern medicalised vision of death—a vision that is anything but communal, as Somerville herself concedes.[45]

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[42] T.M. Franck, *The Empowered Self: Law and Society in the Age of Individualism* (Oxford: OUP, 1999).

[43] M. Somerville, 'Legalising Euthanasia: why now?' (1996) 68(3) *Australian Quarterly* 1, p.5.

[44] See generally, S. Avineri and A. de-Shalit (ed.), *Communitarianism and Individualism* (Oxford: OUP, 1992); A. Hutchinson and L. Green, *Law and the Community: the End of Individualism?* (Toronto: Carswell, 1989).

[45] *op. cit.*, at p.5.

The media

Another factor to be taken into account is the impact which has been made by the revolutions in access to information and communications. We are, as Somerville has observed, media societies. 'We are the first age in which our collective story-telling takes place through television'.[46] This has had a dramatic effect on raising awareness of the assistance in dying debate. For instance, anyone who saw the BBC's Panorama documentary following Diane Pretty in her final weeks could not have failed to contemplate whether, in the same circumstances, they too would wish for help in killing themselves.[47] And the same applies also, perhaps with less force, to the way such cases are portrayed in the newspapers. In the last decade or so, of course, it is the internet which has come to the fore; and we have already started to see how powerful this can be in the rise of the phenomenon of 'death tourism': where individuals, because of prohibitory laws in their own countries, research the web in order to find help in dying in certain foreign jurisdictions.[48]

As well as raising awareness, however, the 'mediatisation' of the assistance in dying debate may also have a distortive effect on perceptions of death and dying. Because our story-telling is carried out through television and the newspapers, at a physical distance from each other, it is possible that we only see the issues as the media want to present them. As Professor Somerville notes, while it makes dramatic, emotionally gripping television to feature the cases of those who are arguing in favour of a right to assistance—the suffering, the pain, the tragedy all being there—by the same token the case *against* does not make for such compelling viewing: visual images are difficult to find, we do not personally identify with the arguments as we do with those seeking assistance, and society cannot be interviewed and become a familiar, empathy-evoking figure to the viewing public. Somerville rightly points out that comparably gripping images communicating the case against a right to die with help could be created only if assisted dying were legalised and there were obvious cases of abuse.[49]

An important way in which the media has influenced and promoted the assisted dying debate is in the way that it has portrayed the stories of what Roger Magnusson has described as 'a class of celebrity law-breakers, dissident doctors who openly flout the law' to campaign for legalised assistance in dying.[50] Specific examples will be well known. In the USA, there is Dr Jack

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[46] *ibid*., p.6.

[47] 'Please Help Me Die', shown 12 May 2002, BBC 1. Just over a year later, the BBC also produced a documentary following the plight of another motor neurone disease sufferer, Phil Such, who also wished to be helped to die. The film showed how Phil, who had followed Mrs Pretty's case in the hope of being able to benefit from any ruling in her favour, had attempted to starve himself to death rather than suffer the same fate: 'Kill or Cure: Phil's Story', shown on 12 June 2003, BBC 2.

[48] J. Revill, 'First Briton Helped to End Life at "Death Tourism" Clinic' *The Observer*, 3 November 2002; N. Bunyan, 'Terminally Ill Man plans Swiss Trip to commit Suicide' *The Daily Telegraph*, 1 January 2003.

[49] M. Somerville, *op. cit*. p.6.

[50] R. Magnusson, *Angels of Death: exploring the Euthanasia Underground* (London: Yale University Press, 2002), p.49.

Kevorkian with his 'assisted suicide machine'.[51] In the UK, most recently there has been Dr David Moor, who was tried for, and acquitted of the murder of an 85 year old patient with terminal cancer; [52] before him there were Drs Cox[53] and Bodkin Adams.[54] Australia has the 'Melbourne 7' and Dr Nitchke.[55] The media has clearly made celebrities out of all these campaigners. Their stories, however, intimate yet another trend underlying the current debate. The media could not have reported these cases unless the doctors had been prepared in the first place to talk about their experiences. It seems that now, more than at any time in the past, doctors are willing to admit that, yes, sometimes they do help their patients to die.

Candidness of doctors

As well as the 'celebrity campaigners', there have been numerous examples of ordinary doctors admitting to participating in patients' deaths. One of the earliest examples, at least in this country, is to be found in George Mair's book *Confessions of a Surgeon*. Mair details how in the 1940s as a young, inexperienced Resident Surgical Officer, he participated in the death of a woman in her middling forties 'whose expectation of life could be measured only in months'. He recounts how an evening came when she asked if he would do her a favour. She explained to him that her house was now in order, her will organised, and that she had seen her family and friends while she was still looking reasonably well. She thought that there was nothing left for her to do but die. She wished Mair to take her to a side room, lay on certain of her favourite music, and then, when she gave the signal, to help her die by way of a suitable injection. Mair states: 'I did exactly as

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[51] Kevorkian's campaigning eventually came to an end in April 1999 when he was jailed for second-degree murder following the broadcast on *60 Minutes* of a videotape showing him administering a lethal injection to Thomas Youk, a 52 year-old man suffering from Lou Gehrig's disease. In handing down her sentence, the judge told Kevorkian that he should consider this the end of his crusade to legalise assisted suicide. 'This trial was not about the political or moral correctness of euthanasia' she said. 'It was about lawlessness...You had the audacity to go on national television, show the world what you did and dare the legal system to stop you. Well sir, consider yourself stopped'. Anon., 'Kervorkian Jailed for 10-25 Years' *The Guardian*, 14 April 1999. It was later suggested that an associate of Kevorkian, Dr Georges Reding, may have continued his work in New Mexico, when it emerged that he had been involved in the death of a 54 year-old woman suffering from multiple sclerosis. The woman at first was thought to have died as a result of her disease, but an autopsy initiated by her family later found that she had died from a lethal dose of sedatives. C. Reed, 'Kervorkian Friend Accused' *The Guardian*, 21 August 1999.

[52] See C. Dyer., 'All I tried to do was relieve his Agony, his Distress and Suffering' *The Guardian*, 12 May 1999. Dr Moor, who died in October 2000 just eighteen months after his acquittal, has given his own blow-by-blow account of his trial in a book entitled *Allowing Dignity in Death* (privately published, copies available at £10 each from Michael Irwin, 15 Hovedene, Cromwell Road, Hove, East Sussex BN3 3EH).

[53] Nigel Cox, a consultant rheumatologist, was tried in 1992 for killing an elderly arthritis sufferer with an injection of potassium chloride. In the absence of a body (it having been cremated shortly after the patient's death), Dr Cox, instead of being tried for murder which would have been difficult to prove in the circumstances, was tried for attempted murder. He was convicted and sentenced to a twelve month suspended sentence.

[54] P. Devlin, *Easing the Passing: the Trial of Dr John Bodkin Adams* (London: Bodley Head, 1985).

[55] In March 1995, seven Melbourne doctors went public on the front page of *The Age* newspaper in an open letter to the Premier of Victoria, admitting to having performed euthanasia and calling for the introduction into Parliament of assisted suicide legislation. Philip Nitchke is the Darwin doctor who presided over all four of the deaths carried out under the Northern Territory's *Rights of the Terminally Ill Act 1995* before this was overturned in 1997. For a detailed account of these, and all of the other 'celebrity doctors' campaigns, see R. Magnusson, *op. cit.*, ch.2.

she wished, and she squeezed my hand while listening to the second movement of Beethoven's ninth symphony. I then slipped the needle into a large vein and gave her an enormous dose of suitable drugs. She slept swiftly and died in less than an hour. Her last words were whispered, but very clear. "Thank you. Thank you so very, very much."'[56]

Similar admissions have been made by doctors in other countries. In 1988, for example, the *Journal of the American Medical Association* published a first-person account of assisted death by an anonymous author entitled 'It's Over, Debbie'.[57] The piece told how, in the middle of the night, the author, a gynaecology resident rotating in a large private hospital, was called to attend a twenty-year-old woman dying of ovarian cancer. Horrified by her severe distress—she was relentlessly vomiting due to a sedating alcohol drip, her breathing was laboured and she had not eaten or slept in two days—the author, at the patient's request but acting alone without consulting anyone, gave her a lethal injection of 20mg of morphine sulphate and watched as the woman relaxed, and then died.[58] In 1991, a New York physician, Timothy Quill, described how he had helped end the life of a leukaemia patient of his, called 'Diane'. Quill's admission, which was published in the *New England Journal of Medicine*,[59] told how Diane, after learning of her diagnosis and the chances of a long-term recovery, had first decided that she did not wish to pursue further treatment, and then, because she was worried about the prospect of dying slowly, had asked Quill for a lethal quantity of barbiturates. Quill, a former director of a hospice programme, initially tried to dissuade Diane from this course by explaining the philosophy of palliative care, and by informing her that in most cases medicines could be used to make her relatively comfortable. But although Diane understood and appreciated this, she wanted no part of it. When the time came, she wanted to be able to make her exit in the least painful way possible. After probing to make sure she was not depressed or acting irrationally, Quill came to the conclusion that if he did not help her, she would become preoccupied with how she might die and would not be secure enough to live fully and concentrate on the time she had left. He wrote out the prescription for the barbiturates, but noted that he did so 'with an uneasy feeling about the boundaries I was exploring—spiritual, legal, professional, and personal'. Diane eventually took her life three months later, with Quill certifying the cause of death not as overdose, but as acute

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[56] G.B. Mair, *Confessions of a Surgeon* (London: W. Luscombe, 1974), p.87.

[57] Anon., 'It's Over Debbie' (1988) 259 *JAMA* 272.

[58] It should be noted that the publication of this particular article was met with almost unanimous condemnation. Not only were the actions of the doctor castigated as 'scandalously unprofessional and unethical', the actions of 'an impulsive yet cold technician, arrogantly masquerading as a knight of compassion and humanity'—but also the Journal itself was criticised for even publishing the piece: 'the conduct of the editor of the *JAMA* is incomprehensible', stated one reply. 'By publishing this report, he knowingly publicizes a felony and shields the felon. He deliberately publicizes the grossest medical malfeasance and shields the malefactor from professional scrutiny and judgment, presumably allowing him to continue his practices without possibility of rebuke and remonstrance'. E. Pellegrino *et al*, 'Doctors must not Kill' (1988) 259 *JAMA* 2139; see also the letters at pp.2094-98. Responding to these charges, the editor wrote that, 'We published "It's Over, Debbie" to provoke responsible debate within the medical profession and by the public...Such discussions should not be confined to whispers in doctors' dressing rooms and hallways', G. Lundberg, '"It's Over, Debbie" and the Euthanasia Debate' (1988) 259 *JAMA* 2142.

[59] T.E. Quill, 'A Case of Individualized Decision Making' (1991) 324 *NEJ M* 691.

myelomonocytic leukaemia. According to him, he did this 'to protect all of us, to protect Diane from an invasion into her past and her body, and to continue to shield society from the knowledge of the degree of suffering that people often undergo in the process of dying'.

Personal narratives such as these provide only part of the picture. We must also take into account those more systematic studies detailing doctors' participation in patients' deaths. For instance, in Ward and Tate's 1994 paper,[60] which surveyed all general practitioners and 203 hospital consultants in one area of England, out of those who responded to a question on whether a patient had ever asked them to hasten death (273), 163 said they had been asked this; of these, 124 said they had been asked to take *active* steps to hasten death; and 38 out of 119 of these had complied with such a request. Doctors thus admitted to complying with pleas for active hastening of death in some 32 per cent of cases. This proportion is comparable to the 29 per cent of doctors in an Australian study who said they had taken active steps to end a patient's life,[61] but smaller than the 53/54 per cent of Dutch doctors who admitted the same in studies conducted in the Netherlands before formal legalisation (though during the period of decriminalisation).[62] Clearly, with doctors admitting to helping their patients to die in increasing numbers, even if only via anonymous responses to research questionaires, pressure for reform of prohibitory laws will only be likely to increase.

Mystery, science and religion

Another important factor has to do with our changing attitudes toward the unknown and inexplicable. Somerville has remarked that we are 'societies that are very intolerant of mystery. We convert our mysteries into problems'. She believes that if we convert the mystery of death into the problem of death, assistance in dying can naturally be seen as the solution. Somerville points out, quite rightly, that the most important driving force behind this way of thinking is the extraordinary advances that have been made in the sciences. 'New genetic discoveries and technologies, and new reproductive technologies have given us a sense that we understand the origin and nature of human life and that, because we can, we may manipulate—or even "create"—such life'. Somerville argues that if we transfer these same sentiments to the opposite end of life, then, naturally, the view that we should be able to control death too becomes acceptable.[63]

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[60] B.J. Ward and P.A. Tate, 'Attitudes among NHS Doctors to Requests for Euthanasia' (1994) 308 *BMJ* 1332.

[61] H. Kuhse and P. Singer, 'Doctors' Practices and Attitudes regarding Voluntary Euthanasia' (1988) 148 *Med J Aust* 623.

[62] P.J. van der Maas *et al*, 'Euthanasia and other Medical Decisions Concerning the End of Life' (1991) 338 *Lancet* 669; G. van der Wal *et al*, 'Euthanasia, Physician-Assisted Suicide, and other Medical Practices Involving the End of Life in the Netherlands' (1996) 335 *NEJM* 1699.

[63] M. Somerville, *op. cit.*, p.9. See also, D. Clark and J.E. Seymour, *Reflections on Palliative Care* (Buckingham: OUP, 1999), p.91.

Related to, or indeed in consequence of this, is the declining influence of the church,[64] a further factor motivating the assistance debate. Throughout the Western world, mainline denominations are struggling with the question of relevance. Declining memberships within largely secularised societies have meant the church as institution has become marginalised. As the church has become marginalised, so have its doctrinal arguments against helping others to die. The view held by believers that, as a divine gift, human life is sacred and that, as such, only the Almighty is qualified to decide when it should be given and taken away, just does not hold the same sway that it once did. So to state is not to suggest that the sanctity of life doctrine has been completely discredited; just that it is more likely nowadays to be based in some secular notion—such as respect for the creative wonder of evolution or individual human endeavour[65]—that does not necessarily lead to the conclusion that helping others to die is always wrong.

HIV and AIDS

The emergence in the 1980s of the AIDS epidemic has also played its part in fuelling the debate. Although demands for legalisation from those suffering from the disease have in recent years probably diminished, due to significant breakthroughs in the treatment of HIV through the use of protease inhibitors in combination with antiretroviral drugs, AIDS nevertheless remains a compelling impetus for reform. As Roger Magnusson has recently put it, 'twenty years into the epidemic, AIDS remains the disease that most justifies the right to die'.[66] In spite of the new therapies, 'AIDS continues to manifest itself in chronic wasting syndromes, lymphatic cancers, AIDS-related dementia, cryptococcal meningitis and other infections involving the central nervous system'.[67] These medical realities coupled with the fact that, in the developed world, the hardest hit section of society has been the male gay community—'an activist community capable of pursuing this aspect of patient self-determination with a zeal similar to that with which other gay and HIV patient issues have been pursued'[68]—have seen those suffering from HIV and AIDS become amongst the most vocal of advocates for a right to assisted death: research suggests that within the HIV/AIDS community, the level of support for assistance in dying is remarkably high, with one study finding that 90 per cent of men with HIV would wish to have that option if a life-threatening diagnosis were made.[69]

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[64] R. Inglehart and W. Baker, 'Modernization, Cultural Change, and the persistence of Traditional Values' (2000) 65 *American Sociological Review* 19, which showed that among 20 advanced industrial democracies surveyed, 16 showed declining rates of church attendance.

[65] See e.g., R. Dworkin, *Life's Dominion: an Argument about Abortion and Euthanasia* (London: HarperCollins, 1993), especially ch.3.

[66] R. Magnusson, *op. cit.* p.49.

[67] *ibid.*, p.50.

[68] *ibid.*, p.51.

[69] B. Tindall *et al*, 'Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease' (1993) 6 *Journal of Acquired Immuno Deficiency Syndrome* 1069. See also, W. Breitbart *et al*, 'Interest in Physician-Assisted Suicide among Ambulatory HIV-Infected Patients' (1996) 153 *American J of Psychiatry* 238, where the authors report 63 per cent of HIV patients supporting policies

Right-to-die organisations

Finally, mention should briefly be made about the impact that right-to-die organisations have had. Although right-to-die organisations have existed for over 70 years—the UK Voluntary Euthanasia Society, the first such organisation, was established in 1935—it is only in the last few decades that these organisations have become well-organised at the international level. The international right-to-die movement can trace its roots back to 1976, when Dr Tenrei Ota, upon foundation of the Japan Euthanasia Society (now the Japan Society for Dying with Dignity), called for an international meeting of all other existing national right-to-die societies. The societies of Japan, Australia, the Netherlands, the UK, and the USA were all represented at the first meeting, which took place in Tokyo, and at the second which took place two years later in San Francisco. However, it was not until the third meeting, held in Oxford in 1980, that the individual organisations agreed to establish the World Federation of Right-to-Die Societies. Since its foundation, the World Federation has come to include some 38 right-to-die organisations from around the world, and has held eleven additional international conferences, each hosted by one of the member organisations. Such international coordination must certainly be counted as a factor when considering why there is at present such increased societal awareness of the debate.

C. Why rights?

Having considered the reasons for the recent prominence of the debate, in this segment I shall now examine the reasons why the debate is currently taking the form which it is, i.e. why the debate has shifted to the language of rights. It is not enough to suggest, as I have, that the common law approach, concentrating on the assister's conduct, has led us into a muddle and that, in our exasperation, we have simply decided to turn away from this. This would only provide a negative explanation for the changed landscape, whereas I believe that the debate has turned to rights for more positive reasons. Of course, it is the rise of individualism which I have already touched on that must provide the backdrop: rights, we might say, act as the standardly accepted currency in individualistic societies. However, baldly to state this does not tell us very much about why this is the case. What is it about rights that make them so apposite to individualistic societies? What are the central features of rights that make them so attractive? If we can discover this, then we can also discover why the particular debate on assistance in dying has moved to a rights discourse—we work, as so often we must, from the general to the specific.

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favouring assisted suicide; and Z. Haghbin *et al*, 'Assisted Suicide and AIDS Patients: a Survey of Physicians' Attitudes' (1998) 39 *Psycosomatics* 18, finding that 9 per cent of physicians surveyed had received requests for assistance in dying from AIDS patients.

Rights as trumps I: the anti-utilitarian nature of rights

In *Taking Rights Seriously* Dworkin characterises rights as buffers against runaway majoritarian rule. Recognising the fact that in the modern world the best form of governance we know is democracy, rule by men and women who are elected by and responsible to the majority, Dworkin believes that the proper function of rights is to protect those who fall outside of, or who do not conform to, mainstream political opinion. He writes: 'The bulk of law—that part which defines and implements social, economic, and foreign policy—cannot be neutral. It must state, in its greatest part, the majority's view of the common good. The institution of rights is therefore crucial, because it represents the majority's promise to the minorities that their dignity and equality will be respected'.[70] It is this view of rights which has led Dworkin to describe rights as 'political trumps' held by individuals. 'Individuals have rights when, for some reason, a collective goal is not a sufficient justification for denying them what they wish, as individuals, to have or to do, or not a sufficient justification for imposing some loss or injury upon them.'[71]

Exactly what Dworkin means when he speaks of rights as trumps is not altogether unambiguous. There has been much debate about whether he means that rights are (a) limits on the kinds of reasons which the state can properly rely on to justify its policies, or (b) immunities which protect certain choices in all circumstances, come what may.[72] The difference between these two conceptions is not insignificant. If the former view is true, then rights can only be considered trumps over general utility to the extent that they prevent certain *corrupting* considerations justifying state action, but they do not render individual choices impervious to *all* considerations of the general good. Take, for example, the constitutional right of women to an abortion granted in the US Supreme Court case of *Roe v Wade*.[73] Now, many people believe that this right is a right which protects women's choices concerning their physical and procreative autonomy, a right demarcating a sphere of personal freedom insulated from majoritarian preferences. But this is only true if the idea of rights as trumps is to be understood in the second, immunities sense of rights. If, on the other hand, the reasons-restraining approach is taken, then it is possible to view the right to abortion, not as a right protecting procreative liberty, but rather as a right not to have the state prohibit abortions on the basis of restricted reasons relating to its view of the sanctity of foetal life.[74] On this understanding of the right, it is not completely inconceivable that abortions could be prohibited for other, non-restricted reasons; for example,

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[70] R. Dworkin, *Taking Rights Seriously* (London: Duckworth, 1977), p.205.

[71] *ibid.*, p.xi.

[72] See, e.g., the exchange between Richard Pildes and Jeremy Waldron: R.H. Pildes, 'Two Conceptions of Rights in Cases Involving Political Rights' (1997) 34 *Houst L Rev* 323; R.H. Pildes, 'Why Rights Are Not Trumps: Social Meanings, Expressive Harms, and Constitutionalism' (1998) 27. *J Legal Stud* 725; J. Waldron, 'Pildes on Dworkin's Theory of Rights' (2000) *J. Legal Stud.* 301; R.H. Pildes, 'Dworkin's Two Conceptions of Rights' (2000) *J Legal Stud* 309.

[73] (1973) 35 L Ed 2d. 147.

[74] This is the view that Dworkin himself argues for. See *Life's Dominion: an Argument about Abortion and Euthanasia* (London: HarperCollins, 1993), p.154-168.

where there was a significant drop in the national birth rate, to the extent that the economy was being irreparably damaged by the declining productivity of an ageing population.[75]

Throughout the corpus of his work, Dworkin seems to waver at different points between both of these conceptions.[76] In *Taking Rights Seriously*, for example, he states, seemingly adopting the immunities approach to rights, that 'It makes sense to say that a man has a fundamental right against the Government, in the strong sense, like free speech, if that right is necessary to protect his dignity, or his standing as equally entitled to concern and respect, or some other personal value of like consequence. It does not make sense otherwise.'[77] Earlier in the same book, he writes 'The claim that citizens have a right to free speech must imply that it would be wrong for the Government to stop them from speaking, even when the Government believes that what they say will cause more harm than good.'[78] But these statements must be contrasted with those others which seem to show Dworkin plumping for the reasons-restraining view of rights. For example, in his later *Law's Empire*, referring to the famous US desegregation case of *Brown v Board of Education*,[79] Dworkin argues that the rights upheld in that case can be explained 'either on grounds of banned sources, that some preferences must be disregarded in any acceptable calculation of what makes the community better off on the whole, or on grounds of banned categories, that some properties, including race, must never be made the basis of a legal distinction'.[80]

Whichever of the two conceptions does more truly reflect Dworkin's views, the important point is that the idea of rights as trumps remains intact. Obviously this is the case on the immunities understanding of rights, but it is also true on the reasons-restraining view. This is because, as Waldron points out, in many cases there will be the impossible problem of disentangling the restricted reasons which the government might wish to rely on, from those more respectable reasons on which it might be perfectly legitimate to base state action.[81] Thus, to return to the *Roe v Wade* example, if it was impossible to determine on which of the two grounds the government wished to prohibit abortions—i.e., the restricted reason of upholding some view of the sanctity of

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[75] Indeed, this seems to have happened recently in Russia, where the government has reduced the number of reasons woman can legally present for an abortion from 13 to 4. Although some have interpreted this change as a sign of the increasing influence of the Orthodox Church, which was suppressed during the Soviet era but which is now speaking out much more frequently on issues of public morality, a more plausible explanation for the clamp down relates to the country's worrying demographic trends. Recent figures showed that the 144.5 million-strong population is falling at a rate of about 1 million a year, caused by a declining national birth rate and a low life expectancy. N. Paton Walsh, 'Low Birth Russia curbs Abortions' *The Guardian*, 24 September 2003.

[76] Although Waldron, *op. cit.*, would argue otherwise.

[77] *op. cit.* p.199.

[78] *ibid.*, p.190. Further examples of statements made by Dworkin which seem to show him leaning toward the immunities approach to rights are provided in Pildes' 'Dworkin's Two Conceptions of Rights', *op. cit.*, note 18.

[79] (1954) 98 L Ed 873.

[80] R. Dworkin, *Law's Empire* (London: Belknap, Harvard University Press, 1986), p.388. Further examples of Dworkin's statements which seem to support the reasons-restraining approach are provided by Waldron, *op. cit.*

[81] Waldron, *op. cit.*, p.303.

foetal life, or the unrestricted reason of raising the national birth rate to protect the economy—then in these circumstances it would be better to err on the side of safety and allow the right to abortion to trump even if the government would, in fact, have relied on the legitimate justification.

The rights as trumps thesis thus holds good on both accounts. And this, for proponents of assistance in dying, is the important thing. For it is the idea that there is a way of presenting the arguments in favour of allowing assistance which cannot simply be knocked down by majority opinion that is one of the most significant reasons why the assisted dying debate has shifted towards rights. Whether we wish to say that the state should be prohibited from preventing such assistance because it must not rely on reasons which effectively impose the state's opinion of the sanctity of life on citizens who may disagree with this opinion; or because decisions about how one wishes to die should fall within a protected sphere of personal decision-making immune from governmental interference, the attraction of rights when they are viewed as trumps is undeniable. As Dworkin says, they represent a promise to those whose views may be in the minority that their dignity and equality will be respected no less because of this fact.

Rights as trumps II: rights as arbiters of controversy

It seems an obvious point to make, but the fact that rights can be considered trumps means that it is usual to appeal to them in situations of controversy. Just as in a game of cards if two players produce a jack it will be the jack which belongs to the trumping suit that wins, so in issues of political controversy, other arguments being equal, it will be the side which can point to a right which will prevail. As Dworkin states: 'The concept of rights, and particularly the concept of rights against the government, has its most natural use when a political society is divided, and appeals to co-operation or a common goal are pointless.'[82] The point need not be laboured: the issue of assisting in others' deaths at their request is just the sort of politically divisive question where rights arguments are most at home; it should be little surprise therefore that the debate has swung to the language of rights. But, though the idea of rights as trumps acting as arbiters of political controversy is a neat metaphor, it is not without its problems. Unlike in a game of cards, where there can only ever be one trumping suit, in political discourse this need not necessarily be so. What happens if both sides to a dispute produce jacks from the trumping suit? In other words, what happens if, as is often the case, both sides can point to a right? This, possibly, as will be seen, is one of the real costs to be paid if arguments are framed in the language of rights. Before we look at these, however, let us consider another important characteristic of rights.

Rights, claims and dignity

A key feature of rights is that they are claimable; they entitle individuals to claim. The relationship between rights and claims has long been noted by legal scholars, ever since the foundational

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[82] *Taking Rights Seriously, op. cit.*, p.814.

work done by Wesley N. Hohfeld in his *Fundamental Legal Conceptions*.[83] However, though the link between rights and claims has long been perceived at the analytical level, it is only more recently that the substantive implications of this relationship have become properly understood. In an essay entitled 'The Nature and Value of Rights', Joel Feinberg has used the idea of claims to elucidate on what rights are, and what would be wrong with a world where there were no such things as rights, a place which Feinberg calls Nowheresville.[84] Feinberg suggests that when we employ the words 'claim' and 'claiming' in our speech, we do so in a variety of different ways. He distinguishes between, inter alia: (i) making claim to..., and (ii) claiming that...When we *make claim to something*, Feinberg argues what we do is 'to petition or seek by virtue of supposed right; to demand as due'. Sometimes we do this as an acknowledged right-holder, as for example when we demand something which has already been acknowledged as ours: say, rent from a tenant, or money borrowed under promise of repayment. Often, when we make claim in this sense, we present some sort of receipt, or agreement, or IOU, that is, a *title* to whatever the thing is that we are claiming and which is now in the possession of someone else. On other occasions, we are one step back from this and making claim to something means making an application for the title itself, by showing that one has satisfied the conditions which, as it were, entitle us to the title, as for example when a mining prospector stakes a claim to mineral rights, or an inventor asserts his intellectual property rights. This sort of claim Feinberg calls a *performative* claim, since once the claim is made, ordinarily, machinery (usually legal) should be in place to ensure that it is met.

Feinberg contrasts *performative* claiming with those situations covered by (ii) above, where, rather than making claim to something, an individual *claims that...*This type of claiming Feinberg terms *propositional*. When an individual makes a propositional claim, what they are doing is making an assertion that something is so and making it in such a manner as to demand or insist that this be acknowledged. To claim that one has a right, say, to eat cheese is not merely to say 'I believe I should be allowed to eat cheese', but rather to obtrude my putative knowledge upon others' attention, demanding that it be recognised and that appropriate notice be taken of it by all concerned. To claim propositionally is to frame a statement of belief as a statement of fact. Often, of course, this will simply not be warranted and, as Feinberg notes, to claim that something is the case in circumstances that justify no more than calm assertion is to behave like a bumptious boor. However, not to claim in the appropriate circumstances is just as deserving of censure, for it is, as Feinberg says, to be spiritless or foolish. (I shall have more to say on this issue of when it is appropriate to claim rights in the following section when I consider the risk of trivialising rights.)

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[83] W.N. Hohfeld, *Fundamental Legal Conceptions as applied in Judicial Reasoning* (D. Campbell and P.Thomas eds.) (Aldershot: Ashgate, 2001). Originally published as, 'Some Fundamental Legal Conceptions as applied in Judicial Reasoning' (1913) 23 *YLJ* 16, (1917) 26 *YLJ* 710. The Hohfeldian scheme is considered in detail in chapter 5.

[84] J. Feinberg, 'The Nature and Value of Rights' (1970) 4 *J of Value Enquiry* 19, reproduced in C. Nino, *Rights* (Aldershot: Dartmouth, 1992), p.185.

For Feinberg, the ability to claim in either of the above two senses is the most significant difference between our world and a place without rights like Nowheresville. He states of rights:

> There is no doubt that their characteristic use and that for which they are distinctively well-suited, is to be claimed, demanded, affirmed, insisted upon. They are especially sturdy objects to 'stand upon', a most useful sort of moral furniture. Having rights, of course, makes claiming possible; but it is claiming that gives rights their special moral significance. This feature of rights is connected in a way with the customary rhetoric about what it is to be a human being. Having rights enables us to 'stand up like men', to look others in the eye, and to feel in some fundamental way the equal of anyone. To think of oneself as the holder of rights is not to be unduly but properly proud, to have that minimal self-respect that is necessary to be worthy of the love and esteem of others. Indeed, respect for persons (this is an intriguing idea) may simply be respect for their rights, so that there cannot be one without the other; and what is called 'human dignity' may simply be the recognizable capacity to assert claims. To respect a person then, or to think of him as possessed of human dignity, simply *is* to think of him as a potential maker of claims. Not all of this can be packed into a definition of 'rights'; but these are *facts* about the possession of rights that argue well their supreme moral importance. More than anything else I am going to say, these facts explain what is wrong with Nowheresville.[85]

There are two points to be taken from Feinberg's work which help to explain why advocates of assisted dying have been motivated to talk in the language of rights. The first is that, from the distinction between performative claiming and propositional claiming, we can see that rights are a particularly useful tool when, as in the case of the right to assistance in dying, the assertion we wish to make is perhaps not widely (or even at all) acknowledged by the rest of a community and its institutions, but we believe that it certainly should be. It is this idea, then, that without rights people find themselves in a state of 'rhetorical deficit.'[86] That rights can be used as 'attention-getting',[87] spotlight-focusing devices which can challenge public complacency about the prevailing rules and norms of society, and that this is something that can be done on an ongoing basis. For as one commentator has remarked, within the ambit of rights discourse there falls not only 'all efforts to claim new rights, to resist and alter official state action that fails to acknowledge such rights', but also 'even those claims that lose, or have lost in the past, if they continue to represent claims that muster people's hopes and articulate their continuing efforts to persuade'.[88]

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[85] *ibid*, p.195.
[86] M.J. Meyer, 'Dignity, Rights, and Self-Control' (1989) 99 *Ethics* 520, p.522.
[87] P. Lewis, 'Rights Discourse and Assisted Suicide' (2001) *American J of Law and Medicine* 45, p.49.
[88] M. Minow, 'Interpreting Rights: an Essay for Robert Cover' (1987) 96 *YLJ* 1860, p.1867.

The second point is that, more than any other form of moral discourse, rights talk is underpinned by, and offers the hope of, the dignity of every individual. As Feinberg states, rights allow us to feel in some fundamental way the equal of anyone. I shall write at length about why this is so in chapter 4 and, as we shall see, though I agree with Feinberg that respecting persons is largely about respecting the rights of persons, I do not agree with him that 'human dignity may simply be the recognizable capacity to assert claims.' The idea of dignity is more complicated than this.[89] But it will suffice to note here that, for the person contemplating assisted dying, maintaining dignity and being in a position where they do not feel in any way disrespected by others, will be one of the very foremost concerns.

Drawbacks of a rights approach

So far, via a consideration of the central characteristics of rights, in this segment I have been concerned to show why the assistance in dying debate has gravitated towards the language of rights, what it is about rights and rights discourse that proponents of assisted dying find so attractive. What I now want to look at, however, to round off this introductory chapter, is the other side of the coin: what are the costs involved in the turn to rights? Often, it will be the case that both sides to a political dispute will be able to point to a right which they believe should trump matters, and this is certainly one of the drawbacks of adopting the language of rights. Rights are, by their nature, adversarial and thus can be a socially divisive means of conflict resolution. As Loren Lomasky has pointed out:

> Rights stake out chunks of moral turf that others are forewarned not to trespass; they issue demands with which others *must* comply. It is not for nothing that we tend naturally to speak of someone 'standing' on his rights. One who is entitled as a matter of right to some outcome is under no obligation to move away from that result in his dealings with others.[90]

This unyielding nature of rights, Lomasky believes, means that sometimes problems which need not be insoluble become so purely because they happen to have been framed in terms of rights. He argues that if two people have opposed preferences then they find themselves in a conflict situation; but certain strategies short of all out combat may be employed to reach a reasonable solution. Through a process of persuasion and compromise, an agreement may be reached which, though perhaps not 100 per cent satisfactory to both sides, nevertheless safeguards that

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[89] As we shall see in chapter 4, an important facet of dignity is that it is can be seen as a matter of virtue, as well as of value. It is not only about the capacities one has, but also about the way one conducts oneself. It is this which explains why claiming rights in certain inappropriate circumstances can make one 'bumptious' or 'boorish', and be can directly opposed to the expression of one's dignity. This is a point that is elucidated by Meyer, *op. cit.* p.525.

[90] L.E. Lomasky, *Persons, Rights, and the Moral Community* (Oxford: OUP, 1987), p.5.

which is most important to each. Alternatively, the parties may resort to some sort of mutually acceptable second-order resolution mechanism, for example, binding arbitration or even something as unsophisticated as drawing straws. Of course, things might not always turn out to be as amicable as this, and often conflicts will remain intractable, but there is at least good reason to look in his direction. But with disputes of right against right, unless there is some sort of hierarchy between the claims (which there usually is not, at least where fundamental human rights are concerned), such negotiation and accommodation is far less likely. A right is a right and that, as far as the party invoking it is concerned, is the end of the matter.

A similar point is made by the American legal scholar Mary Ann Glendon, in her thoughtful book *Rights Talk*. She argues, however, that as well as provoking antagonism and stifling other means of conflict resolution between individuals, rights are also responsible for a much deeper societal malaise. Her view—which can firmly be placed in the 'communitarian' school alluded to earlier—is that a certain kind of rights talk is the responsible, or at least a contributing, cause of the general impoverishment of political discourse. She suggests that, along with consumerism and a natural dislike of inconvenience, rights regularly promote short-term fixes over long-term solutions, crisis-management over prevention, and particular concerns over the common good. She writes: 'Saturated with rights, political language can no longer perform the important function of facilitating public discussion of the right ordering of our lives together'.[91]

It is the same idea which was so eloquently expressed by the Archbishop of Canterbury, Dr Rowan Williams, in his 2002 Richard Dimbleby lecture.[92] The broad subject of his lecture was the legitimacy and function of government in the modern democratic state. What Dr Williams argued was that in the economically developed, Western countries the traditional idea of the nation state is being replaced by what some have called the 'market state'. Following the lead of the American strategist and historian, Philip Bobbitt,[93] Dr Williams argued that, as a model of government, these days the nation state does not really make all that much sense any more. This is because the conditions on which the legitimacy of a nation state depends no longer exist. Under the nation state model, obedience to government rests on its promises to a particular coherent nation—i.e. both a piece of territory and a fairly homogeneous community—that it will be defended against outside attack, and that it will benefit from a high degree of internal stability provided by a firm directive hand in the economy and a safety net of social welfare provisions.

But such aspirations are simply unrealisable in the new millennium. As the Archbishop pointed out, intercontinental missile technology designed to carry weapons of mass destruction makes nonsense of the state's claim to be protector against external threats; these days you have to rely on strategic means such as deterrent counter threats if anything. The same applies with the government's promise to provide internal stability. With capital now able to move freely where it

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[91] M.A. Glendon, *Rights Talk* (New York: Free Press, 1991), p.xi.

[92] Broadcast by BBC1, 19 December 2002.

[93] See his *The Shield of Achilles: War, Peace, and the Course of History* (London: Allen Lane, 2002).

pleases, ignoring frontier controls, no isolated national community can guarantee employment levels in the old way. And, of course, unstable employment means higher, increasingly unmanageable levels of welfare support. So what happens, then, when the government can no longer keep to its side of the bargain? Where, in these modern-day conditions, does its legitimacy, and our duty of obedience, reside?

Williams' view is that this is why we have moved to the market state. The new function of government, and the basis of its modern legitimacy, is to facilitate the conditions within which individuals or groups can do their own negotiating, to secure the best deal or the best value for money in pursuing whatever it is that they want. It involves deregulation and the withdrawal of the state from many of those areas where it used to bring some kind of moral pressure to bear. The government is free to encourage enterprise but cannot protect against risk; to try and increase the literal and metaphorical purchasing power of citizens, but not to make judgments about what the common goals or values of society should be. In the market state, politics and political discourse become matters of consumerism and consumer rights. The individual confronts the state asking for what he has been promised: maximal choice and the power to determine how he should lead his life.

This, at first sight, might seem a rather attractive picture of a more direct relation between the individual and government. However, for Dr Williams, the market state is not quite as rosy as it appears. For one of the major worries in a marketised environment is that politics becomes reduced to instantaneous, button-pushing responses to surface needs. Discourse on important matters of public policy, in the simplest sense of that term, is neglected as governments seek only to ensure that *individual* preferences are satisfied, or at least the conditions exist in which they can be. Ideas of community, responsibilities, the relationship of the individual with society and the history and traditions of that society—all of this falls by the wayside in the market state. Yet, as Dr Williams points out, all of these things are vitally important if individuals are not to fall into the trap of endlessly going round in circles, repeating patterns of behaviour that never move humanity as whole onwards. A richer political discourse is one that looks beyond, but does not ignore, what I as an individual want for the here and now, to what in the long-run is good for all individuals.

Now, although the Archbishop's lecture did not specifically touch on the question of rights, the themes of the criticism he levels at the idea of consumer politics and the market state—that under such a model, discourse on the abiding general good of society becomes impossible—are clearly the very same as those which are laid at the door of those who seek to over-emphasise the importance of individual rights. It is the idea of rights as the quick-fix or, as Williams would put it, 'button-pushing' approach to political controversies, one which ignores the benefits of looking at problems through the prism of an enduring communal sagacity which links a particular society's past with its future.

This view of rights is not without its supporters among those members of the judiciary who have had to consider the specific question of whether there is, or ought to be recognised, a right to assistance in dying. For instance, in the US case of *Kevorkian v Thompson*, where Dr Jack Kevorkian applied to have a Michigan statute prohibiting assisted suicide declared unconstitutional, District Judge Rosen noted that:

> The Court cannot help but observe that we live in an age of instant gratification—people want things when they want them and how they want them. Those who are unable to achieve the result they wish through the policy branches of government (or through the referendum process) immediately come to the courts for relief; and, all too often, courts are seduced by the siren call to 'do justice'. Indeed, it sometimes seems that the Judiciary is in danger of becoming the 'fast-food' institution of government. If we are not careful, the sign 'Welcome to McJustice' may replace 'Equal Justice under Law' above courthouse doors.[94]

Elsewhere, Judge Rosen has likened rights claimants to children who, when they do not get what they want from one parent, go crying to the other, who of course indulges them.[95]

Such criticism, of course, would not have arisen but for the huge proliferation of rights or alleged rights which there has been in recent years.[96] Whether or not they have been granted any legal or formal recognition, we have seen individuals and groups appeal to a whole myriad of entitlements, ranging from the foetus's right to life; to the woman's right to an abortion; to the right of a woman to bear a child, whether by natural or artificial means; to the right not to have unwanted medical treatment imposed on us; to the right to marry; to the right of gay couples to equal recognition of their relationships; to the right to one's proper gender, if one believes that gender is not always properly determined at birth; to the right to practise whichever religion one chooses; to the atheist's right not to believe at all; to the right of the child to a loving family and to a decent education; to the rights of animals, and even plants, and indeed the environment as a whole. All of these rights and many more have arisen in one form or another during the course of the public debate of the last ten years. And this brings us to another problem with the turn to rights: the risk of trivialising rights.

There are two versions of the trivialisation argument. The first has to do with restricting the use of rights in general; the second is more to do with how specific rights should be limited. The general argument is essentially an appeal that rights should be viewed as some sort of moral 'nuclear option', the heavy artillery which should only be resorted to in disputes involving the most

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[94] (1997) 947 F Supp 1152, p.1171, n.17.

[95] Remarks made at the Institute of Continuing Legal Education, Michigan, 16 April 1998. Available at: www.icle.org/sections/labor/judindep.htm.

[96] For an interesting allegory detailing the rights explosion, see the story of Reitz van Winkle in S. Walker, *The Rights Revolution: Rights and Community in Modern America* (Oxford: OUP, 1998) pp.viii-x.

profound and widely-affecting societal concerns.[97] On this view, to appeal to rights in the case of, say, animals, would be to overstate the importance of an issue which, by all accounts (given that we live in a society where the majority has no compunction at all about eating meat), is only the concern of a very small, albeit vocal, minority. (I ignore for now the question of whether animals are capable of possessing rights; on this see chapter 4.)

The second, specific argument runs something like this: if there is a right, say, to X, then just what constitutes X must be construed fairly strictly, in order that X, but only X, is given the special status of being rights-protected. In other words, we cannot allow X also to include Y and Z, because in doing so we would not just be broadening the right to X but, in reality, creating a new right to XYZ. To express the matter algebraically like this perhaps does little to enlighten the concern. But the point is that, in the opinion of some, rights are like balloons: if they are inflated too much, they burst and become useless. A practical example where the risk of this sort of trivialisation is an especial worry arises in relation to the right to be free from torture and inhuman and degrading treatment found in Article 3 of the European Convention on Human Rights. In several cases, the Strasbourg authorities have warned against 'overloading the content and of amplifying the Article with matters of a lesser degree of severity and thus weakening the very serious nature of a breach of Article 3'.[98]

Is a rights analysis worth pursuing?

Given these concerns and criticisms of rights and rights talk, should we not just abandon a rights analysis, and revert back to the traditional common law discourse about the rightness or wrongness of helping others to die? I do not think we should. My reasons for this are two-fold. First, I do not believe that the common law approach offers any real prospect for the satisfactory resolution of the problem of assistance in dying. As long as the common law is primarily concerned with the conduct of the assister, and continues to make purely linguistic distinctions—for they are not real, at least not in this context—between intention and foresight, actions and omissions, causing and contributing to, the opposing sides will be able to go on convincing themselves that they, and only they, understand the true subtlety of the debate, and it will be language not logic that continues to mean the difference between life and death, pain and peace. Secondly, however, and more importantly, I do not view the criticisms of rights that we have looked at as fatal to a specific right to assistance in dying.

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[97] Lomasky, *op. cit.*, p.8.

[98] *Warwick v UK* Appl. 9471/81, 60 D&R 5, at p.22; see also the opinion of Judge Fitzmaurice in *Ireland v UK* (1976) Series A no. 25, at paras.14, 15, 22. For academic comment, see D. Harris *et al*, *Law of the European Convention on Human Rights* (London: Butterworths, 1995), p.55; D. Gomien *et al*, *Law and Practice of the European Convention on Human Rights and the European Social Charter* (Strasbourg: Council of Europe Publishing, 1996), p.105; *cf.* A. Cassese, 'Prohibition of Torture and Inhuman and Degrading Treatment or Punishment' in R. St. J. Macdonald *et al* (ed.), *The European System for the Protection of Human Rights* (Dordrecht: Kluwer, 1993), pp.256-259.

None of the considered drawbacks suggest total abandonment of the rights project. Rather, they caution against an intemperate approach to rights which fails to take into account legitimate objections relating to goals and values that transcend the concerns of any one individual or group. This salutary warning must act as the lodestar for the arguments presented in this thesis. In attempting to show that there is such a thing as a right to assisted dying, at all times I shall be keen to show, first, that by recognising this right we need not automatically assume that we are drawing the battle lines between those in favour of such a right and those who can perhaps point to some opposing right. It is true that rights can sometimes be adversarial, even if only to the extent that they translate but do not initiate conflict,[99] there is no getting away from this. However, when properly invoked, they can also be a cohesive force directing and informing a society as a whole: those who accept, acknowledge and invoke rights agree to abide by a communal standard or currency and to accord similar regard to the claims of others as they would expect others to give their own. Second, and leading on from this, I shall show that a right to assisted dying does not exist at the expense of wider debate, but is rather dependent upon it (hence I place the rights analysis in this thesis 'in context'). A true understanding of rights conceives of rights as only being appropriate when *all* of the important arguments point in that direction; this means taking into account both individual and communal concerns, for the present and for the future, and being able to relate these to some sort of tradition that exists within the society (see chapter 2). Finally, a right to assisted dying must be shown neither to trivialise rights as whole, nor to dilute any specific positive right from which we may attempt to derive it. This will mean not only showing that the issue of how we die is sufficiently profound and widely-affecting as to deserve to be debated in terms of rights (see chapters 3 and 4), but also being sensitive enough to realise when to stop in our efforts to extract the right from those concrete legal provisions that are simply not going to yield it (see chapter 5). If the right to assisted dying is to be taken at all seriously, then its provenance must be shown to be natural, logical, cogent and not in any way contrived or artificial.

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[99] M, Minow, *op. cit.*, p.1871.

2. PROSCRIBING ASSISTANCE IN DYING: ORIGINS AND EVOLUTION

History is important to the assistance in dying debate not only because it gives us a richer understanding of the background, but also because, in recognising and giving official acknowledgement to novel rights, judges do not like to feel that they are breaking utterly with the traditions of their society. We see this most prominently in the North American debate: both the US[100] and Canadian Supreme Courts,[101] as well as the US Ninth Circuit Court of Appeals,[102] have undertaken historical analyses seeking to discover whether a right to assistance in dying has any support in the beliefs and practices of the past; indeed, in the US such historical analysis is specifically required by constitutional doctrine.[103] In Europe, the position is slightly different. In the *Pretty* case, reference to the annals of the debate figured neither in the domestic courts' opinions nor that of the ECtHR. This can perhaps be put down to the fact that the European Convention on Human Rights must be treated as a 'living instrument',[104] to be interpreted in the light of current social conditions. But even taking this into account, history should matter just as much on this side of the Atlantic as it does across the water. The US Constitution and the Canadian Charter of Fundamental Rights and Freedoms are also 'living instruments' evolving with the mores and standards of each age.[105] However, the reason that judges ought to refer back to history is to rein in the possibility of the *subjective* element in rights interpretation, which will necessarily change with each successive constitution of a court, and which is likely to be just as much of a problem in European human rights jurisprudence as it is under any other system.

Of the courts mentioned, only the Ninth Circuit Court of Appeals found that the historical record positively offered any support for the right to assistance in dying. In contrast, the US Supreme Court found itself 'confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues to explicitly reject it today, even for terminally ill,

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[100] *Washington v Glucksberg* (1997) 138 L Ed 2d 772, pp. 781-785.

[101] *Rodriguez v British Columbia (AG)* [1993] 3 SCR 519, pp. 596-598.

[102] *Compassion in Dying v Washington* (1996) 79 F 3d 790, pp.806-810, 845-847.

[103] In cases involving the substantive review of the Due Process Clause, courts must bear in mind that the Clause offers protection only to those fundamental rights and liberties which are, objectively, 'deeply rooted in the Nation's history and tradition': *Moore v East Cleveland* (1977) 52 L Ed 2d 531, p.540; *Washington v Glucksberg*, at p.787.

[104] *Tyrer v UK* (1978) Eur Court HR, Series A No 26, para. 31.

[105] The Canadian Supreme Court has remarked that the Charter of Fundamental Rights and Freedoms must 'be capable of growth and development over time to meet new social, political, and historical realities often unimagined by its framers': *Hunter v Southam* [1984] 2 SCR 145, p.155. As for the US Constitution, although this opens up the whole originalist/constructivist 'can of worms', it is clear that even the most conservative members of the Supreme Court interpret the constitution with regard to the prevailing conditions of the day. For example, Chief Justice Rehnquist wrote extra-judicially that: 'The framers of the Constitution wisely spoke in general language and left to succeeding generations the task of applying that language to the unceasingly changing environment in which they would live...Where the framers...used general language, they...[gave] latitude to those who would later interpret the instrument to make that language applicable to cases that the framers might not have foreseen': W.H. Rehnquist, 'The Notion of a Living Constitution' (1976) 54 *Tex L Rev* 693, p.694.

mentally competent adults'.[106] The Canadian Supreme Court simply reviewed the record but did not state either whether it supported or undermined the right (although, reading between the lines, the Court seems to have had more sympathy for the latter view[107]). Yet, as we shall now see, this is peculiar. For as the Ninth Circuit Court stated, 'the relevant historical record is far more checkered'.[108] Everything depends on how far one goes back. If, as the Supreme Courts did, one only traces the issue as far back as the Anglo-American common law tradition takes us, then historical support for the right will, unquestionably, be slight. But there is no good reason why our inquiry should be so limited. In *Roe v Wade*, for example, the US Supreme Court considered attitudes to abortion in ancient Greece, Rome, and the Persian Empire.[109] This chapter likewise begins by looking back to classical times.

A. Historical attitudes

Suicide in antiquity[110]

In ancient Greece, self-killing appears to have been viewed with ambivalence: suicide was considered disgraceful and unlawful, but only if it had not been authorised by the city-state. Under Athenian law, the hand that committed the suicide was cut off and buried apart from the rest of the body without the usual solemnities.[111] Similarly, Theban law denied the suicide customary exequies. But these sanctions were reserved for suicides that had not obtained the proper permission or had committed suicide for some dishonourable reason. At Athens, if a citizen asked the authority of the Senate, stating his reasons for wanting to die, and the Senate viewed his choice as rational, then state countenance could be granted. The same laws existed at Ceos and the colony of Marseilles, where magistrates kept a supply of hemlock, the necessary quantity of which they gave to all who succeeded in putting their case to the Council of the Six Hundred.[112]

Self-killing, however, was no trivial matter, and was only condoned for the 'best possible reasons: grief, high patriotic principle or to avoid dishonour'.[113] In *Phaedo*, Plato records Socrates' views on the subject as follows:

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[106] *Washington v Glucksberg*, at p.789.

[107] e.g. *Rodriguez*, at p.597, where the Court, after mentioning Francis Bacon, who condoned assistance in dying, states that there 'has never been any consensus with respect to this school of thought'.

[108] *Compassion in Dying v Washington*, p.806.

[109] (1973) 35 L Ed 2d 147, p.164.

[110] Little can be said with certainty about the attitudes of prehistoric peoples toward suicide except that there was probably little accord between the different cultures. Some regarded the suicide as accursed and reacted with due superstition in their burial rituals; others, whilst adjudging suicide deviant, accepted it calmly as within the realm of acceptable behaviour: L. I. Dublin & B. Bunzel, *To Be or Not to Be* (New York: Harrison Smith and Haas, 1933).

[111] E. P. Garrison, 'Attitudes toward Suicide in Ancient Greece' (1991) 121 *Transactions of the American Philological Association* 1, p.9.

[112] E. Durkheim, *Suicide: a Study in Sociology* (trans. J.A. Spaulding & G. Simpson) (London: Routledge, 1970), p.330.

[113] A. Alvarez, *The Savage God: a Study of Suicide* (London: Weidenfeld and Nicolson, 1971), p.52.

> Man...is situated in this life, as it were on a post or station, which he must not quit without leave; because the gods exert a providential care over us, on which account we are a part (as it were) of their property and possessions; and because we should think it unjust and punishable (if it were in our power to punish) in any slave of our own, to kill himself without leave...However the leave of the gods *can be made manifest by a visible necessity of dying.*[114]

Plato offers some explanation of Socrates' 'visible necessity' clause in the ninth book of his *Laws*: suicide only becomes a justifiable act (if not ordered by the state) when the suicide is burdened by some intolerable misfortune or disgrace that is beyond all remedy.[115] Other thinkers also commented on the subject. To Aristippus, another of Socrates' pupils, the aim of life was to attain the highest possible sensory enjoyment. 'The highest good is pleasure', he said, 'the greatest evil is pain'. Developing this thesis, Epicurus naturally drew the conclusion that where pain outweighed pleasure a man was free to make his own exit.[116] The Cynics held that, since virtue is the only good, life is only worth living for the wise man because he alone can possess virtue; there is nothing to tie the fool to life: 'reason or the rope', they proclaimed.[117] And the Stoics, too, admitted that suicide could become a rational choice. The act itself, like all other acts in the Stoic world, was unimportant; what mattered was the intention.[118] The intention to kill oneself had to be rational; and it would be when unmitigated pain or illness, or shame, or patriotism was in question.[119]

In mythology and art, also, there are many examples to be found of the laudable suicide. For instance, in six of the seven extant plays of Sophocles there is at least one suicide and/or suicide threat.[120] The most famous of these, of course, appears in *Oedipus the King*, when Jocasta, the mother/bride of Oedipus, hangs herself in order to avoid the terrible shame that will come with the discovery of Oedipus's parentage.[121] Homer also records self-murder without comment, as something natural and heroic, when he records how Aegeus threw himself into the sea when he saw the black sails and mistakenly thought his son Theseus had been slain by the Minotaur. Erigone hanged herself from grief when she discovered the dead body of her father Ikarios. Leukakas jumped from a rock in order to avoid being raped by Apollo. Charondas, the law-giver of Catana, took his own life when he broke one of his own laws. And when the Delphic oracle

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[114] K. Dorter, *Plato's Phaedo: an Interpretation* (Toronto: University of Toronto Press, 1982), emphasis added.

[115] E. P. Garrison, *op. cit.*, p.17.

[116] G. Williams, *The Sanctity of Life and the Criminal Law* (London: Faber and Faber, 1958), p.227.

[117] M. Griffin, 'Philosophy, Cato, and Roman Suicide' (1986) 33 *Greece and Rome* 64, p.71.

[118] J.M. Rist, *Stoic Philosophy* (Cambridge: CUP, 1969), p.239.

[119] M. Griffin, *op. cit.*, p.73.

[120] E. P. Garrison, *op. cit.*, p.21.

[121] Sophocles, *The Three Theban Plays* (trans. R. Fagles) (London: Penguin, 1984).

announced that the Dorians would capture Athens unless the King died, the last Athenian monarch Codrus entered the enemy camp and allowed himself to be killed by a soldier.[122]

In Roman times, it is the Stoic stance which seems to have predominated:

> It is in fact Stoicism that is normally given credit for making the practice of suicide acceptable, not only to members of the school but society at large...Its 'stiff upper lip' attitude accorded better with traditional Roman morality, which the first Emperor, Augustus, was at pains to endorse. There was also another factor at work. While Stoicism and Epicureanism both emphasized the independence of the individual...and were both good philosophies in adversity, Stoicism gave men dignity as well and a feeling of moral superiority.[123]

As a result of this Stoic philosophy, suicide became a frequent practice amongst the Romans. Famous suicides such as those of Cato, Seneca and Paulina, Atticus, Brutus, Arria, and Lucan were admired, celebrated, and even emulated. It would be easy to conclude that self-killing in Roman times was something which was almost universally accepted; as one commentator notes 'it is difficult to avoid thinking of suicide as the characteristic Roman way of death'.[124] However, such a conclusion would be facile, for suicide was not a matter of absolute indifference to the Romans. Servius tells us that according to the laws of the Pontiffs, whoever had hung himself was deprived of burial;[125] the statutes of a religious confraternity of Lanuvium prescribed the same penalty.[126] And according to Cassius Hermina, Tarquin the Proud, to combat an epidemic of suicides, ordered the bodies of the dead to be crucified after torture and left a prey to birds and wild beasts.[127]

But, as in Greece, these penalties seem only to have been imposed upon those suicides who killed themselves or attempted to kill themselves for ignoble reasons. For example, the soldier who tried to kill himself in order to avoid military service was punished—rather oddly—with death; although, even here, if the soldier could prove that he was impelled by some plausible reason then the sentence was commuted—again, rather oddly—to dismissal from the army.[128] 'There is certainly no doubt that at Rome consideration of the motives leading to suicide always played a preponderant role in the moral or judicial estimation of it.'[129] As, too, did the method of the

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[122] A. Alvarez, *op. cit.*, pp.51-52.
[123] M. Griffin, *op. cit.*, p.67.
[124] *ibid*, p.64.
[125] E. Durkheim, *op. cit.*, p.330.
[126] *ibid*, p.331.
[127] *ibid*, p.331.
[128] *The Digest of Justinian*, vol. IV, bk. XLIX, title XVI, law 6, par. 7. (T. Mommsen, *et al* trans.) (Philadelphia: University of Pennsylvania Press, 1985), p.342.
[129] E. Durkheim, *op. cit.*, p.331.

suicide.[130] For the Romans, there was a definite hierarchy to the ways of doing away with oneself. Taking one's life by sword or dagger was considered the best, because it followed the example of the soldiers and generals. Next was opening the veins, like Seneca. The elderly often took their lives by self-starving themselves. But poison was generally considered unmanly, unless it was hemlock (after Socrates). Hanging seems to have been frowned upon and was almost never used, at least by members of the elite. Perhaps the burial laws of the Pontiffs were no more than an expression of distaste at the method used. Whatever the case, it is clear that throughout classical antiquity there was never a blanket proscription on self-killing. Certainly there is evidence of both Greek and Roman laws and customs that seem to suggest a certain societal uneasiness about suicides. But these seem to relate only to the unjustified, cowardly suicide, not the rational and honourable exit made in order to preserve dignity. With the advent of Christianity, however, attitudes changed and the prohibition of suicide became an inflexible principle.

Early Christianity

The popularised account of the provenance of the Christian attitude to suicide is typified by the following passage from Glanville Williams' book, *The Sanctity of Life and the Criminal Law*:

> [E]arly Christians were...morbidly obsessed with death. Those were the days when, instead of learning how to live, men studied how to die. The Christian belief was that life on earth was important only as a preparation for the hereafter; the supreme duty was to avoid sin, which would result in perpetual punishment. Since all natural desires tended towards sin, the risk of failure was great. Many Christians, therefore, committed suicide for fear of falling before temptation. It was especially good if the believer could commit suicide by provoking infidels to martyr him, or by austerities so severe that they undermined the constitution, but in the last resort he might do away with himself directly.[131]

Williams, like others,[132] then goes on to suggest that the eagerness of early Christians to realise their righteous abode in heaven led Saint Augustine, worried that such fanaticism would irremediably deplete the ranks of Christians, to denounce suicide as a sin, and, thus, to become the chief architect of the Christian view that self-killing is wrong. Whilst this account is

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[130] N. Kapur, 'Cato and his Heirs: Roman Ideals of Suicide' (2000) http://www.stanford.edu/~nickpk/writings/Romansuicide.html

[131] G. Williams, *op. cit.*, p.229.

[132] e.g., M. Pabst Battin, *Ethical Issues in Suicide* (London: Prentice-Hall, 1982), p.29; and A. Alvarez, *op. cit.*, p.59.

undoubtedly the result of bona fide scholarship, a recent historiographical analysis by a classics scholar, Darrel Amundsen, has suggested several reasons for questioning its accuracy.[133]

First, there are very few recorded instances of early Christians (i.e., those living before the legalisation of Christianity in 313) actively taking their own lives; and those that did, it seems, did so under extreme duress, not because they were excessively keen to enter the Kingdom of God. Amundsen has identified three categories of such suicides, all of which are scantily evidenced.[134] First, there are those who killed themselves to avoid being arrested and subjected to extreme suffering. Eusebius records the only evidence of these cases:

> Need I rekindle the memory of the martyrs at Antioch, who were roasted over lighted braziers, not roasted to death but subjected to prolonged torture? Or of others who plunged their hands right into the fire sooner than touch the abominable sacrifice? Some of them were unable to face such a trial, and before they were caught and came into the hands of their would-be destroyers, threw themselves down from the roofs of tall houses, regarding death as a prize snatched from the scheming hands of God's enemies.[135]

Secondly, there are those who had already been arrested but took their own lives before being executed. Again, it is Eusebius that provides the evidence, in this case just two examples. The first occurred in Alexandria in 249 under Decius:

> Next they seized the wonderful old lady Apollonia, battered her till they knocked out all her teeth, built a pyre in front of the city, and threatened to burn her alive unless she repeated after them their heathen incantations. She asked for a breathing-space, and when they released her, jumped without hesitation into the fire and was burnt to ashes.[136]

The second was during the 'Great Persecution':

> [T]here was a conflagration in the palace at Nicomedia, and through a groundless suspicion word went round that our people were responsible. By imperial command God's worshippers there perished wholesale and in heaps, some butchered with the sword, others fulfilled by fire; it is on record that with an inspired and mystical fervour men and women alike leapt onto the pyre.[137]

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[133] D. W. Amundsen, 'The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide' in R. F. Weir (ed.), *Physician-Assisted Suicide* (Indianapolis: Indiana University Press, 1997).

[134] *Ibid.*, pp.12 -13.

[135] Eusebius, *The History of the Church from Christ to Constantine* (trans. G. A. Williamson) (Harmondsworth: Penguin, 1965), p.342.

[136] *Ibid.*, p.276.

[137] *Ibid.*, p.334.

Finally, there are cases of virgins and married women who committed suicide to avoid being raped. When Rome was captured by Alaric and his Goths, pagan and Christian women were ravaged indiscriminately. There is some evidence that Christian women committed suicide in order to preserve their chastity.[138] So the idea that early Christians, fresh from their baptisms, were committing suicide en masse appears to be unsupported by historical writings.

The second reason that we might want to question the accuracy of the popularised account of the origin of the Christian attitude is that Augustine was not the first Christian to condemn suicide. Clearly, there are earlier denouncements. In the late second-century, anonymous *Epistle to Diognetus* the following passage is found:

> The Soul is locked up in the body, yet is the very thing that holds the body together; so, too, Christians are shut up in the world as in a prison, yet are the very ones that hold the world together. Immortal, the soul is lodged in a mortal tenement; so, too, Christians, though residing as strangers among corruptible things, look forward to the incorruptibility that awaits them in heaven. The soul, when stinting itself in food and drink, is better for it; so, too, Christians, when penalized, increase daily more and more. Such is the important post to which God has assigned them, and it is not lawful for them to desert it.[139]

This is clearly a similar argument against suicide to the one that Plato attributes to Socrates in *Phaedo*. But there are examples of other pre-Augustine reprovals. Tertullian (160-220) classifies as demented or insane anyone who cuts his own throat.[140] Lactantius (240-320), in his *Divine Institutes*, asserts that 'if a homicide is guilty because he is a destroyer of man, he who puts himself to death is under the same guilt, because he puts to death a man';[141] in his later *Epitome*[142] he offers an even sterner invective: not only are suicides homicides, but they are impious as well. Saint Ambrose (339-397), Augustine's mentor, simply states that Holy Scripture forbids suicide and does not feel compelled to defend that opinion.[143] Suicide, then, was regarded as wrong by Christians for at least the century and a half prior to the birth of Augustine in 354.

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[138] D. W. Amundsen, *op. cit.*, p.13.

[139] 'The Epistle to Diognetus', in J. Quasten, *Patrology: vol. 1, The Beginnings of Patristic Literature* (Brussels: Spectrum, 1950), p.248.

[140] T. D. Barnes, *Tertullian: a Historical and Literary Study* (Oxford: Clarendon, 1971), pp.218-219; Tertullian, 'Apology', Ch. 23, in *Fathers of the Church*, vol. 10 (Washington, D.C.: Catholic University of America Press, 1950), pp.71-72.

[141] Lactantius, 'Divine Institutes', book III, ch. 18, in *Fathers of the Church*, vol. 49 (Washington, D.C.: Catholic University of America Press, 1964), p214.

[142] Lactantius, 'Epitome', in *Ante-Nicene Fathers*, vol. 7 (Michigan: WM. B. Eerdmans, 1951), p.237.

[143] Ambrose, 'Concerning Virgins', book III, ch. 7, para. 32, in *A Select Library of Nicene and Post-Nicene Fathers of the Christian Church*, vol. 10 (2nd series) (Michigan: WM. B. Eerdmans, 1969), p.387. Of course, with the exception of Judas's suicide, self-killing is never discussed in the New Testament, much less condemned.

However, it was the thoroughness of Augustine's treatment of the subject in his monumental work, *City of God*, which consolidated the Christian prohibitive stance.

Saint Augustine

It was concern for the problem of women committing suicide in order to preserve their chastity, and not a fear that en masse suicides would diminish Christian numbers, that prompted Augustine to consider suicide in book one of his *City of God*. In sections 16-28 Augustine condemns the following motivations for suicide: (i) to avoid or escape from temporal problems; (ii) to avoid or escape from another's sinful actions (including doing so to preserve chastity); (iii) because of guilt over past sins; (iv) because of a desire for heaven; and (v) to avoid sinning. The basis of his condemnation is fourfold: (i) holy scripture does not expressly permit, much less command, suicide as a means of achieving heaven or as a way to escape or avoid evil; (ii) a prohibition of suicide is explicit in the Sixth Commandment; (iii) since no private party has the authority to kill a criminal who deserves capital punishment, those who kill themselves are homicides; and (iv) suicide allows no opportunity for repentance.[144]

It is worth noting that none of Augustine's arguments against self-killing is immune to criticism. First, just as Holy Scripture does not expressly permit suicide neither does it prohibit it, either expressly or implicitly. In the Old Testament, four cases of suicide are recorded (Samson, Saul, Abimelech, and Achitophel) and none is treated as an act worthy of censure. Similarly, the only New Testament suicide—that of Judas—is reported without comment. Secondly, taking Augustine's second and third arguments together, again one can disagree. Augustine says that the Sixth Commandment prohibits homicide; homicide is the killing of man; to kill oneself is to kill a man; ergo suicide is homicide and contrary to the will of God. However, as Glanville Williams has pointed out, this is sophistry, 'for there are obvious differences between an act of violent hostility to another and the act of a man voluntarily putting an end to his own life. For example, it becomes a man to leave his life voluntarily for a noble cause, when he would have no right to kill others for that same cause.'[145] Thirdly, in claiming that self-killing is wrong because it denies the suicide a chance for a healing penitence, Augustine was not offering an argument against suicide per se; rather, suicide is taken as an a priori wrong—after all, one need only repent if one has sinned in the first place. Moreover, and perhaps this is no more than a criticism of the example used, in stating the penitence argument, Augustine refers to Judas. Yet Judas's suicide was itself an expression of remorse.[146]

Augustine's other considerations of suicide are to be found in his anti-Donatist writings, and it is from these that the popular account—of Augustine declaring suicide a sin to prevent Christians committing suicide in droves—is derived. The Donatist movement had been formed in the early

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[144] D. W. Amundsen, *op. cit.*, p.20.
[145] G. Williams, *op. cit.*, p.230.
[146] *ibid.*, p.230.

fourth century by purists who disapproved of the Church's reacceptance of those Christians that had apostatised during the Great Persecution. From its beginning, the Donatist movement was a thorn in the side of the Catholic Church and so the Church persecuted it, eventually enacting the death penalty in 415 for those Donatists that continued to assemble.[147] It was at this time that a particularly militant branch of the group, the Circumcellions, launched a campaign of violence against Catholics, provoking the authorities to martyr them; and where this expedient failed, the Circumcellions would commit suicide in spectacular numbers.

> They sometimes forced their way into the courts of justice and compelled the affrighted judge to give orders for their execution. They frequently stopped travellers on the public highways and obliged them to inflict the stroke of martyrdom by promise of a reward, if they consented—and by a threat of instant death, if they refused to grant so singular a favour. When they were disappointed of every other resource, they announced the day on which, in the presence of their friends and brethren, they should cast themselves headlong from some lofty rock; and many precipices were shown, which had acquired fame by the number of these religious suicides.[148]

For twenty years, intermittently, Augustine composed anti-Donatist treatises, and a frequent focus of his attacks was the Donatist's attitude toward suicide.[149] As well as the arguments against suicide which he employed in book one of his *City of God*, in his anti-Donatist writings, Augustine presented a new reason for the wrongness of self-killing: suicide violates the Christian principle of patient endurance. In *De Patienta* (415), without specifically referring to the Donatists, Augustine rebuked them with the endurance of Job:

> At him let those men look who bring death upon themselves when they are being sought out to be given life, and who, by taking away their present life, reject also the life to come. For, if they were being forced to deny Christ or to do anything contrary to justice, they ought, as true martyrs, to bear all things patiently rather than to inflict death upon themselves in their impatience. If he could have done it righteously to escape evil, holy Job would have destroyed himself so that he might have escaped such diabolical cruelty in his own possessions, in his own sons, in his own limbs.[150]

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[147] D. W. Amundsen, *op. cit.*, p21.

[148] E. Gibbon, *The Decline and Fall of the Roman Empire*, III (D.M. Low ed.) (London: Chatto and Windus, 1960), p.401, cited in A. Alvarez, *op. cit.*, p.60.

[149] D. W. Amundsen, *op. cit.*, p21.

[150] Augustine, 'Patience', ch.13, para. 10, in *Fathers of the Church* vol. 16 (Washington, D.C.: Catholic University of America Press, 1952), p.246.

Patient endurance is also a theme in Augustine's final statement on the subject of suicide, in book nineteen of the *City of God*. But, as with his other arguments, one may question the validity of Augustine's contention regarding Christian endurance. The argument seems to suggest that the suicide is in some way cowardly. However, if one accepts, as Glanville Williams urges we should, that the only difference between cowardice and caution is that the coward does not do what he ought to do, then the question arises: is there a duty to live?[151]

Suicide at common law

The criminalisation of suicide was undoubtedly the result of Augustine's huge influence upon the development of Christian dogma and early ecclesiastical law. Yet Augustine himself had never demanded earthly penalties in the case of suicide; that, he believed, was the charge of the Creator; after all, Christian teaching is to judge not. And so, self-killing seems not to have been declared a secular crime until the year 452 at the Council of Arles. Even then, however, penal sanctions appear not to have been attached to the act. Those came in the following century when, at the Council of Braga, 563, it was decided that suicides should be 'honoured with no memorial in the holy sacrifice of the mass, and the singing of psalms should not accompany their bodies to the grave'.[152] In England, suicide was first condemned by the general canon law that was accepted by the Council of Hereford in 673. The penalty was denial of burial rites, and this was distinctly reaffirmed by a canon of King Edgar in the year 967.[153] To this ecclesiastical penalty, popular custom added the further punishment of dishonouring the corpse. Fulbecke, writing in 1601, said that the suicide 'is drawn by a horse to the place of punishment and shame, where he is hanged on a gibbet, and none may take the body down but by the authority of a magistrate'.[154] Blackstone recorded that burial 'was in a highway, with a stake driven through the body'.[155] Most often, suicides were buried at a crossroads.[156] The choice of the crossroads as the burial place appears to have an obvious explanation in that it represents the cross of Christ. However, as has been pointed out by several scholars,[157] although this may have contributed to the survival of the custom into the Christian era, it has a much earlier ancestry. Among earlier pagan peoples, both murderers and suicides were buried at crossroads. Suggested reasons for this practice include that the constant traffic over the grave would help to keep the ghost down; or that the number of roads would confuse the ghost, thereby preventing it from finding its way

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[151] G. Williams, *op. cit.*, p.231. The question of whether there is a duty to live is addressed further in chapter 4.

[152] E. Durkheim, *op. cit.*, p.327.

[153] N. St. John-Stevas, *Life, Death and the Law* (London: Eyre and Spottiswoode, 1961), p.233.

[154] W. Fulbecke, *A Parallel or Conference of the Civil Law, the Canon Law, and the Common Law of England* (London: Thomas Wight, 1601-02), cited in G. Williams, *The Sanctity of Life and the Criminal Law* (London: Faber and Faber, 1958), p.233.

[155] W. T. Blackstone, *Commentaries IV* (Oxford: Clarendon, 1775), 190.

[156] For a brief discussion of the archaeological evidence of this practice, see R. Halliday, 'Criminal Graves and Rural Crossroads' (1997) 25 *British Archaeology*.

[157] See, e.g., G. Williams, *op. cit.*, p.233; and N. St. John-Stevas, *op. cit.*, p.233.

home; or that the cross would act as the disperser of evil energy concentrated in the body. In any event, these burial practices were followed throughout the eighteenth century, and, in 1755, when a suicide, Barlow, who had killed himself in prison after murdering his child, was buried unobtrusively, his body was dug up and reburied at Moorfields crossroads, impaled with the requisite stake.[158] The last documented case of crossroad burial in England was the suicide Abel Griffiths, a 22 year-old law student who was buried without a stake at the crossroads formed by Eaton Street, Grosvenor Place, and King's Road, London, at 1.30 a.m. (it was customary to bury suicides during the night) in June of 1823.[159] By this time, however, the practice had become almost obsolete, and, indeed, in the month following the burial of Griffiths, a statute was passed which abolished it. Henceforth, burials of suicides took place privately, in a churchyard or public burial place, between the hours of 9 p.m. and midnight, but without religious rites. Further reform occurred in 1882, when it was permitted that suicides could be buried during daylight hours. But, in terms of burial rites, this was the last concession to be made. Even today it appears that suicides, if of sound mind, may not be buried with full Anglican rites. Cripps writes that 'the office of burial is not to be used for any that die unbaptized, or excommunicate, or have laid violent hands upon themselves'.[160] And, since the Suicide Act 1961 is silent on the matter of the burial of suicides, it appears that the rubric is still in force.[161]

Ecclesiastical sanctions and contemptuous burial were not the only consequences of self-killing. Suicides were also subject to secular penalties that took the form of forfeiture of property. Exactly when the practice of forfeiture of goods of a suicide was first introduced is not known. However, the custom was already known to the Danes before they came to England, and would naturally have been brought with them.[162] The canon of King Edgar, mentioned above, stated that a suicide's goods shall be forfeited to his lord unless he is driven to the act by madness or illness. Bracton, in the mid-thirteenth century, repeats the rule of forfeiture of moveables, without saying who takes them (the Crown or the lord); the suicide's land, however, was preserved to his heir unless the suicide was committed to avoid punishment or conviction for a felony, in which case even the land would be forfeit.[163] It is not clear whether, here, Bracton was merely Romanising the law by demanding escheat. At any rate, the rule is not repeated by later commentators:

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[158] L. Radzinowicz, *A History of English Criminal Law and its Administration from 1750, Vol. 1* (London: Stevens & Sons, 1948), p.196.

[159] J. Aston, *The Dawn of the Nineteenth Century in England II* (London: 1886), p.283, cited in N. St. John-Stevas, *op. cit.*, p.233. Halliday, *op cit.*, states that Griffiths' burial attracted a crowd of spectators which blocked the way and was responsible for delaying George IV's carriage.

[160] K.M. Macmorran, *Cripps on Church and Clergy* (8th ed.) (London: Sweet and Maxwell), p.576.

[161] See G. Moore, *An Introduction to English Canon Law* (Oxford: Clarendon, 1967), p.93; and W. Dale, *The Law of the Parish Church* (6th ed.) (London: Butterworths, 1989), p.76.

[162] G. Williams, *op. cit.*, p.235.

[163] H. de Bracton, *On the Laws and Customs of England* (trans. S. Thorne) (Cambridge (Mass.): Harvard University Press, 1968).

forfeiture is restricted to the suicide's chattels,[164] and these go to the Crown and not the lord.[165] This is important because it is the first written evidence that shows that the act of suicide was considered a felony notwithstanding the fact that the suicide himself could never be convicted of it.[166] Later authorities also repeated the rule of Edgar's canon that forfeiture would not occur where the suicide was driven to take his life by sickness or infirmity of the mind.[167] By the eighteenth century, it was common practice for the Crown to waive forfeiture in all cases of suicide except those committed to avoid conviction of another felony; later, forfeiture was waived even in this case.[168] Thus by the time the Forfeiture Act 1870 was enacted, which finally abolished forfeiture for suicide or other felony, the legislature was doing no more than putting the established practice on a statutory footing.

Although the rule of forfeiture played a key role in the development of the law, it is important to recognise that, even during the period when forfeiture was enforced, it was common for coroners' juries to avoid it by returning a verdict of insanity instead of one of *felo de se*.[169] This indulgence appears to have inspired the aphorism that in England you must not commit suicide on pain of being regarded as a criminal if you fail and a lunatic if you succeed. Even after the abolition of forfeiture, juries continued to resist the verdict of *felo de se* preferring instead to declare that the suicide occurred 'whilst the balance of the mind was disturbed'. In order to end this unsatisfactory state of affairs, in 1936 a Committee on Coroners recommended that the verdict of *felo de se* should be replaced by the non-committal statement that the deceased 'died by his own hand'.[170] The proposal was implemented by the Coroners' Rules of 1953, which made the standard form of verdict that the deceased 'killed himself'.[171] However, the rules also permitted the words to be added: 'whilst the balance of his mind was disturbed'. These additional words are of no legal

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[164] In his *Institutes*, Sir Edward Coke authoritatively stated that suicide did not entail escheat because that occurred only on conviction for a felony, which *ex hypothesi* was impossible in the case of suicide. E. Coke, *The Third Part of the Institutes of the Laws of England* (London: J. Flesher, 1660); see also *Hales v. Petit* (1562) 1 Plowd. Comm. 260.

[165] See G. Williams, *op. cit.*, p.235, citing the writings of Britton and Coke.

[166] Glanville Williams has suggested that suicide was only made a felony to enrich the Crown, since every felon forfeited his goods to the King and not merely to the lord, as would have been the case if suicide was not a felony: *ibid.*, p.245.

[167] See Cowell, *Institutiones Juris Anglicani* [1630], book IV, Tit. 18, s.16: there is no forfeiture if the suicide took his own life through the weariness of any disease; Coke, *Institutes III* [1644]: no forfeiture for someone who, 'by the rage of sickness or infirmity or otherwise', kills himself 'while he is not of compos mentia'.

[168] Umfreville, *Lex Coronatoria* (1761), cited in G. Williams, *op. cit.*, p.236.

[169] See B.T. Gates, *Victorian Suicide: Mad Crimes and Sad Histories* (Princeton: PUP, 1992), where the author cites an 1820 letter to the *London Times* supporting this practice, which stated that, 'a jury is fully warranted in bringing in a verdict of insanity in such cases, unless there is clear and decided proof to the contrary; and that to err on that side, if we are to err, is more just than on the other'.

[170] Cmnd. 5070 of 1936, paras. 82-83.

[171] For this verdict to be returned, it must be proved beyond reasonable doubt both that the deceased killed himself and that he intended to kill himself. In order to meet this burden, positive evidence should be produced, e.g. a suicide note. Coroners should only infer suicide from the facts in the clearest circumstances and where there can be no explanation other than that the deceased killed himself and intended so to do.

significance, but coroners often add them, when the evidence merits,[172] in order either to soften the impact of the suicide on the deceased's relatives, or to entitle the deceased to full Anglican exequies.[173]

The punishment of attempted suicide

By a gradual erosion of the sanctions that accompanied self-killing, then, a state was arrived at where, legally speaking, successful suicides could not be punished. Yet self-killing remained a felony, with the consequence that, where an attempt to commit suicide failed, perversely, the would-be self-destroyer *could* still find himself liable to punishment.

Prior to the Criminal Attempts Act 1981, one of the most salient features of the English common law of attempts was its uncertainty as to just what offences should and could attract criminal liability. Attempted suicide offers a perfect case in point. The early reasoning of the judiciary went along the following lines: (i) every attempt to commit a crime is punishable; (ii) suicide is a crime; therefore (iii) attempted suicide is punishable.[174] We have seen the historical process by which Christian ethics and early canon law translated themselves into the English common law, and, regardless of how we feel about this, it would be futile to deny that, by the end of the process, suicide was a crime. However, the problem with the above judicial syllogism lies not in stage two, but in stage one: is every attempt to commit a crime punishable? To answer this question, it will be necessary briefly to consider the theory behind the law of attempts.

Generally, criminal liability is imposed upon those actors that: (i) are in some way *blameworthy* and (ii) have caused a prohibited *harm*. Note, these elements are conjunctive, not disjunctive, in determining who should be punished. But, in instances of attempts, the proscribed harm has not occurred. So the question is this: is it right for the law to punish an actor who may be said to be blameworthy but who has not caused the interdicted harm? To this, there are usually three replies, all of which lead to an affirmative answer.

First, where a crime is attempted, there *is* a harm, namely, a threat to the general security. For example, if an attempted murder is committed, and the attempt becomes known to a community at large, then many people in that community, particularly those of the same age and sex as the victim of the attempted crime, will realise that the same thing could happen to them at any moment. Their lives will become fraught with anxiety, and they will presumably enjoy themselves much less than if they knew that murder attempts were not going to be committed against people

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[172] The use of the additional words indicating the suicide's state of mind ought to be based upon some evidence to that effect given at the inquest: P. Matthews and J.C. Foreman, *Jervis on the Office and Duties of Coroners* (10th ed.) (London: Sweet and Maxwell, 1986), p.194; *R v Horner, ex parte Jones* [1956] Crim L R 482 (C.A.),

[173] The Church of England does not deny burial rites to those who have 'laid violent hands upon themselves' if they are persons of unsound mind. Only those who may be deemed responsible for their acts, that have wilfully destroyed themselves, are supposed to have died in the commission of a mortal sin: K.M. Macmorran, *Cripps on Church and Clergy* (8th ed.) (London: Sweet & Maxwell), p.576.

[174] The first application of the law of attempts to suicide appeared in the case of *R v Doody* (1854) 6 Cox CC 463.

like themselves. This threat to safety represents a kind of utilitarian harm that, of itself, is a violation of an interest that concerns the law.[175]

The second justification for a general law of attempts suggests that even if the prohibited harm has not actually been caused, it is correct to punish an inchoate offence because, in many cases, the general threat of punishment will deter persons that are tempted to commit offences. Moreover, even if the general deterrent does not work, and persons actually go on to attempt to commit offences, there is still an individual deterrent, consisting not merely of the threat of punishment for future offences, but also of the application of punishment to individuals who have not been deterred by the law's mere threats.[176]

Thirdly, it is right to punish attempted crimes because, on a retributive view, the criminal has gone so far as to do his best to execute a wicked intention, and the difficulties of proof and so on are removed by his overt act.[177]

Whilst these arguments may or may not provide justification for a general rule whereby attempts are punished, they certainly do not justify punishment of attempted suicide, for the following reasons. First, the utilitarian justification—that punishing attempts will ameliorate the fear that otherwise might exist among other members of the community—cannot apply to the case of suicide. For when people are killed by their own hand, at their own desire, there is no tendency for other people to fear for their own safety. Other members of the community know that they will not die by suicide unless they choose to kill themselves. There is no threat from any external agent, for in suicide the perpetrator and the victim are one.

Secondly, as a general deterrence, punishment for attempted suicide is risible. Where successful suicides are unindictable but failed suicides are punished, there can only ever be one result: people will be more determined to succeed in their efforts. As Harry Roberts, writing in 1936, put the point:

> It is hard to believe that anyone intent on suicide and with resolution and means to carry it out is ever dissuaded from his purpose by reason of its illegality. It is not unilluminating that in England the annual number of suicides is seventy-nine per million of the population, whereas in Scotland [where attempt was not an offence] the figure is forty-five per million.[178]

Nor is punishment of attempts efficacious as an individual deterrent. If people have not been deterred by the threat of punishment for future attempts, and have gone on to actually make an attempt on their own lives, what they need is not penal sanction but help. It can scarcely be

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[175] H. Gross, *A Theory of Criminal Justice* (Oxford: OUP, 1979), p.125.
[176] H. L. A. Hart, *Punishment and Responsibility* (Oxford: Clarendon Press, 1968), p.128.
[177] *ibid.*
[178] H. Roberts, *Euthanasia and Other Aspects of Life and Death* (London: Constable, 1936), pp.15-16.

doubted that, for a person so despairing of life as to attempt to make his exit, punishment, in whatever form it takes, can only exacerbate things. As H.R. Fedden wrote:

> It seems a monstrous procedure to inflict further suffering on even a single individual who has already found life so unbearable, his chances of happiness so slender, that he has been willing to face pain and death in order to cease living. That those for whom life is bitter should be subjected to further bitterness and degradation seems perverse legislation.[179]

Finally, if one is to justify punishment of attempted suicide under a retributive theory, then one must first accept self-killing as a wicked or wrong act. But, as we have seen, the view that suicide is always wicked or wrong, and must inflexibly be prohibited, is due largely to the influence of one particular system of religious belief—Christianity. For those who do not accept Christian teaching, there is no obligation to view self-killing as something that ought always to be punished.

The foregoing arguments were vehemently wielded during the early years of the twentieth century to condemn the practice of imprisoning those who had attempted suicide[180]—and they were effective. In 1916, with the approval of the Home Secretary, the Metropolitan Police inaugurated a new policy for dealing with attempted suicides in the London area. Apprehended attempted suicides were not to be charged; rather, where possible, they were to be turned over to relatives or friends who were prepared to accept responsibility for their welfare. Incarceration was only to be considered where there were special reasons, e.g., where no person was prepared to accept the charge of the attempted suicide, where there had been the commission of another crime or a previous attempt to commit suicide, or where there were some definite indications of insanity. In 1921, a Home Office circular brought the practice of the Metropolitan Police to the attention of all other forces. The circular stated that imprisonment should be an option only where there was some definite circumstance calling for punishment, or where custody constituted the only chance of refuge and asylum for one too weak to stand alone.[181] This formula was commended for widespread adoption and came to represent the general practice of the police up until the enactment of the Suicide Act 1961.[182]

But, in spite of these policy changes, disparity remained between the ways that attempted suicides were dealt with by different police forces. Interpretation, particularly the interpretation of 'some definite circumstance calling for punishment', varied. Hence, right up until the passing of

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[179] H. R. Fedden, *Suicide: a Social and Historical Study* (London: P. Davies, 1938), p.263.

[180] Before the First World War, imprisonment was a regular punishment for attempted suicide: G. Williams, *op. cit.*, p.249, citing the cases of *R v Crisp* (1912) 7 CAR 173, in which a suicide was sentenced to six weeks imprisonment, and *R v Mann* [1914] 2 KB 107, in which the sentence was six months.

[181] Reply of the Home Secretary, Mr R. A. Butler, to Mr K. Robinson MP, in the House of Commons: *Parliamentary Debates*, Comms, vol. 584, (London: HMSO, 1958), written answers pp.75-6.

[182] L. Dunning, (1928) *Police Journal* 1, p.46, cited in G. Williams, *op. cit.*, p.249.

the Suicide Act 1961 attempted suicides were still being penalised for their actions. In 1959, the criminal statistics for England and Wales record that there were 4,980 cases of attempted suicide known to the police. In 518 of these cases people were proceeded against. The following table details the results of those proceedings: [183]

Result of proceedings	*Number*
Discharged under s.7 of Magistrates' Court Act 1952	1
Charge withdrawn or dismissed	22
Sent to institution for defectives or Reception Order made	4
Found guilty	484
Otherwise disposed of	7
Total	**518**

The sentences of those 484 summarily convicted of attempted suicide are set out below:

Sentence	*Number*
Absolute Discharge, Recognisance or Conditional Discharge	135
Probation Order	317
Fine	4
Police cells (not more that 4 days)	1
Released to the care of a fit person (juveniles under 14 yrs)	1
Approved school (juveniles under 14 yrs)	1
Imprisonment without option of fine	
14 days and under	1
Over 14 days and up to 1 month	2
Over 1 month and up to 2 months	1
Over 2 months and up to 3 months	7
Over 3 months and up to 6 months	11
Otherwise disposed of	3
Total	**484**

One person was also tried on indictment and a Probation Order was made in respect of him.

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[183] Home Office, *Criminal Statistics: England and Wales 1959* (London: HMSO, 1959).

Similarly, in 1960, 5,145 attempted suicides were known to the police, of which 467 were proceeded against. The results of those proceedings read as follows:[184]

Results of proceedings	*Number*
Discharged under s.7 of the Magistrates' Court Act 1954	3
Charge withdrawn or dismissed	26
Sent to institution for defectives or Reception, Hospital, or Guardianship Order made	5
Found guilty	425
Committed for trial	2
Otherwise disposed of	6
Total	**467**

The sentences of the 425 found guilty by magistrates are detailed in the following table:

Sentence	*Number*
Absolute Discharge, Recognisance, or Conditional Discharge	107
Probation Order	275
Fine	6
Police cells (not more that 4 days)	1
Released to the care of a fit person (juveniles under 14 yrs)	1
Imprisonment without option of fine	
14 days and under	1
Over 14 days and up to 1 month	2
Over 2 months and up to 3 months	6
Over 3 months and up to 6 months	12
Otherwise disposed of	14
Total	**425**

In addition, in 1960, the two persons committed for trial, plus one other person who was proceeded against by the Director of Public Prosecutions, received between them two probation orders and a term of imprisonment not exceeding six months.

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[184] Home Office, *Criminal Statistics: England and Wales 1960* (London: HMSO, 1960).

These figures speak for themselves. Not only do they illustrate the preparedness of police forces to charge attempted suicides despite the general statement of policy advising the contrary, but also they highlight the inequality of sentences imposed by judges and magistrates trying such cases—inequality which, at least in some instances, may have been no more than a manifestation of a religious opinion held by the individual judge or magistrate. This, perhaps, was the most unsatisfactory feature of the law in this area at the time.

Finally, and largely as a result of pertinacious efforts by Mr. Kenneth Robinson, M.P., in 1959 it was indicated by the Home Secretary that the government was prepared to reconsider the law relating to suicide. The legislature had, at last, reached the logical conclusion that self-killing could no longer remain a crime. If it did, then suicide attempts would have to continue to be punished, but this, quite simply, was unjustifiable.

In October 1960 the Criminal Law Revision Committee published its command report.[185] The Committee had been asked to consider the consequential amendments that would need to be made to the criminal law if suicide and attempted suicide ceased to be self-murder and attempted self-murder respectively. However, crucially, the Committee was requested to conduct its work upon the assumption that it would remain an offence to incite or assist another to kill or attempt to kill himself—suicide being regarded as self-murder meant that, at common law, a person who *incited* another to commit suicide would, as an accessory, be guilty of murder, and thus would be given the mandatory sentence of life imprisonment. Similarly, one who *assisted* another to commit suicide would be guilty of abetting murder and, again, would be imprisoned for life.[186] The most important recommendations made by the Criminal Law Revision Committee are to be found in clauses 1 and 2 of Appendix 2 of the report, The Draft Suicide Bill. These are now embodied in sections 1 and 2 of the Suicide Act 1961.

B. The current law

After passing through Parliament practically unnoticed during the spring and summer of 1961, on 28 July that year, the Suicide Bill was given its Third reading and passed without amendment. The Suicide Act received the Royal Assent on 3 August, 1961, and came into force immediately. In pertinent part the Act provides:

> S.1 Suicide to cease to be a crime
>
> The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.
>
> S.2 Criminal liability for complicity in another's suicide

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[185] Criminal Law Revision Committee, *(2nd report) Suicide*, Cmnd 1187 (London: HMSO,1960).

[186] An exception to the rule that accessories to killings are guilty of murder exists, however, under section 4 of the Homicide Act 1957, which provides that the survivor of a suicide pact will be guilty of manslaughter and not murder.

> (1) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.

Section 1, then, abolished the felony of suicide. In doing so it also necessarily ended the existence of the crime of attempted suicide: once the rule that suicide is a crime is repealed, all consequences of that rule must, at once, fall. This is precisely the reason for section 2 of the Act. One consequence of suicide being regarded as a felony was that any person who assisted or incited another to commit suicide would also be guilty of murder. However, once suicide ceased to be a crime, so, too, complicity in suicide ceased to be murder. But this, Parliament thought, was an undesirable state of affairs. Though it was prepared to accept that punishment for attempted suicide was inappropriate, it did not want to be seen to be condoning suicide or making inroads into the Christian sanctity of life principle. John Keown has concluded that what this means is that it is quite clearly erroneous to say, as some advocates of assistance in dying do, that the decriminalisation of suicide created a right to suicide, and that in doing so it also gives succour those who wish to be assisted in suicide. He writes: 'It does not follow that, because conduct is not, or is no longer, a criminal offence, it is 'lawful', let alone that one has a 'right' to engage in that conduct...The law regards a whole panoply of conduct which is not criminal as unlawful or contrary to public policy and seeks to discourage such conduct by means other than criminal sanction'.[187]

Whether or not Keown is right to say that suicide remains 'unlawful' I am not so sure. If something is no longer criminal then it is not against the law and is therefore lawful, unless there is some other sort of duty not to do the act. Keown points out that it is not a criminal offence to negligently injure another but it is nonetheless unlawful. True. But this is only so precisely because, in some circumstances, the courts have held that we owe others a duty of care. However, there is no similar duty not to kill oneself. Indeed, as we shall see in chapter 4, such a duty is logically impossible. Who could we owe such a duty to but ourselves? In which case, it is not a duty at all for we can release ourselves from it at any time.[188] But Keown is at least correct to say that the Suicide Act did not create a *right* to commit suicide.[189] This was never Parliament's intention.

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[187] J. Keown, *Euthanasia, Ethics and Public Policy: an Argument against Legalisation* (Cambridge: CUP, 2002), p.65.

[188] As to the possibility of owing a duty to others not to kill oneself, see the case of *Greatorex v Greatorex, The Times*, 6 June 2000, where it was held that no duty of care was owed by the victim of self-inflicted injuries towards a claimant who suffers psychiatric injury as a result of witnessing the event which caused the injury or its aftermath, because to recognise such a duty would be to impose an unacceptable curtailment on the right of individual autonomy.

[189] In Hohfeldian terms, all we could say is that there is a 'liberty' to commit suicide. For there to be a 'right' to commit suicide, we would have to say that there was a 'duty' on others not to interfere with suicide attempts, so that no-one could call the emergency services if they came across such an attempt. By contrast, a Hohfeldian 'liberty' would only mean saying that those against whom the 'liberty' is held have a

C. Does history support a right to assistance in dying?

Clearly, the historical record of assistance in dying is complex and more nuanced than many people would have us believe. To say, as the US Supreme Court did, that there is a 'consistent and almost universal tradition' rejecting the right is to neglect those earlier eras of history when to take one's life for rational and dignified reasons was, if not universally accepted, then at least widely practised and officially condoned. Only with the coming of Christianity did any absolutist position prevail (even here we saw that the popularised account of the birth of this position has been misrepresented); and we have seen how, through the ages, this prohibitive stance found its way into the English common law. However, proponents of assistance in dying are equally guilty of over-simplifying matters. The Suicide Act 1961 was not a triumph of the right to self-determination over the sanctity of life, and the Act was certainly not intended to create a right to commit suicide. Rather, it was an acknowledgement that the common law's harsh punishment of attempted suicides was utterly out of place, if not a downright incentive for suicides to make sure that they were successful. Had the Suicide Act really been about self-determination, why would Parliament have bothered with the section 2 prohibition?

What, then, are we to make of all this? In the end, we cannot do better than to accept the summary of the Ninth Circuit Court of Appeals: 'the relevant historical record *is* checkered' and we could probably make of it both a case for supporting the right to assistance in dying or denying it. However, we should remember that if we deny that the right can be grounded in the past, we must do so in the knowledge that we base our assessment on a tradition that ultimately is based on one particular theological dogma. I would simply ask: is such a narrow reading of history compatible with the modern notion of universal human rights?

'no-right' concerning the activity or state of affairs to which the 'liberty' pertains, i.e. others have no right to demand us to refrain from committing suicide. Nonetheless, although they have a 'no right' to the halting of that activity or state of affairs, they themselves may well have a 'liberty' to interfere. W.N. Hohfeld, *Fundamental Legal Conceptions as Applied in Judicial Reasoning* (D. Campbell and P.Thomas ed.) (Aldershot: Ashgate, 2001). For a succinct exposition of Hohfeld's 'Jural Relations', see M.H. Kramer, 'Rights without Trimmings' in M.H. Kramer, N.E. Simmonds and H. Steiner, *A Debate over Rights: Philosophical Enquiries* (Oxford: Clarendon, 1998), pp.7-22.

PART II: JUSTIFYING THE RIGHT

3. THE AVOIDANCE OF PAIN AND SUFFERING

> Scholarship that tells us what is really at stake in the lives of people affected makes the law honest and responsive. Whether or not it directly shapes doctrine, this type of scholarship can capture imagination and influence judgment...Rights talk is thin and vulnerable when it develops without any genuine effort to understand and articulate the significance of the right claimed to the protected class.[190]

The message of these words is simple and difficult to dispute: without an understanding of the human impact which rights can have, the law cannot hope to be either relevant or sincere. All the theorising in the world will mean little if it does not reflect on how the law can alter an individual's social reality, what difference it can make to a person's actual day-to-day experience. It is the aim of this chapter to show the humanitarian justification for the right to assistance in dying. Too often, lawyers either skim over this aspect or skip it altogether in favour of moving on to those arguments more familiar to the legal mind—arguments relating to dignity and autonomy. Whilst these are clearly issues which, as we shall see in the following chapter, lie at the very heart of the assisted dying debate, providing, as they do, the philosophical justification for the right to an assisted death, to concentrate on them solely, failing to consider in detail also the compassionate effect which the right might have, would be to ignore what is, for perhaps a majority of people, the most important reason of all for permitting assistance in dying: the avoidance of pain and suffering.

The reluctance on the part of lawyers to tackle the humanitarian aspect of the debate is, of course, highly understandable. After all, most lawyers would feel they are unwisely intruding into areas about which others are far more knowledgeable. This is a problem which I am acutely aware of in this chapter, and it will be obvious how much I have had to draw on the work of others, especially those in the fields of palliative medicine and medical sociology. But, any discussion of the right to assisted dying that ignores this area of the debate will be an impoverished one for that.

To fully appreciate the weight of the humanitarian case for the right to assistance in dying, it will be necessary to set out the pain and suffering that the terminally ill can experience quite explicitly. I do not do this simply to tug at heart strings, even though I think that in a debate such as this emotional appeals are a perfectly valid mode of argument (as Jonathan Glover has pointed out, sympathy is one of the strong 'moral resources' that prevents us treating others cruelly or standing by and watching others suffer).[191] But rather, my reason for setting out the pains of dying is simply to inform. Many people are quite ignorant of what can sometimes occur in

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[190] C. Whitman, 'Looking back on Planned Parenthood v Casey' (2002) 100 *Michigan LR* 1980.

[191] J. Glover, *Humanity: a Moral History of the Twentieth Century* (London: Jonathan Cape, 1999), ch.4 and *passim*.

the run up to death. Mistakenly, they think that medicine has vanquished most that is unpleasant about dying apart from death itself. This is because, under the medicalised model, death is a 'hidden' event which has been removed from the home to the hospital, so people do not get to see the reality of dying anymore. So the first section of this chapter simply sets out to describe, without too much comment, the range of symptoms that individually or in combination can contribute to the dying patient's torment, physical, mental and social. Following this, I shall then look at how much of this suffering has been alleviated by the admirable work carried on within the hospice movement. Finally, I shall provide a critique of the hospice movement and show how, in spite of its achievements, it has not managed to avert the need for a right to assistance in dying, and indeed should even embrace the idea of such a right as a way of fulfilling its commitment to helping patients die peacefully.

A. The pain and suffering of the dying individual

Physical suffering

In those diseases and conditions which are most commonly associated with requests for help in dying—cancer, AIDS, multiple sclerosis and other wasting conditions—pain is a very real prospect. Its incidence in advanced cancer patients is generally thought to be as high 70 per cent, even in the most developed countries.[192] The World Health Organization estimates that, worldwide, at least 3.5 million people suffer with cancer pain every day.[193] For AIDS, the figure is even higher: overall prevalence has been observed at 88 per cent, with 69 per cent of patients suffering from constant pain interfering with daily living to a degree described as moderate or severe.[194] The incidence of clinically significant pain in multiple sclerosis is thought to be in the range of 28 to 55 per cent.[195]

The nature of pain, of course, is purely subjective: pain is what the patient says hurts. Despite all our advances in the understanding of pain, experts still do not agree on any standard definition of the concept, though perhaps the definition which has been most widely accepted is that proposed by the International Association for the Study of Pain:

> Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is always subjective. Each individual learns the application

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[192] C. Saunders and M. Baines, *Living with Dying: the Management of Terminal Disease* (2nd ed.) (Oxford: OUP, 1989), p.14; T. O'Brien, 'Pain' in N. Sykes and C Saunders (ed.), *The Management of Terminal Malignant Disease* (3rd ed.) (London: Edward Arnold, 1993), p.34; R. Twycross *et al*, 'A Survey of Pain in Patients with Advanced Cancer' (1996) 12 *J of Pain and Symptom Management* 273, p.274.

[193] World Health Organization, *Cancer Pain Relief* (Geneva: WHO, 1986).

[194] L.M. Frich and F.M. Borgbjerg, 'Pain and Pain Treatment in AIDS Patients: a Longitudinal Study' (2000) 19 *J of Pain and Symptom Management* 339.

[195] D.B. Clifford and J.L. Trotter, 'Pain in Multiple Sclerosis' (1984) 41 *Archives of Neurology* 1270; D. Moulin *et al*, 'Pain Syndromes in Multiple Sclerosis' (1988) 38 *Neurology* 1830.

> of the word through experiences related to injury in early life. It is unquestionably a sensation in a part or parts of the body but it is also always unpleasant and therefore an emotional experience.[196]

However, though this definition has been commended for highlighting the association between tissue injury and pain, and also for identifying the emotional dimension of pain, the use of the word 'unpleasant' does not seem adequately to describe the 'misery, anguish, desperation and urgency that are part of the pain experience'.[197] This is particularly true when what we are talking about is pain of the chronic terminal type. As Dame Cicely Saunders has pointed out, the chronic pain of cancer is quite unlike the acute pain of trauma or the resolving pain of the post-operative period. These pains are easily understood—in that they force the body to rest the damaged area—and even borne, when recovery is expected in a limited time. But cancer pain can appear to be pointless and unending, except by death.[198]

Dame Cicely thinks that a clearer understanding of the sort of pain often endured by terminal patients can be better achieved by looking at visual representations of their experiences. She tells how a series of pictures painted by terminally ill patients at St Christopher's Hospice, London, illustrate well the 'feeling of being impaled by a red hot nail, of being totally isolated from the world by the encircling muscles of tension, with nothing but the hypodermic to pierce through them, the sudden jabs on movement, and the implacable heaviness of pain.' One especially powerful drawing shows the patient represented as a building that is being pounded and destroyed by a demolition crew. All of these works, Dame Cicely thinks, offer a valuable insight into the much more intense, much more isolating and exhausting nature of chronic pain, as opposed to acute, what we might call 'normal' pain.[199]

It is tempting to think that all pain suffered by a terminally ill patient is always directly related to the specific disease or disorder from which they suffer. But, as Robert Twycross and Sarah Fairfield have pointed out, pain can arise from several different sources:[200]

> (1) *Pain directly caused by the disease itself.* This is by far the most common cause of pain, at least in cases of cancer, and is responsible for over two-thirds of all reported pains. Bone pain, neuropathic pain caused by nerve compression, visceral pain, and pain caused by soft tissue infiltration, may all be caused by the direct activity of the tumour.
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> (2)*Pain related to treatment.* Pain in this category may be postoperative pain related to incisional scars, pains caused by chemotherapy or by radiotherapy, or pains caused by adverse drug reactions.

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[196] Cited in T. O'Brien, *op. cit.*, p.34.
[197] R. Melzack and P. Wall, *The Challenge of Pain* (London: Pelican, 1988), p.45.
[198] C. Saunders and M. Baines, *op. cit.*, p.13; O'Brien, *op. cit.*, p.36.
[199] C. Saunders and M. Baines, *op. cit.* p.13.
[200] R. Twycross and S. Fairfield, 'Pain in Far-Advanced Cancer' (1982) 14 *Pain* 303.

(3) *Pain indirectly related to the disease* (associated pains). Pains associated with profound weakness and prolongued immobility are classified under this heading. Cramps, bedsores, and constipation (caused by a combination of inactivity, low-residue diet and the use of opioids) may all give rise to significant levels of discomfort.

(4) *Other pains* (unrelated pains). In many cases, for example where the patient is elderly, as well as pain stemming from the illness or its treatment, there may also be present other pains resulting from totally unrelated conditions. Osteoarthritis and angina, for instance, can both cause pain, but these are clearly discrete diseases which are not connected to the terminal illness.

From whichever of these sources it may stem, of course, it must be remembered that pain is but only one of the symptoms which may be present in the dying patient; there are also many others which can make life seem burdensome. Nausea and vomiting are exceptionally common in the terminally ill, especially in cases of cancer and AIDS.[201] There are many potential causes, ranging from the side-effects of chemotherapy, to bowel obstruction, to raised intracranial pressure and the initial effects of analgesic opioids. All of these can result in a patient feeling wretched and, in the case of treatment-induced sickness, to him doubting whether he should continue with his therapy.[202] It is well-documented that, from the perspective of the terminally ill patient at least, nausea and vomiting rank among the most distressing and feared of all symptoms/side-effects.[203] Feeling and being sick can have a terrible impact on an individual's quality of life, limiting his ability to enjoy meals, spend time with family and friends, and maintain daily function and recreation.[204]

Dyspnoea, or the terrifying shortness of breath experienced by many dying patients, is another factor which can influence a person's desire to go on living, as can be seen from the Diane Pretty case. As well as being caused (as in motor neurone disease) by failure of the muscles which control breathing, the sensation of choking or suffocation can also result from metastatic malignancy to the lungs or pleura, from heart failure, or from primary pulmonary disease. The incidence of dyspnoea in the terminally ill varies greatly between studies, but it is universally recognised as being at least a highly significant problem. In a small series of patients being cared

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[201] D.B. Reuben and V. Mor, 'Nausea and Vomiting in Terminal Cancer Patients (1986) 146 *Archives of Internal Medicine* 2021; P. Han *et al*, 'The Challenge of Chronic AIDS-Related Nausea and Vomiting' (2001) 4 *J of Palliative Medicine* 65.

[202] J. Lazlo, 'Nausea and Vomiting as Major Complications of Cancer Chemotherapy' (1983) 25 *Drugs* Supp. 1, 1; finding that as many 25-50 per cent of patients with uncontrolled nausea and vomiting may delay or refuse potentially curative therapy. See also, A. Molassiotis *et al*, 'Factors associated with adherence to Antiretroviral Medication in HIV-Infected Patients' (2002) 13 *Int J of STD & AIDS* 301.

[203] A. Coates *et al*, 'On the Receiving End—Patient Perception of the Side-Effects of Cancer Chemotherapy' (1983) 19 *European J of Cancer and Clinical Oncology* 203.

[204] C.M. Lindley *et al*, 'Quality of Life Consequences of Chemotherapy-Induced Emesis' (1992) 1 *Quality of Life Research* 331; *cf.* P.J. Selby *et al*, 'The Impact of Nausea and Vomiting upon Quality of Life Measures' (1992) 66 *British J of Cancer* Supp. XIX, S14.

for by a London hospital support team, for example, dyspnoea was found in 18 out of 26 patients (69 per cent).[205] Another survey has found that about 55 per cent of patients were dyspnoeic on admission to a terminal care unit.[206] In a large-scale study in America, Reuben and Mor observed a prevalence rate of over 70 per cent in patients during the last six weeks of life.[207] And at St Christopher's Hospice, London, dyspnoea has been noted in 41 per cent of 607 consecutively admitted patients.[208] Almost all studies observe that dyspnoea increases as death approaches, and that it is the most common final stage symptom, as well as one of the most distressing to observe. As one husband noted of the death of his wife, who died 'gasping', 'drowning in her own secretions': 'It was a nightmare and now I can't get those pictures out of my head'.[209]

Many individuals suffer from anorexia (loss of appetite) and cachexia (the wasting of physical appearance) during the advanced stages of terminal disease.[210] Again, the causes of these symptoms are manifold and may be the result, for instance, of tumour factors, macrophage factors, endogenous peptides, or delayed gastric emptying leading to early satiety.[211] Also, of course, nausea has a dramatic impact on food intake, as do several other factors such as dysphagia (the difficulty in swallowing which many dying patients experience)[212] and altered or diminished sense of taste.[213] Depression can also lead to patients refusing food.[214] The presence of anorexia in the terminally ill individual can be harrowing. Cancer and AIDS-induced wasting has considerable impact not only on the patient's own body image and understanding of his illness, but also on relatives' and carers' perceptions:

> Anorexia reminds the family that they will lose the patient. The acts of preparing food and feeding someone have a nurturing component and are an important element of personhood for many caregivers. An anorexic patient quickly produces a sense of helplessness in the carer. These feelings are made worse by the emaciated appearance of patients with advanced cancer which suggests they are dying of starvation, a sign of

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[205] J.M Hockley *et al*, 'Survey of Distressing Symptoms in Dying Patients' (1988) 296 *BMJ* 1715.

[206] L. Heyse-Moore, 'How much of a Problem is Dyspnoea in Advanced Cancer?' (1991) 5 *Palliative Medicine* 20.

[207] D.B. Reuben and V. Mor, 'Dyspnea in Terminally Ill Cancer Patients' (1986) 89 *Chest* 234.

[208] Cited by S. Ahmedzai, 'Palliation of Respiratory Symptoms' in D. Doyle *et al* (ed.) *Oxford Textbook of Palliative Medicine* (2nd ed.) (Oxford: OUP, 1998), p.586.

[209] J. Corner *et al*, 'The Experience of Breathlessness in Lung Cancer' (1999) 8 *European J of Cancer Care* 37.

[210] E. Bruera and R.L Fainsinger, 'Clinical Management of Cachexia and Anorexia' in D. Doyle *et al* (ed.) *op. cit.*, p.548.

[211] *ibid.*, p.549.

[212] M.M Grant and L.M. Rivera, 'Anorexia, Cachexia and Dysphagia: the Symptom Experience' (1995) 11 *Seminars in Oncology Nursing* 266.

[213] W.D. Dewys and K. Walters, 'Abnormalities of Taste Sensation in Cancer Patients' (1975) 36 *Cancer* 1888.

[214] E. Bruera and R.L Fainsinger, *op. cit.*, p.549.

> extreme neglect. It is little wonder that anorexia and cachexia are two of the symptoms most feared by patients and their families.[215]

I have already mentioned the pain which can be caused by severe constipation, but blocked bowels can have a substantial impact on quality of life even where, rarely, the patient may not be suffering from physical discomfort. As well as causing the patient considerable anxiety, unchecked constipation can also exacerbate other symptoms in the dying patient. It may increase the patient's feeling of nausea, may lead to decreased mobility, impact upon cognitive functioning, or even further contribute to anorexia and malnutrition. As one palliative expert has noted 'How often do I hear "He's not eating so he won't have his bowels opened will he?" In fact the patient may not be eating *because* he has had no bowel action for a week.'[216]

Then there is the problem of diarrhoea. Although this is a much less prevalent concern in cancer patients than constipation (diarrhoea is a complaint in between 7 and 10 per cent of cancer patients on admission to hospice, compared with a rate of 50 per cent for constipation[217]), in HIV and AIDS patients diarrhoea is much more common, with an incidence rate of 27 per cent.[218] As we shall see later, uncontrollable chronic diarrhoea can be incredibly distressing both for the patient and for his carers, diminishing the dying individual's sense of personhood and, in extreme cases, causing him or her to literally beg for assistance in dying.

A symptom which has until fairly recently been largely overlooked or ignored, in spite of the fact that it affects a very great number of dying individuals, is asthenia, the general fatigue or loss of strength which accompanies terminal decline. Asthenia is a frequent accompaniment to advanced malignancy and is thought to occur in anything between two-fifths and three-quarters of advanced cases of cancer.[219] Although it is strongly associated with anorexia and cachexia, recent work has started to highlight the importance of recognising asthenia as a self-standing problem with its own complex pathophysiology.[220] It is now realised that as well as malnutrition, asthenia may be induced by substances released by tumours,[221] by infection (particularly in HIV-infected patients),[222] by anaemia,[223] hypoxia (a shortage of oxygen in the tissues),[224] insomnia (from

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[215] R. Dunlop, 'Metabolic Symptoms' in N. Sykes and C. Saunders (ed.),*op. cit.*, p.94.

[216] R. Lamerton, *Care of the Dying* (Harmondsworth: Penguin, 1973), p.51.

[217] N. Sykes, 'Constipation and Diarrhoea' in D. Doyle *et al* (ed.) *op. cit.*, pp.513, 521.

[218] K.V. Rolston *et al*, 'Diarrhea in Patients with the Human Immunodeficiency Virus' (1989) 86 *American J of Medicine* 137; J.M. Miro *et al*, 'Infectious Gastroenteritis with the Acquired Immunodeficiency Syndrome' (1988) 109 *Annals of Internal Medicine* 342.

[219] H. Neuenshwander and E. Bruera, 'Asthenia' in D. Doyle *et al* (ed.), *op. cit.*, p.573.

[220] *ibid.*

[221] A. Theologides, 'Anorexins, Asthenins, and Cachectins in Cancer' (1986) 81 *American J of Medicine* 696.

[222] A. Adolphi, 'Assessment and Treament of HIV-Related Fatigue' (2001) 12 *J of Association of Nurses in AIDS Care* 29; L. Rose *et al*, 'The Fatigue Experience: Persons with HIV infection' (1998) 28 *J of Advanced Nursing* 295.

[223] R. Morant, 'Asthenia: an Important Symptom in Cancer Patients' (1996) 22 *Cancer Treatment Rev* Supp. A, 117; *cf.* E. Bruera *et al*, 'Association between Asthenia and Nutritional Status, Lean Body Mass, Anemia, Psychological Status and Tumor Mass in Advanced Breast Cancer' (1989) 4 *J of Pain and Symptom Management* 59.

which many dying patients suffer terribly),[225] and by treatment such as chemotherapy[226] and radiotherapy.[227]

The impact which asthenia can have on the quality of life of a dying individual is obvious: lacking sufficient strength and energy, the patient will be neither able to properly care for himself,[228] nor to enjoy doing the things which once gave value and meaning to his life. In her highly illuminating hospice-based ethnographic study (on which I shall be drawing substantially in this chapter), Julia Lawton has highlighted the case of one patient, Frank. Frank originally developed cancer in his prostate, but it later spread to his bones and then to his lungs. A few weeks prior to his admission for respite care his mobility had decreased markedly. Up to that point Frank had been independent, ambulant, and able to do attend to his bodily care and to carry on the activities he enjoyed; but by the time he came into the hospice this had all changed. Of his weakness and fatigue, Frank stated that:

> I've found as I've got weaker I've become a lot more apathetic and withdrawn...I've abandoned a lot of my favourite pastimes. A couple of months ago I stopped doing the crossword in the newspaper. Last month I stopped reading the newspaper altogether. I've just lost interest. I suppose that's why so many patients here spend so much time sleeping. There's so few things we're able to do...so you just give up.[229]

Lawton flags Frank's experience of asthenia as not just an example of physical fatigue, but of the much more deeply rooted 'existential fatigue' which has been described elsewhere by Toombs:

> The effortful nature of worldly involvement that is characteristic of incapacitating disorders can engender a sense of fatigue that I shall call 'existential fatigue'. To organise and carry out projects requires not only physical ability but, as importantly, an exercise of will. When ceaseless and ongoing effort is required to perform the simplest of tasks (getting out of bed, dressing, taking a shower, going on a trip), there is a powerful impulse to withdraw, to cease doing what is required.[230]

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[224] H. Neuenshwander and E. Bruera, *op. cit.*, p.574.

[225] J.R. Davidson *et al*, 'Sleep Disturbance in Cancer Patients' (2002) 54 *Social Science and Medicine* 1309.

[226] A. Richardson and E. Ream, 'The Experience of Fatigue and Other Symptoms in Patients receiving Chemotherapy' (1996) 5 *European J of Cancer Care* Supp.2, 24.

[227] B.A. Jereczek-Fossa *et al*, 'Radiotherapy-Related Fatigue' (2002) 41 *Critical Reviews in Oncology/Hemotology* 317

[228] P. Stone *et al*, 'Fatigue in Patients with Cancer' (1998) 34 *European J of Cancer* 1670; V.A. Rhodes *et al*, 'Patients' Descriptions of the Influence of Tiredness and Weakness on Self-Care Abilities' (1988) 11 *Cancer Nursing* 186; M. Frank-Stromborg and P. Wright, 'Ambulatory Cancer Patients' Perception of the Physical and Psychosocial Changes in their Lives since the Diagnosis of Cancer' (1984) 7 *Cancer Nursing* 117.

[229] J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), p.89.

[230] S. Toombs, 'The Lived Experience of Disability' (1995) 18 *Human Studies* 9, p.15.

Here, of course, perhaps more clearly than with any of the other symptoms hitherto considered, we see the overlap of physical suffering with certain other types of suffering experienced by the terminally ill. And this is important in gaining an understanding of why individuals do sometimes ask for help in dying. For the point about terminal suffering is that it is more than the sum of the patient's physical complaints. The physical symptoms of terminal decline can, in many cases, be just the tip of the iceberg, a cause, in turn, of other forms of anguish. While physical suffering can unquestionably make life unbearable of itself, often it will be the mental and social suffering which decidedly swing a patient to a decision that his life is now no longer worth living.

Mental and social suffering

Mental anguish can arise in the terminally ill patient for any number of reasons. But experience shows that it can usually be attributed to one of several perfectly normal reactions to the knowledge of impending death.

Fear is something that we are all vulnerable to, but to which the dying patient is peculiarly exposed. It may stem from a variety of factors, but most of us, when facing death, will be anxious to know what lies ahead. In this sense, fear can be seen as a response to the unknown but imaginable. How will the disease progress? What will precede death and will there be adequate symptom control? What will happen to our dependants after we are gone? What happens when we die and is there something more than physical existence? All these questions are common and understandable enough in the terminal care setting; but the fact that most of them cannot be definitively answered means that, naturally enough, they will cause anxiety in even the most stoic of patients. For the dying individual, however, fear is not just the product of an unknown future. There is also the awesome fear of loss which the terminally ill person must come to terms with. When we die, we lose everything we have—life and all that that entails. Whereas the relatives of the dying individual lose but one beloved member of the family, the dying individual himself anticipates losing everything: not only his whole family, his friends, his home, his job, his future plans and projects, but also those goods, like perception, desire and thought, which are so general as to be actually constitutive of human life.[231] The thought of such deprivation strikes terror into the heart of us all. It is the sense of dread which is so brilliantly described by Philip Larkin in his poem *Aubade*.[232]

It has been observed by some who work with the terminally ill that, faced with such loss, the dying patient will often go through a type of grieving process.[233] And this, too, we must take into account when we are considering the terminal patient's mental suffering; because grief of course is clearly different from fear, and the emotional response that it evokes will be quite distinct. Most

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[231] T. Nagel, 'Death' in P. Singer (ed.), *Applied Ethics* (Oxford: OUP, 1986), ch. 1.

[232] P. Larkin, *Collected Poems* (London: Faber & Faber, 2003).

[233] C. Knight Aldrich, 'The Dying Patient's Grief' (1963) 184 *JAMA* 329.

of us who have lost a loved one know that grief, in contrast to fear, is a much more melancholic and despondent state—but for that, none the less distressing.

Another emotion common in the terminally ill which can contribute to mental suffering is guilt. Guilt will usually be experienced in one of several ways. Either in a general sense, in that the dying individual may feel that he has not lived the life he should have—guilt over what Larkin describes as 'the time Torn off unused': that he has failed to be true to himself; that he has not achieved all he hoped he would; that opportunities have slipped through his fingers. Or, an individual may feel guilty about something very specific— 'The good not done, the love not given': a relationship gone wrong; a promise not fulfilled; a secret kept from loved ones. Left unresolved, both these types of guilt can have a huge bearing on the overall well-being of a patient, with some individuals simply becoming overwhelmed by feelings of regret and remorse.

There is in the terminally ill community, however, yet another kind of guilt which needs to be recognised. This is the sense of guilt which can arise when a patient feels that, to his friends and family, he is nothing but a burden and an impediment to the normality of their lives. Such feelings are far too common in those who are dying, as Lawton's study clearly shows. She highlights the case of one hospice patient whom she refers to as Roz, who early in her illness had said of the hospice where Lawton was based: 'You'll never get me into a place like that...that death factory watching the other patients drop off like flies'. But about a year later Lawton met with Roz again, just after she had been admitted to the hospice for terminal care, at which time she explained that:

> It was okay until a couple of days ago, when I could still walk with a frame. Then suddenly my legs gave way beneath me. The next thing I knew I was lying flat on the carpet in the living room. I couldn't move, and my husband couldn't help me up. I was lying there for such a long time. I'm sure the imprint from my body must still be there. In the end he had to get a neighbour to help lift me up...I've come in here more for my husband than myself. What I want doesn't really matter that much anymore anyway. I've become such a burden. He had to give up his job seven weeks ago to help care for me. He's reached the end of his tether. When I had the fall I knew he couldn't cope. So, yes, I've done it for him, I suppose. It's not fair to drag him down with me any longer.[234]

For Roz, the choice was between being a burden to her husband and submitting herself to the care of a hospice. For others, however, the choice is starker: to be a burden to family, or to opt to put an end to life altogether. That some might be prepared to sacrifice themselves for their family in this way is, to many people, one of the reasons why a right to assisted dying should be

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[234] J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), pp.95-96.

opposed at all costs. The idea that individuals might choose to die, not because they really want to, but purely because of the guilt that they feel, seems morally repugnant. However, several commentators have suggested that where a person's wish to die is in part motivated by altruistic concerns for their family, this should not necessarily mean that the request should just be dismissed as an outrage and yet another shocking indictment of the uncaring society in which we live. 'To do so', as Otlowski has written, 'would be to undermine the patient's right of self-determination, including the liberty to have regard to the needs and interests of others in making decisions in respect of their own health care'.[235]

Closely related to guilt is the notion of shame, something else which affects many dying patients. Terminally ill individuals often become embarrassed about their appearance, which can be drastically altered both by the disease itself or by treatments such as surgery or chemotherapy. Comments such as 'I don't want visitors to come. They mustn't see me like this' or 'If people know my secret (a stoma) they won't want to eat with me' are common occurrences on the hospice ward.[236] So too are shameful feelings aroused by the inability to control bodily functions or offensive odours which may be caused by the illness. (I shall have more to say on this later.) In some cases individuals even seem to isolate themselves because they believe that others, in spite of the medical facts, will find them dirty or contageous in some way. For instance, one leukaemia patient interviewed by a researcher told how, at his local pub, he had to have his own glass 'in case somebody don't like it and thinks it's catching or something'.[237]

Here, of course, we are crossing into the realm of the *social* pain often experienced by the dying, and in many ways this type of pain can be the most traumatic of all.

Stigmatisation of the sort experienced by the above leukaemia patient is apparently widespread amongst the terminally ill. Dying patients have repeatedly described incidents of being ignored and even of being outright avoided because of their disease. Lawton details the case of Anne, a patient whose physical appearance had deteriorated significantly because of her illness. Anne told how on several occasions after she became 'visibly unwell', she had been sitting in her front garden at home when neighbours had, 'crossed the street and ignored me completely'. In addition, her best friend had stopped coming to see her. When Anne's daughter confronted the friend about this matter, she explained that: 'She doesn't look normal; she doesn't act normal, so I can't talk to her in a normal way. I suppose I've started avoiding her because I don't want to hurt

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[235] M. Otlowski, *Voluntary Euthanasia and the Common Law* (Oxford: Clarendon, 1997), p.233. See also *Compassion in Dying v Washington* (1996) 79 F 3d 790, at p.826; M. Gunderson and D. Mayo, 'Altruism and Physician Assisted Suicide Death' (1993) 18 *J of Medicine and Philosophy* 281; G. Williams, '"Mercy Killing" Legislation – a Rejoinder' (1958) 43 *Minnesota L Rev* 1, at p.5: 'If a patient, suffering pain in a terminal illness, wishes for euthanasia partly because of his pain and partly because he sees his loved ones breaking under the strain of caring for him, I do not see how this decision on his part, agonizing though it may be, is necessarily a matter of discredit either to the patient himself or to his relatives'.

[236] P. Speck, 'Spiritual Issues in Palliative Care' in D. Doyle *et al* (ed.) *op. cit.*, p.807.

[237] G. Mclean, *Facing Death: Conversations with Cancer Patients* (London: Churchill Livingstone, 1993), p.31.

her feelings'. Anne's husband had also made it clear that he resented her appearance, saying that he didn't like to take her out in public in case he might be spotted by his 'mates'.[238]

Lawton states that such experiences were commonplace amongst the patients she observed. For many relatives and friends, the sad fact is they appear only able to relate to a patient when he or she looks and acts like someone who is not dying. As one woman interviewed by Lawton remarked: 'On those bad days when I wake up and feel terrible, and look terrible, no-one wants to know me'.[239]

Comments such as these, coupled with the experiences of individuals such as Anne and the leukaemia patient, naturally cause one to question the humanity of those surrounding the patient. Where, one might reasonably ask, is their compassion? Surely, people who isolate dying individuals because of their appearance or because of some sort of irrational fear of catching something are either completely selfish or utterly ignorant. In some instances this may indeed be the case. But, to believe that stigmatisation of the terminally ill is always the product of such shortcomings is to see only part of the picture; for stigma conceals a double perspective. As John Hinton has pointed out,[240] the withdrawal from the dying by those with the prospect of life is, in many respects, perfectly understandable, for the latter have to cope with the certain knowledge that the person who they know and love will soon be no more. Stigma, on this reading, can be seen to arise not so much from any uncaring or unsympathetic attitude, but rather, from an instinctive human desire to minimise the suffering and grief that will inevitably come when the patient does die.

The isolating effect of stigmatisation is often compounded in many cases by the debilitative consequences of the terminal illness. Patients frequently tell of the frustration they feel when they no longer have the energy necessary to keep up with those around them who are healthy.[241] Patients who become house-bound and who live on their own can become especially isolated. Lawton encountered several cases where, because of their immobility, individuals had almost completely lost contact with the outside world. One patient, Iris, a woman with breast cancer and bone secondaries which meant she could only manage to walk short distances with the aid of a stick, complained of the 'endless empty hours vegetating in front of the television', with the monotony of her routine only ever being broken by visits from her daughter who brought her meals. Similarly, Fred, a patient with cancer which had spread to his lungs, felt like 'an animal trapped in a cage'. He was no longer able walk to the pub or to his local pensioners' club, and no one visited him apart from a neighbour who did his shopping, and a care assistant who came briefly in the mornings and evenings to help him to get up and go to bed.[242]

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[238] J. Lawton, *op. cit.*, p.44.
[239] *ibid.*
[240] J. Hinton, *Dying* (London: Penguin, 1972), p.88.
[241] L. Rose *et al*, 'The Fatigue Experience: Persons with HIV infection' (1998) 28 *J of Advanced Nursing* 295.
[242] J. Lawton, *op. cit.*, pp.42-43.

Total physical isolation of this sort can clearly have a marked impact on an individual's perception of the quality of his life. The thought of spending one's final days alone and friendless is not a prospect any of us would relish. But isolation can occur even in those dying individuals who *are* able to maintain social relations. For isolation is not just a description of the physical relationship between persons, it is also in part a state of mind. Terminally ill individuals often describe how they feel 'isolated with their disease'. In *Cancer Ward*, Solzhenitsyn's Stalinist character Rusanov considers how his family has been 'cut off from him' by his disease and is now on the 'other side of his tumour. They were alive and would go on living, whatever happened to their father. However much they might worry, fuss or weep, the tumour was growing like a wall behind him, and on his side of it he was alone'.[243] Solzhenitsyn's fictional account is corroborated by real-life experiences. Lawton's work reports how she gained the impression that, for many patients, terminal illness had caused their 'subjective realities to come out of line with those of family and friends. Patients were, it seemed, often drawn into...an "odyssey of self"'.[244]

Lawton suggests that part of the explanation for this sense of isolation relates to the changed perception of time which dying individuals seem to experience. Whereas for the healthy individual time is ordinarily experienced as a gearing towards the future, for the dying person, understandably, life is much more likely to be set in a present-orientated temporal framework. Lawton highlights her point via the case of Fiona, a patient with advanced cervical cancer. Fiona was extremely bitter after her husband had gone behind her back and researched her illness, thereby establishing that she probably had a prognosis of less than six months. Whilst Fiona knew of the serious nature of her illness, she had chosen not to 'dwell on it' or to discuss the future with her family at all. She wanted, she said, for her life to remain 'normal for as long as possible'. The danger was that if her family knew the true nature of her cancer they would start to treat her differently.

On the husband completing his research, Fiona's worries seemed to materialise. Her family started to plan for a future when she would no longer be around. For instance, arrangements were made to have their disabled daughter's attendance allowance transferred from Fiona's name over to the husband's. Whilst of course this seemed perfectly reasonable to the rest of the family, for Fiona it felt as if she were being treated as if she were 'already dead'. To her, such forward planning seemed to fail to take into account her need to live 'one day at a time only', and left her 'feeling totally redundant'. As Lawton notes 'In effect, the "gap" Fiona was going to leave in her kinship network was already being filled before her death'. In such circumstances, is it any wonder that the dying person should feel isolated? How could they not? After all, to feel as if one is 'already dead' must surely be to experience the most extreme form of exclusion there is.

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[243] A. Solzhenitsyn, *Cancer Ward* (trans. N. Bethell and D. Burg) (Harmondsworth: Penguin, 1971), p.24.

[244] J. Lawton, *op. cit.*, pp.46.

All of this of course—the physical suffering, the mental anguish and the social isolation—should not, and does not, lead us directly to a right to assisted dying as the only possible societal response. However much suffering such a right might negative, whatever torments it might prevent, no matter the release it might bring, it would be a mark of unconscionable callousness if we simply decided to apply a veterinary approach to terminal care, without first exploring how far we are able to ease the trials of the dying. What can modern medicine offer in the way of pain and other symptom relief? How can we help the terminally ill come to terms with their fears and other anxieties? What are we able to do to help people feel less alone in their final days? These are all questions which must be answered before we can even consider moving to a permissive policy—and in the opinion of many, they have already been answered: by the hospice movement. For the argument is that, with good palliative services available, the very great majority of people never need contemplate the option of assisted dying.

B. Society's response

The hospice movement: history and innovation

Although the history of the hospice[245] has been traced by some writers through medieval times back to the early Christian era, it was not until much, much later, in the 19th Century, that the word 'hospice' was used to describe an institution specifically concerned with the care of the dying. In 1842, Mme Jeanne Garnier opened up the first of her refuges for the dying in Lyon. It was called both a 'Hospice' and a 'Calvaire'. Several more were opened later by her 'Dames du Calvaire', both in other parts of France and also in Brussels and New York; these still remain, and even now are involved in the care of the dying. A little later, and quite independently, the Irish Sisters of Charity founded Our Lady's Hospice for the Dying at Harold's Cross, Dublin, in 1879. Mother Mary Aikenhead's Order had long been helping the poor and sick of Ireland, ever since she had established St Vincent's Hospital in 1834, but Our Lady's Hospice was the Order's first institution established solely for those nearing the end of life. Mary Aikenhead having died in 1859, the woman who realised the Hospice was Sister Mary John Gaynor. It opened its doors to the first nine seriously ill patients on 9th December 1879, with newspapers hailing the venture 'a unique charity' and one 'previously unknown in these islands'.

The Sisters of Charity later established the Sacred Heart Hospice in Sydney, Australia (1890), and by the time they had opened their third home, St Joseph's Hospice in the East End of London, in 1905, there were three other hospices already operating in the capital: the

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[245] The following historical account has been distilled from several sources, chiefly: G. Golding and J.D. Thompson, *The Hospital: a Social and Architectural History* (London: Yale University Press, 1975); W.E. Phipps, 'The Origin of Hospices/Hospitals' (1988) 12 *Death Studies* 91; C. Saunders, 'History and Challenge' in N. Sykes and C. Saunders (ed.), *op. cit.*, ch.1; C. Saunders, 'Into the Valley of the Shadow of Death: a Personal Theraputic Journey' (1996) 313 *BMJ* 1599; D. Clark and J. Seymour, *Reflections on Palliative Care* (Buckingham: OUP, 1999), ch.4.

Friedensheim Home of Rest (later St Columba's Hospital), opened in 1885; the Hostel of God (now Trinity Hospice, Clapham), 1891; and St Luke's House, founded 1892. Interestingly, out of all these it was only St Luke's which was set up by a medical man, a Dr Howard Barrett. According to Dame Cicely Saunders, who arrived as a volunteer nurse in St Luke's Hospital (as it was by then) in 1948, much of the spirit of the modern hospice movement was to be found, even at this early stage, in the lively and full annual reports which Dr Barrett compiled. From the beginning, it was clear he was interested more in individuals than in their medical notes. In 1909 Dr Barrett wrote:

> We do not think or speak of our inmates as 'cases'. We realise that each one is a human microcosm, with its own characteristics, its own aggregate of joys and sorrows, hopes and fears, its own life history, intensely interesting to itself and some small surrounding circle. Very often it is confided to some of us.

Undoubtedly, Dr Barrett's person-centred approach left a lasting impression on the young Dame Cicely. But her time St Luke's also exposed her to another innovation, the regular giving of oral morphine to control pain *before* its onset. Although she had previously encountered the use of such drugs as a method of pain relief—for example, the Bromptom cocktail of opioids, cocaine and alcohol for patients with advanced tuberculosis—elsewhere it had been a case of patients 'earning' their drugs by suffering pain first, a practice which arose because of the fear of drug dependence, and which often led to patients being asked to 'hold on a little longer'.

Armed with the experience she gained at St Luke's, and in the meantime having re-qualified as a doctor, in 1958 Saunders began a clinical research fellowship at St Joseph's Hospice. It was here that she was able to lay the foundations for the work that would earn her the reputation of Mother of the modern hospice movement.[246] Having been virtually passed over by recent medical advances, the nuns at St Joseph's gave an enthusiastic welcome to a doctor who was prepared to introduce regular routine to the drugs they were administering on an 'on-demand' basis, medical and nursing records, and who, by tape-recorded conversations with patients, was able to build up a clinical record of the treatment of over 1,000 dying individuals. The presentation of this work in a series of six articles in the *Nursing Times* in 1959[247] proved to be one of the major catalysts for the hospice movement in this country.

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[246] Much of Saunders' early work has recently been described by the medical sociologist, David Clark: see 'Someone to watch over Me: Cicely Saunders and St Christopher's Hospice (1997) 93(34) *Nursing Times* 50; 'Originating a Movement: Cicely Saunders and the Development of St Christopher's Hospice, 1957-67' (1998) 3 *Mortality* 43; 'An Annotated Bibliography of the Publications of Cicely Saunders: Part 1, 1958-67' (1998) 12 *Palliative Medicine* 181; 'Part 2, 1968-77' (1999) 13 *Palliative Medicine* 485.

[247] C. Saunders, 'Care of the Dying' (1959) 55 *Nursing Times* 960, 994, 1031, 1067, 1091, 1129.

The hospice philosophy: total pain

It was while at St Joseph's, through talking and listening to the patients, that Saunders developed the concept of 'Total Pain'. She has told how one patient expressed the idea in answer to the simple question, 'Tell me about your pain':

> Well, doctor, it began in my back but now it seems that all of me is wrong...I could have cried for the pills and the injections but I knew I mustn't. It seemed as if all the world were against me and no one understood how I felt. My husband and son were marvellous but they were having to stay off work and lose their money. But it's so wonderful to feel safe again.[248]

With startling brevity, this patient had explained how important it was not only to have relief from the physical symptoms of dying, but also to know that people were concerned for her mental and social well-being. The pain, fear, isolation, and guilt at being a burden to her family—which, as we have seen, affect so many dying people—all of this is perfectly encapsulated in the simple phrase 'all of me is wrong'. So this, then, became the challenge for the modern hospice movement: to provide relief from the *totality* of suffering experienced by the dying individual.

It has risen to this challenge admirably. Saunders continued to pioneer and, in 1967, opened St Christopher's Hospice in Sydenham, South East London. This became a model for hospices the world over.[249] For instance, the research that has gone into pain management there has undoubtedly eased the dying days of countless individuals, and it is now widely accepted amongst those caring for the terminally ill that, if carefully monitored, patients may be given morphine even for extended periods of time without danger of addiction;[250] also, studies carried out at St Christopher's have shown that, when orally administered, there is no reason to prefer diamorphine to morphine, even though the former drug was previously considered to be the analgesic of choice, because of its fewer side-effects.[251] As Saunders has noted, contact with fundamental scientists and clinicians was central both to the hospice movement's success, and to its acceptance by the wider medical community, palliative medicine becoming a recognised medical specialty in 1987.[252]

The hospice movement quickly embraced new treatments aimed at managing the many other symptoms experienced by the terminally ill. Anti-emetic drugs, such as metoclopramide,

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[248] C. Saunders, 'History and Challenge' in N. Sykes and C. Saunders (ed.), *op. cit.*, p.7.

[249] R. Kastenbaum and C. Saunders (ed.) *Hospice Care on the International Scene* (New York: Springer, 1987).

[250] G. Hanks and N. Cherny, 'Opioid Analgesic Therapy' in D. Doyle *et al* (ed.), *op. cit.*, p.350.

[251] R. Twycross, 'Choice of Strong Analgesic in Terminal Cancer Care: Morphine or Diamorphine? (1977) 3 *Pain* 93.

[252] C. Saunders, 'Foreword', D. Doyle *et al* (ed.)*op. cit.*, p.viii.

haloperidol and ondansetron are used to control nausea and vomiting;[253] dyspnoea can be eased both by low doses of opioids such as dihydrocodeine, or by certain of the benzodiazipines;[254] constipation will be treated by laxatives or, where it is opioid induced, by drugs such as naloxone;[255] and although there is no way of completely reversing anorexia and cachexia in advanced cancer patients, hospice staff are often able to stimulate appetite by using progestational drugs or a short course of corticosteroids;[256] these are treatments which may also be effective in combating asthenia.[257] All this of course is standard therapy, which the terminally ill person should be able to expect in any modern hospital. However, it is in its adoption of an approach to the care of the dying that goes beyond merely a symptomological one that the hospice movement has set itself apart from the rest of the medical establishment.

Since its inception the hospice movement, above all, has been about providing time and space for individuals to come to terms with the psychological and social dimensions of dying. In this respect the movement, like the assisted dying debate itself, can be seen as a reaction against the medicalised model of dying, an attempt to recapture some of the elements of the 'natural'/'tame'/'good' death which was described in the introductory chapter.[258] While affirming life, hospices seek to promote both an acceptance of death, and a creative final flourish during which, free from physical symptoms, the dying individual will not only be able to work through his feelings to find meaning in his life, but also will be able to maximise his potential to develop relationships and to tie up any unfinished business. The pledge of the hospice movement, as Dame Cicely has recounted many times, is: 'You matter because you are you, and you matter until the last moment of your life. We will do all we can not only to help you die peacefully, but also to help you live until you die'.[259]

In practice, this means several things. First, there is the idea of an 'open confrontation with death'.[260] In response to the charge that, under the medical model, death has become a taboo that is sequestered away in the side rooms of hospitals, the hospice movement has sought to

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[253] M. Baines and N. Sykes 'Gastrointestinal Symptoms' in N. Sykes and C Saunders (ed.), *op. cit.*, pp.68-69.

[254] S. Ahmedzai, 'Palliation of Respiratory Symptoms' in D. Doyle *et al* (ed.), *op. cit.*, pp.597-600.

[255] N.P. Sykes, 'Oral Naloxone in Opioid-Associated Constipation' (1991) 337 *Lancet* 1475; N.P. Sykes, 'An Investigation of the ability of Oral Naloxone to correct Opioid-Related Constipation in Cases of Advanced Cancer (1996) 10 *Palliative Medicine* 135.

[256] E. Bruera and R.L Fainsinger, 'Clinical Management of Cachexia and Anorexia' in D. Doyle *et al* (ed.), *op. cit.*, p.551-552, although it should be noted that the value of stimulating appetite in the dying by pharmocological means is a debated point. Many would argue that if the patient sees a return of appetite and consequential weight gain, this will just give him false hopes of recovery, thereby delaying or preventing him from accepting the inevitable. Others, however, would say that such treatments lift patients out of the normal downward slope of cancer and maintain them on a plateau until nearer the time of death. R. Dunlop, 'Metabolic Symptoms' in N. Sykes and C. Saunders (ed.), *op. cit.*, p.96.

[257] H. Neuenshwander and E. Bruera, 'Asthenia' in D. Doyle *et al* (ed.) *op. cit.*, p.578-79.

[258] D. Clark and J. Seymour, *op. cit.*, p.79; J. Lawton, *op. cit.*, p.12; Beverly McNamara, *Fragile Lives: Death, Dying and Care* (Buckingham: OUP, 2001), pp.121-122.

[259] C. Saunders, 'Foreword', D. Doyle *et al* (ed.), *op. cit.*, p.vii.

[260] C. Seale, 'What happens in Hospices? a Review of Research Evidence' (1989) 28 *Social Science Medicine* 551, p.552.

make dying a much more visible event, and hence one which is less frightening. Hospice professionals suggest that patients and families can gain much from witnessing the peaceful death of another person. Thus, in-patient hospice buildings are usually designed to house the majority of their patients on communal wards, and it is the policy of many hospices to allow patients to die on the ward, rather than move them into side rooms. Typically, patients can expect to witness the death of at least one person during a stay of even just a week or two.[261]

Lawton has concluded, from her own observations and what little other research is available, that hospice patients who have witnessed the death of another patient do appear to fare better than those who have not.[262] She notes how one woman, after seeing a patient on her ward slip into a coma and then die shortly afterwards, had remarked: 'Well, if that's what death's like then I have nothing to be afraid of'. However, Lawton warns that the benefits of the openness policy are quickly negated when there is a less than peaceful death on the ward. 'Patients found it extremely distressing when another patient on their ward became very out of breath or experienced paranoia, agitation or confusion before dying'; also, the repeated witnessing of death appears to have a negative effect. Lawton tells of one woman in the hospice where she worked who had been exposed to the deaths of at least seven other patients during her stay. While she agreed that the first death had been comforting, she became increasingly demoralised as the deaths continued, and told Lawton that she felt her time at the hospice had been 'a thoroughly depressing experience'.

Whatever the merits of the openness policy in terms of its capacity to provide reassurance and comfort to those surrounding the dying patient, there seems here to be an important question which is being largely overlooked. Apart from Lawton,[263] few commentators have examined how the dying person himself might feel about being put on display; moreover, this does not seem to be an issue which overly concerns many hospice workers. I shall briefly return to this issue in the following chapter when I consider the whole question of dignity and the idea of a dignified death. But it is enough to note here that there are obvious difficulties with the open dying approach if the end to which this is pursued has more to do with furthering hospice philosophy and the attendant benefits to those patients surviving on the ward, than it does with looking after the interests of the dying individual.

Much of the task of helping patients to accept their impending deaths and to live out their remaining time fully rests on the multi-disciplinary approach of hospice care. As well as specially trained doctors and nurses, hospice care incorporates the expertise of many other professionals. Psychologists are frequently used to help with anxiety, depression and general feelings of

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[261] J. Lawton, 'A Room with a View' (1997) 93(34) *Nursing Times* 53.
[262] *ibid.*, citing the studies of J. Honeybun *et al*, 'The Impact of a Patient Death on Fellow Hospice Patients' (1992) 65 *British J of Medical Psychology* 67; S. Payne and R. Hiller, *The Impact of Death on Fellow Patients in a Palliative Care Unit: Final Report* (Wessex: Wessex RHA, 1995).
[263] J. Lawton, 'A Room with a View' (1997) 93(34) *Nursing Times* 53; J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), pp.117-121.

pessimism and apathy; they can also help patients overcome anger, guilt and issues relating to changes in body image, all of which can prevent an individual making his peace with the world. Social workers may play an important role in helping patients deal with the stresses that terminal illness can place on close personal relationships. They may see patients either on their own, or with family members or friends. Often, there may be important but difficult things that a patient wants to say to those close to him, and a social worker, someone less emotionally involved, can help marshal these conversations. Physiotherapists can improve patients' quality of life in several ways. For instance, exercise programmes can be designed to help build muscle strength, thus improving mobility; pain relief can be provided by acupuncture or heat and ice therapy; and symptoms such as breathlessness can be alleviated by relaxation techniques, massage, or simple advice on matters such as posture and energy conservation. For those with spiritual concerns, all hospices provide chaplaincy services, and most nowadays cater for non-Christian denominations with multi-faith rooms or specialist advisers. Finally, many hospices also now employ financial and welfare advisers, who can provide practical assistance to families facing reduced incomes, or who may need help and advice in dealing with benefits agencies. If a patient can be sure his family will be provided for even without his contribution to the household, this can often do more to provide peace of mind than anything else.

Indeed, the family has always been considered by the hospice movement to be crucial, both in that the concept of 'Total Pain' incorporates the suffering of relatives and friends, recognising that they too must be offered comfort and support, but also in that the movement has always considered the family to be the natural unit of care for the dying person. It is for this reason, at least in part, that since the late 1970s there has been a shift in emphasis away from the establishment of in-patient units, to the provision of more extensive home care and day care services,[264] with the latter being tacit recognition of the fact that, if the burden of caring for those who are terminally ill is mostly borne by relatives and friends, then there needs to be some provision for respite from this burden.[265] However, even when a patient does have to be admitted to an in-patient unit, the family retains its central importance. As well as involving relatives in the continuing care of the individual, as far as that is practicable, it is a founding objective of the movement that all hospices shall strive to emulate a sense of 'real community', becoming a sort of 'extended family' that can 'give the kind of welcome and hospitality of a good home'.[266]

It is indisputable that all this has gone far in lightening the gloom cast on those expecting imminent death. And this is as nothing compared to the illumination that emanates from the

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[264] As we shall see later, however, there are also probably important practical reasons for this shift in emphasis.

[265] As one widow of a former day care patient remarked in Lawton's study, 'Day care [was] a safety valve...When my husband came to day care I got a whole day in which I could plan and do my own thing...one day to look forward to, one day to be free': J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), p.52.

[266] *ibid.*, p.12, citing C. Saunders, 'Watch with Me' (1965) *Nursing Times*, Nov.

simple but fundamental message that the hospice movement treat each person as an individual, someone whose death will be as unique as the life that preceded it. Yet, for all that the hospice movement has achieved—for all the understanding and knowledge of the terminal condition it has attained, for all the pain and suffering it has prevented and continues to prevent, for all those deaths that it has made and will continue to make easier, both for the individuals and for the relatives and friends who have to bear witness—there remain questions about how far the hospice ideal can carry.

C. The shortcomings of the hospice ideal

The hospice movement does not obviate the need for a right to assisted dying for a number of different reasons, some of which relate to the way the original aims of the hospice movement have been compromised and deformed as the movement has matured; others are more about how the movement just cannot, in reality, always live up to its pledge to help people die peacefully and to help them live until they die.

The compromise of an ideal

As we have seen, the modern hospice movement grew up in large part as a result of a popular reaction against what was viewed as the inadequate and inappropriate care that many dying people were receiving in general NHS hospitals. The hospice idea, commentators have pointed out, received widespread 'grass roots' support and much of the money for the first modern facilities was provided not by central government, but by energetic community groups relying primarily on voluntary contributions.[267] This charitable underpinning of the movement has had certain consequences. It has been suggested[268] that because most of the initiatives were brought about by local groups, the movement as a whole lacked overarching coordination and direction. Individual groups had scant understanding of how their units would dovetail with other services, both locally and at the national level. Furthermore, although initial funds to establish units were reasonably forthcoming (because of the movement's widespread appeal), continued backing to meet running costs was more difficult to secure and many hospices began to run up ever larger debts. Fairly quickly it became clear that if the much good work which was being done was to continue, a helping hand in the shape of public money would be needed. Thus, in the mid-1970s the National Society for Cancer Relief (one of the major charitable backers, now known as Macmillan Cancer Relief) took the decision to provide financial support for hospice projects only if they were built within the grounds of NHS hospitals, on the understanding that running costs would be met by the NHS Health Authorities. The first of these NHS Hospices (or 'Continuing

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[267] J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), p.17.
[268] *ibid.*, Lawton citing the work of B. Lunt, 'Terminal Cancer Care Services: Recent Changes in Regional Inequalities in Great Britain' (1985) 20 *Social Science Medicine* 753, and H. Taylor, *The Hospice Movement in Britain: its Role and its Future* (London: Centre for Policy and Ageing), p.17.

Care Units' as they were called) was opened in 1975; by the 1980s the NHS had become at least partially involved in many hospice initiatives.

These organisational changes have led a number of writers to suggest that the hospice movement has been routinised, its wings having been clipped by its realignment with the mainstream healthcare structure. Although an early example of this sort of argument can be found in a 1986 paper by Emily Abel,[269] where the subject under examination was the institutionalisation of the American hospice movement, perhaps the most influential work in this field has been carried out by two British academics, James and Field.[270] In 1992 they argued, via an examination of Weberian theory, that the hospice movement was undergoing changes which were symptomatic of a creeping bureaucratisation. According to Weber, all social movements must evolve from 'charismatic' infancy periods (when they will be 'radical', 'oppositional' and 'essentially creative and disruptive') to the routinised maturity which is necessary if such movements wish to continue growing and influencing wider social structures. James and Field suggest that this analysis fits the history of the hospice movement almost perfectly. Not only, they point out, does the early work of pioneers such as Cicely Saunders typify the 'charismatic' infancy period, with her essentially alternativist, critiquing stance, but also the later history of the movement seems to tally with Weber's view of developed movements being essentially bureaucratic and conformist: as well as highlighting the increased involvement of the NHS in the funding of hospice care, James and Field also note significant changes in the way which hospices now, much more than when the movement was starting out, tend to operate according to traditional hierarchies (often doctor led) and traditional divisions of labour; how the training of hospice staff has moved away from aiming to produce a 'generalist' hospice worker toward the specialisation of staff in different 'aspects' of Total Care; and how workers are now entering hospices as career professionals, rather than as committed individuals who have a 'calling' to care for the dying.[271]

All of this, James and Field contend, has come at a cost to the movement. They write 'the early hospices left the mainstream specifically to escape the forces which mitigated against (sic) developing the "model" of care to which the early advocates aspired. Unless the mainstream has changed considerably these "forces" hold the potential for subverting the original hospice ideals...'[272] A particularly 'subverting' accompaniment to routinisation and bureaucratisation is the way which hospices now, because they are tied much more closely to the NHS and public funds, have to account for the care they deliver via financial and clinical audit. While there are

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[269] E. Abel, 'The Hospice Movement: Institutionalizing Innovation' (1986) 16 *Int J of Health Services* 71.

[270] N. James and D. Field, 'The Routinization of Hospice: Charisma and Bureaucratization' (1992) 34 *Social Science and Medicine* 1363. James and Field's arguments are considered in H. Biggs, *Euthanasia, Death with Dignity and the Law* (Oxford: Hart, 2001), pp.156-7

[271] *ibid.*, pp.1368-1369.

[272] *ibid.*, p.1370.

undeniably benefits to be had from such accountability there are also drawbacks, as James and Field note:

> The general pressures within the health services to measure service provision for both quality and cost-effectiveness have also been felt within the hospice movement. Standards and the evaluation of hospice services are being discussed with some urgency at national, regional and local levels...[But] the difficulties of defining and measuring the quality of inputs such as 'effective communication' and 'empathy' and outcomes such as 'feelings', 'satisfaction' and 'well-being' are immense. Yet it is these inputs and outcomes which lie at the centre of hospice care ideals. Will the pressure of audit lead to a diversion of interest away from such 'soft' factors towards the more easily defined and measured 'harder' indicators of treatment and 'output' such as drugs used, physical interventions made and bed throughput? We note for instance that many hospices follow the tradition of leaving a bed empty for 24 hrs after someone has died in recognition of their place in the hospice. With increasing emphasis on bed occupancy, hospices will have to ensure special clauses in their contracts so that they are not penalized for such an essentially 'caring' activity, or else as a society we will have to recognize that it is a 'frill' we do not choose to afford.[273]

Here we see the authors hinting at a further consequence of the (re)integration of the hospice movement within the mainstream: the idea, which is intricately intertwined with the routinisation thesis, that the hospice movement is becoming increasingly medicalised in its maturity. Because traditional hierarchies and labour patterns are reasserting themselves, and because hospice care as it was traditionally envisaged is difficult to appraise in terms of highly rationalised analyses, there is a concern that terminal care is once again becoming biomedically led, with less emphasis on the psycho-social features of dying and more on the physical, tangible aspects. As evidence of this trend, commentators have pointed not only to the 1987 recognition of 'Palliative *Medicine*' as an accredited specialty, but also to a nationwide study which has found that 'more use is made of invasive procedures and that patients are more likely to be referred for palliative surgery and organ donation in hospices where there is a full time consultant or medical director'.[274]

However, as Clark and Seymour have warned, we must be careful that we do not buy into the routinisation/medicalisation hypothesis unquestioningly.[275] They point to evidence from Seale which could be construed as showing that (at least at the beginning of the 1990s, when Seale conducted his work) there had not been the widespread routinisation of hospice care which was

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[273] *ibid.*, pp.1370-71.

[274] I. Johnson *et al*, 'What do Hospices do? A Survey of Hospices in the UK and Republic of Ireland' (1990) 300 *BMJ* 791, p.793.

[275] D. Clark and J. Seymour, *op. cit.*, pp.118-124.

being suggested.[276] Seale reported how in a comparison of interviews with relatives and others of 45 patients who had received hospice care and 126 who had received conventional hospital care, there existed a clear difference in terms of the participants' satisfaction levels between the two environments, with hospice care being viewed as superior in many important respects including the standard of nursing care received. Likewise medicalisation claims need to be verified. For instance, in response to the claim that medicalisation is evidenced by the finding that patients are more likely to undergo invasive procedures in hospices where there is permanent consultant or medical director, one of the researchers involved in the study in which that trend was identified has argued that it is by no means clear from the study that the procedures undertaken were not done in all propriety. The data just does not yield that information: 'one can only say from it that technology is used [more often]. It could be on the other hand, in palliative care units where technological interventions are not on offer, that patients are being denied potentially useful tests and therapies'.[277]

It is worth noting here that the issue of increased intervention is further clouded by research examining the preferences of hospice patients themselves with regard to this matter. In 1997 Meystre *et al*[278] surveyed 23 hospice patients with advanced cancer and 18 hospice nurses about a series of different procedures of increasing invasiveness. Patients were asked whether they would wish to undergo the procedures; nurses how appropriate they thought the procedures were. The interventions ranged from having temperatures taken, to undergoing an operation and the survey culminated in a question about whether, in the event of the patient's heart stopping, resuscitation would be wanted/thought appropriate. The results make for interesting reading. What was found was that the patients were consistently more likely to accept investigations and invasive procedures than were the nurses, with the greatest divergence of opinion found in relation to resuscitation: 12 patients were in favour of the procedure, but none of the nurses. The authors concluded their study by noting, in similar vein to the above commentator, that 'care must be taken to ensure that the judgments and attitudes of staff are not denying patients the opportunity of simple tests or therapeutic interventions from which they may obtain clinical benefit'. Clark and Seymour quite rightly remark that these results 'pose a challenge to the de-medicalisation lobby, given the ethics of individual choice, autonomy, and empowerment' which are in question.[279]

Clearly then, the routinisation/medicalisation thesis is more complicated than some commentators would have us believe. Given the current state of research in this area, it seems that it is simply not possible to say definitively either that hospice care has, or has not been,

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[276] C. Seale, 'A Comparison of Hospice and Conventional Care' (1991) 32 *Social Science and Medicine* 147.

[277] Ahmedzai, cited in D. Clark and J. Seymour, *op. cit.*, p.122.

[278] C.J. Meystre *et al*, 'What Investigations and Procedures do Patients in Hospices want? Interview based Survey of Patients and their Nurses' (1997) 315 *BMJ* 1202.

[279] D. Clark and J. Seymour, *op. cit.*, p.122.

compromised in its original aims and objectives.[280] Nevertheless, I suspect that a certain degree of drift must have occurred. Weber's analysis speaks too much common sense to believe otherwise. If this is true, then here we see one of the ways in which the hospice response to the questions thrown up by terminal illness and the desire to die a 'natural'/'tame'/'good' death may be an inadequate one. If the movement has become more routinised and medicalised, it seems fair to say that the hospice way of dying might not provide as much of an alternative to hospitalised dying as many of its proponents would suggest—it would certainly seem to provide less of an alternative than the right to an assisted death. However, broad sociological critiques provide only one of the weaker reasons why the hospice movement does not obviate the need for a right to assisted dying; so let us now move on to consider some of the stronger reasons.

One of the major criticisms that is made of the hospice movement is that it can facilitate a superior dying experience, but only for a minority of individuals. Writers have described how hospices provide a 'de luxe'[281], '5 star'[282] or 'Rolls Royce'[283] standard of terminal care; in doing so they imply that death for the great majority of the population will be a far less satisfactory affair. In considering this charge, it is necessary to look both at the general availability of hospice and palliative services, i.e. whether there is adequate coverage in terms of units, beds, staff, etc., but also it will be appropriate here to consider the way in which such services are reserved almost exclusively for those suffering from far advanced cancer.

The most comprehensive data available on the general provision of hospice care in the UK is that found in *The Palliative Care Survey 1999*.[284] Published by the National Council for Hospice and Specialist Palliative Care Services, this document was the result of two surveys which were commissioned by the Department of Health to obtain a picture both of the current level of provision of palliative care, and of Health Authorities' views on the adequacy and need for such services. On even the briefest of perusals, the report makes for disturbing reading. Not only does it show an abject national deficiency of palliative care services, but also it highlights the disparities that exist in the provision of palliative care between different areas. The key findings are summarised at the front of the document. They show, *inter alia*, that in England, 52 per cent of Health Authorities considered their in-patient services to be inadequate; 55 per cent thought their home care services were deficient; and 41 per cent believed there were not enough day care places available within their area. Although the report notes that the survey does not allow for objective measures of comparison between Health Authorities about what constitutes 'adequate'

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[280] As Clark and Seymour note, there is a need for 'further elaboration of the theses through an attention to empirical evidence, which may yet reveal some complex institutional and professional processes at work'. *ibid*., p.124.

[281] *ibid*., p.124.

[282] *ibid*., p.95.

[283] J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), p.180.

[284] National Council for Hospice and Specialist Palliative Care Services, *The Palliative Care Survey* 1999 (London: NCHSPS, 2000).

services, the overall message is nevertheless clear: '96 per cent of Health Authorities described their palliative care services as not yet adequate across the board. 15 per cent thought that they were struggling in developing all service components'.[285]

Considering the report's findings on the actual volume of provision, it becomes apparent that the Health Authorities could not, without resorting to disingenuousness, have responded any differently: their perceived picture of things did not distort the reality but rather reflected it. Taking England as a whole, the report found that per million of the population there were just 51 in-patient beds, 21 home care nurses (expressed in whole time equivalents), and 13,088 available day care places. As national statistics, clearly these figures are far from reassuring, especially when one considers that the rate of cancer deaths for England as a whole is 258 per 100,000 of population. The picture worsens when the report comes to detail the volume of service provision per NHS region. Where you live can make a huge difference to the level of palliative services you can expect. For example, it was found that there were 82 per cent more in-patient beds in the North West and South East than there were in the Trent region; that there were 131 per cent more day care places available in Trent than in London; and that there were around 83 per cent more home care nurses in the South West than there were in the Eastern region. The report notes that although some divergence is to be expected, to take account of factors such as the local cancer death rate and levels of social deprivation (which can influence whether the terminally ill individual will be more or less likely be cared for in his own home), 'it is unlikely that such a large variation reflects actual differences in aggregate health needs of the populations'.[286]

This problem of inequity of access is compounded by the overwhelming tendency of the hospice movement to concentrate its efforts on cancer illness to the exclusion of almost all other terminal conditions. Although Cicely Saunders herself has expressed the view that her original vision was much broader based than has subsequently been interpreted,[287] the fact is of the 59,000 new patients who were admitted to an in-patient unit in the UK in 2002, 95 per cent were suffering from malignancy.[288] Though most hospices include within their remit the care of patients suffering from a handful of other conditions such as multiple sclerosis, motor neurone disease and AIDS, anecdotal evidence suggests that the priority given to these illnesses is not high. For example, Lawton observed that in the hospice where she conducted her fieldwork, by the end of her study admissions for non-cancer respite patients had been stopped altogether. 'Both the hospice doctors and the NHS management argued that the young chronically sick were "constipating the service", by "blocking beds" and "draining scarce nursing time and resources"

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[285] *ibid*, p.2.

[286] *ibid*., pp.3, 4, 5.

[287] Saunders and Baines, cited in D. Clark and J. Seymour, *op cit*., p.94.

[288] DoH Information Sheet, *Palliative Care and Hospice Care* (London: DoH, 2003), downloadable at: http://www.doh.gov.uk/cancer/supportandpall.htm. See also A. Eve *et al*, 'Hospice and Palliative Care in the UK 1994-5' (1997) 11 *Palliative Medicine* 31, finding that 96.7 per cent of patients admitted to in-patient services had cancer.

away from more "pressing" and "deserving" cases'.[289] In Lawton's hospice, the change in policy was being impelled by harsh economic factors. The hospice had started its life as a 25 bed unit, but about a year before Lawton arrived six of the beds were cut; a further three were slashed during the course of her study. In both cases, the cutbacks resulted from the decision of the Health Authority to allocate a larger proportion of its palliative care budget to primary care services. This is a trend which seems to be an inevitable and inexorable consequence of the hospice movement's closer ties to the mainstream NHS structure. In spite of much trumpeted cash injections from central government and the setting up of ring-fenced palliative care funds,[290] the evidence on the ground is that in-patient hospice facilities are becoming harder and harder to sustain. Indeed, some commentators have sceptically suggested that it is for these cold economic reasons—and not, as some would have it, a recognition of the fact that most people would people prefer to die at home—that the emphasis of palliative care has shifted in recent years to the provision of more extensive home care and day care services; as Lawton notes it might be that the alleged preference for home dying is nothing more than 'a form of rhetoric congenial to policy makers and planners promoted by them because it is a more cost effective form of care'.[291]

But it is not purely for financial considerations that hospice care is reserved for those suffering with cancer. Although a full and clear picture has yet to emerge, it seems likely that the special status accorded to patients with advanced malignancy stems from a complex of reasons relating both to the way that cancer death resonates with society as epitomising our fears about illness and death, 'striking at random the young and the old, requiring radical and sometimes disfiguring surgery and drug treatments, causing apparently intractable pain';[292] but also to the nature of the trajectory of the disease in its final stages, which usually allows for life expectancy to be predicted with a reasonable degree of accuracy.[293] Of course, some writers have noted that the narrow focus of hospice care has had a lot to do with the movement's success: it has allowed hospice professionals to concentrate on a limited range of symptoms and social and emotional problems,

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[289] J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), p.123, citing a study which found that caring for dying people at home works out as between one-quarter and one-third of the cost of an in-patient bed: H. Taylor, *The Hospice Movement in Britain: its Role and its Future* (London: Centre for Policy and Ageing, 1983), p.15. Although it should also be noted that there is 'some evidence that up to twice the resources are needed to support patients at home in areas of acute deprivation compared with the most affluent areas': *The Palliative Care Survey* 1999, *op. cit.*, p.5.

[290] See, for example, the DoH's *NHS Cancer Plan for England* (London: DoH, 2000), ch.7, where the Government pledged to invest an additional £50 million per annum in specialist palliative care, including in-patient hospices, by 2004.

[291] J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), p.122.

[292] N. James and D. Field, *op. cit.*, p.1365.

[293] For a good meta-analysis of the research in this area, see P. Glare *et al*, 'A Systematic Review of Physicians' Survival Predictions in Terminally Ill Cancer Patients' (2003) 327 *BMJ* 195, where it was found that although doctors' survival predictions are not very reliable when patients are admitted to hospices, with doctors often overestimating survival times, closer to death predictions become much more accurate, a trend referred to as the 'horizon effect'.

and to develop exemplary skills, techniques and even new technologies.[294] But, whatever the benefits of, and explanations for this narrow focus, the upshot is that patients who do not have cancer are not receiving the same standards of palliative care as those who have, and I would concur with the carefully chosen words of Clark and Seymour: 'In some senses, people dying with cancer are now relatively advantaged in terms of palliative care provision *vis-à-vis* those who die from other conditions'.[295]

The question is, then, how likely is it that those who are unable to access hospice or specialist palliative care services—either through a general lack of provision or because of the type of disease they happen to be suffering—will be able to achieve a 'natural'/'tame'/ or 'good' death in the alternative environment for dying, the general NHS hospital? The answer to this question is by no means clear. I would certainly not want to suggest that it is impossible to achieve a good death in hospital, because from personal experience I have seen that given the right circumstances it can be possible; there is also a limited amount of observational research to support this conclusion.[296] However, the great weight of evidence seems emphatically to indicate that this is very much likely to be the exception rather than the rule, and that in most cases a hospitalised death will fall significantly short of the ideals of the good death. Both in the UK and in other countries such as Australia, studies have shown again and again that the principles of hospice and palliative care are not yet being implemented to sufficient degree in the hospital setting.[297] The reasons for this, of course, hardly need stating: on the acute hospital ward there is neither the time nor the resources to help people come to terms with their death; it is all that most ward staff can do to make sure that the patient's basic medical needs are met. But then, where does this leave us?

It seems that the hospice movement and the hospice way of dying remain to the vast majority of the population somewhat of an irrelevance—or if not an irrelevance, then something worse. For though the hospice movement fails to improve the *reality* of dying for most individuals, it has nonetheless 'become a central point of reference for popular *expectations* of dying and standards

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[294] C. Saunders, 'Foreword', D. Doyle *et al* (ed.), *op. cit.*, p.viii; N. James and D. Field, *op. cit.*, p.1367.

[295] D. Clark and J. Seymour, *op. cit.*, p.95. For discussion of how hospice principles might be extended beyond cancer care to cover another specific disease, see: L. Gibbs *et al*, 'Dying from Heart Failure: Lessons from Palliative Care' (1998) 317 *BMJ* 961; C. Ward, 'The Need for Palliative Care in the Management of Heart Failure' (2002) 87 *Heart* 294; R.H. Sloan, 'Palliative Care can be useful in Cardiovascular Disease' (2002) 324 *BMJ* 1035. For discussion of how the focus of palliative care should be broadened generally, see J. Addington-Hall, *Reaching out: Specialist Palliative Care for Adults with Non-Malignant Disease* (London: NCHSPCS, 1998).

[296] Which is reviewed by Clark and Seymour, *op. cit.*, p.120.

[297] P. Edmonds and A. Rogers, 'If only Someone had told me: a Review of the Care of Patients dying in Hospitals' (2003) 3 *Clinical Medicine* 149; J. Pincombe *et al*, 'No Time for Dying: a Study of the Care of Dying Patients in Two Acute Care Australian Hospitals' (2003) 19 *J of Palliative Care* 77; R. Smith, 'A Good Death' (2000) 320 *BMJ* 129; see also letters responding to this editorial at (2000) 320 *BMJ* 1205; C. Seale and M. Kelly, 'A Comparison of Hospice and Hospital Care for People who Die: Views of the Surviving Spouse' (1997) 11 *Palliative Medicine* 93; C. Seale, 'A Comparison of Hospice and Conventional Care' (1991) 32 *Social Science and Medicine* 147; M. Mills *et al*, 'Care of Dying Patients in Hospital' (1994) 309 *BMJ* 583.

of care at the time of death'.[298] So people's hopes are raised but then dashed. What I now want to suggest though is that, even for those who do die in hospices and who do have access to specialist palliative care, the ideals of the good death might not always be attainable. For there are cases where the hospice pledge to help people die peacefully and to help them live until they die, simply cannot be realised. There are some patients for whom even the most sophisticated palliative techniques can offer little comfort. Particularly with certain types of aggressive cancer, the pain and suffering just cannot be ameliorated. To say this may seem a platitude: that some individuals will have an horrific ending to their lives is a truth that few people would dispute. But do we really understand what this means? Healthcare professionals working in the field might, but what about the rest of us? What about the lawyers, the politicians and the philosophers, all of whom eagerly contribute to the assisted dying debate, perhaps without really comprehending what rests on its outcome? To end this section, I shall draw on Julia Lawton's work concerning the 'fundamental, non-negotiable bodily realities of dying',[299] to show not only the degree of suffering that some patients have to go through in spite of the best hospice care, but also how these bodily realities call into question the hospice idea that patients will be able to live right up until death.

The non-negotiable realities of certain types of deaths

Lawton presents a case study of a patient she observed during her fieldwork, who she calls Annie.[300] Annie had been diagnosed with a cancer of the cervix, but following surgery and a course of radiotherapy it was believed that she had made a full recovery. However, 10 months after the initial diagnosis a smear test revealed a large recurrence which was later found to have spread to the pelvic wall. Annie was told by her doctor that there was little further that could be done for her, the cancer by this point being too far advanced.

Initially, Annie managed well at home with regular support from both District and Macmillan nurses. At this stage, her greatest problem stemmed from the development of severe oedema in both her legs which caused her to become bed-bound; but following lymphoedema treatment, she once again became ambulant enough to take herself to the bathroom, although on the whole she remained confined to her bed. Soon after this, however, her condition deteriorated rapidly. Annie developed a recto-vaginal fistula, which meant that her urine and faeces started exiting through the same passageway. It was at this point that she was admitted to Lawton's hospice for symptom control, as she was experiencing faecal leakage. Although Annie had originally expressed reservations about being admitted, she finally accepted that it was necessary, both

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[298] Clark and Seymour, *op. cit.*, p.79, emphasis added.

[299] J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), chs. 3 and 4; J. Lawton, 'Contemporary Hospice Care: the Sequestration of the Unbounded Body and "Dirty Dying"' (1998) 20 *Sociology of Health and Illness* 121.

[300] Annie's case is to be found at pp.124-127 of Lawton's article and pp.124-128 of her book. It is related here slightly abridged but largely in Lawton's own words.

because she could see the strain that her illness was putting on her elderly husband and because she felt deeply distressed and embarrassed about her family witnessing her bodily degradation first hand.

Annie was placed on a communal ward, and to start with she remained sufficiently mobile to take herself independently to the toilet and bathroom. She remained stubbornly self-caring even though she would sometimes have to spend up to an hour cleaning herself after using the toilet. About ten days into her admission, however, Annie deteriorated further. Her fistula enlarged substantially and, as a result, every time she attempted to get up out of bed, diarrhoea would pour straight out of her body. Consequently, Annie had to start using a commode on the ward rather than walking to the toilet. In addition, she contracted a bladder infection which caused her urine to develop an extremely offensive odour. Lawton notes that it was about this time that Annie's bodily deterioration began to have a significant impact on the hospice as a whole. Whenever she used the commode, the smell would penetrate right through the building. Although staff would constantly burn aromatherapy oils, this did little to mask the stench and other patients complained that the smell was making them nauseous.

Annie became increasingly anxious about the possibility of being discharged home. Although she felt that she had lost all sense of dignity in the hospice, she also stressed that she did not wish to be returned home, so that her family would have to witness her condition. At a multi-disciplinary meeting to discuss her case, the Senior Consultant at the hospice argued that (in spite of the shortage of beds) it would be cruel and futile to press for discharge; none of the other staff challenged this, and Annie and her family were told that she could remain in the hospice until she died.

Annie's condition continued to worsen. As one of the nurses put it, she just 'rotted away below'. As a result, she suffered continuous bouts of incontinence and it proved impossible to keep her sheets clean and fresh. On several occasions when the nurses attended her they found her to be covered to her shoulders in urine and excrement. By this stage, the problem of smell had become a continuous one, and staff were growing increasingly concerned about the impact Annie's condition was having on the other patients. In spite of the hospice philosophy of an open confrontation with death and the policy of allowing patients to die on the ward, it was suggested to Annie that she might prefer the privacy of a side room. Annie, however, was adamant that she wanted to stay in the company of others. She was worried that if she were placed in a room of her own she would get lonely. This left the staff with the problem of what to do with the other patients. Although none of them were actually moved out of the ward because of Annie's presence, Lawton observed that when a patient died or was discharged their bed was left empty. Toward the end there were just two other patients remaining on the ward, one of whom was unconscious and remained unaware of her environment until her death; the other patient, however, was fully lucid and was deeply upset by Annie's condition. She eventually insisted on being discharged because of the smell, and made it clear that under no circumstances did she want to be returned to the hospice to suffer the same indignities.

On the morning of the patient's discharge, Annie became very upset and frightened. She was convinced that she must have committed some terrible sin in the past for which her God was now punishing her. She felt worthless and an object of other people's pity and, as the morning wore on, she became increasingly agitated as her diarrhoea escalated. At lunch time Annie asked to be sedated. Lawton notes that the staff fulfilled her request, but only after waiting till she had repeated it several further times, to make sure that this is what she really wanted. Annie was never to regain consciousness and remained heavily sedated until her death approximately a fortnight later. The day after she was first sedated, the remaining patient on the ward died; after this, staff felt they had no option but to move Annie to a side room to free up the beds. Annie's family agreed to this move without objection.

Annie's case, of course, is an extreme. Lawton notes that her death was in some respects remarkable because it was considered by staff to be one of the most distressing that had occurred within the hospice during the period that she was based there. Nevertheless, Lawton details the final days of several other patients who suffered similarly distressing endings, and she notes 'Annie's experience encompasses a number of features shared entirely or in part by the majority of patients receiving care within the hospice'.[301] Lawton's suggestion is that, it is increasingly the function of in-patient hospice units (as opposed to home care or day care palliative services) to deal with a particular sub-group of patients who have the most distressing symptoms of all, patients who Lawton describes as having bodies which are 'unbounded'. She writes:

> During the course of my fieldwork, the most common reason for a patient to be admitted to the hospice was for 'symptom control', a phenomenon which became increasingly marked after the number of beds were cut...Significantly, most symptoms requiring 'control' appeared to share a distinctive feature in common: they were associated with, or caused, a rupturing and breakdown of the surfaces of a patient's body. As a consequence, fluids and matter normally contained within the body were leaked and emitted to the outside, often in an uncontrolled and *ad hoc* fashion. Staff often employed metaphors such as 'falling apart at the seams' when referring to patients who were 'rotting inside' and being 'eaten away by their cancer'. Patients requiring symptom control thus had bodies which I will term here as 'unbounded', meaning the literal erosion of the patient's physical boundaries.[302]

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[301] J. Lawton, *The Dying Process: Patients' Experiences of Palliative Care* (London: Routledge, 2000), at p.124.

[302] *ibid.*, p.128.

Lawton concludes from her time in the unit that, no longer can hospices be seen as concerned with the care of the dying *per se* (or even with the care only of those dying from cancer) but rather with a certain type of dying, a demise which is too disturbing to be to be dealt with outside of the confines of the hospice. Contemporary in-patient hospices, she states, are increasingly becoming 'enclaves in which a particular type of bodily deterioration and decay is set apart from mainstream society...enabl[ing] certain ideas about "living", personhood and the physically bounded body to be symbolically enforced and maintained'.[303] As well as Annie's case, to illustrate her point Lawton describes one patient, Tony, who was admitted after he developed a facial tumour. Apart from causing a gross distortion of his features (Tony's left eye was gradually being pushed out of its socket), the tumour was also rupturing arteries in the nasal area, causing continuous nose bleeds which meant Tony had to have a bolus of cloth permanently attached beneath his nose. Similarly another patient, Marie, had a large tumour in the groin area. During her stay in the hospice it swelled to the size a rugby ball and on several occasions partially ruptured causing blood to spurt out onto the nurses attending her. The staff believed that both Marie and Tony were living with 'time bombs' which could see them bleed to death at any time.[304]

The suffering and deterioration of these patients would clearly be beyond the tolerance of most individuals. Although Lawton acknowledges that on a number of occasions it was possible successfully to treat even very severely 'unbounded' patients, it is not surprising that, where symptoms could not be controlled well, some individuals resorted to asking for help in dying. Lawton tells of the case of Dolly,[305] a patient with cancer of the colon who was admitted after she had become chronically incontinent. Dolly's husband told Lawton that every time she had had a bad bout of diarrhoea at home, she had literally begged him to help her end her life. Her requests for an assisted death continued during the first week of her stay in the hospice, staff being unable to bring her diarrhoea under control in spite of their best efforts. In addition, her tumour expanded causing her to go into obstruction: the cancer had blocked her colon and, as a consequence, digested food would reach the lower gut and then come back up as faecal vomit. Around this time, Dolly's behaviour was observed to change. She stopped asking for help to die and instead seemed to switch off completely: she stopped talking and when members of staff came to attend her she would close her eyes and totally ignore them. Lawton observed similar behaviour in a number of other patients, and notes that the same response has been observed elsewhere, for example amongst groups of Holocaust survivors. She points to studies which show how victims of the Nazi atrocities, overwhelmed by the suffering and helplessness of their situation, descended into a state of 'psychic death', or 'psychic closing off'.[306] Lawton believes it was the same desire

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[303] *ibid.*, p.124.
[304] *ibid.*, p.129.
[305] *ibid.*, p.131.
[306] D. Pines, *A Woman's Unconscious Use of her Body: a Psychoanalytical Perspective* (London: Virago Press, 1993), p.185; L. Langer, 'The Alarmed Vision: Social Suffering and the Holocaust Atrocity' (1996) 125 *Daedalus: J of the American Arts and Social Sciences* 47.

to 'switch off' or 'shut down' which led Annie to request sedation; she saw other patients try to achieve the same by refusing food and water.

The importance of Lawton's work on 'unbounded' patients is in the way it explicitly shows not only how the 'non-negotiable bodily realities of dying' can outstrip even the most advanced and ardent palliative care, but also how for some individuals the idea of living right up until death is simply not an option. For those unlucky enough to be destined for an appalling end, there will come a point in suffering after which the self simply will not be able to continue. Either by 'shutting down' or, more often, by narcotic-induced sedation, the patient will arrive at a state where to say that they are 'living' will mean little more than that they are biologically alive, their heart beating, their lungs respiring, their digestive system processing nutrients and expelling waste. Is this sort of minimal, biological life all that the hospice movement means when it talks about living right up until death? Surely not.

And so the question becomes: would it not be better to allow a patient to choose to die earlier, whilst life still meant something more? Would not an assisted death truly allow a person to live until they die? By choosing an end point before the non-negotiable bodily realities set in, an individual would be able to preclude the situation where, in order to avoid unbearable agony, the self has either to extinguish itself or be extinguished by drugs. True, this must mean that the individual will live a shorter life, but he might ultimately live more; and isn't this what the hospice movement is really all about: quality of life, not quantity? It is in this light, I believe, that the hospice movement and proponents of assisted dying can move closer together.[307] In contrast to what many hospice practitioners would suggest, assisted death should not be viewed as antithetical to the goals of hospice philosophy, but rather as a complementary strategy for fulfilling the hospice pledge in those cases where little further palliation can be offered to the patient other than a terminal sedation. Now, admittedly, if an individual is permitted to bring forward their death then there is always the possibility of a degree of error: both in that the suffering which was predicted might never in fact have arisen, or in that the person might get the timing wrong, choosing a point to die which is too early. If the avoidance of pain and suffering were the sole justification for a right to assisted dying, then the prospect of such mistakes might cause us to baulk at accepting the right. But it is not. The right of individuals to determine the timing and manner of death is also justified by arguments relating to dignity and autonomy. It is to these that we must now turn.

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[307] A similar sentiment is expressed by Biggs: *Euthanasia, Death with Dignity and the Law* (Oxford: Hart, 2001), p.157.

4. DEATH WITH DIGNITY

My starting point in this chapter is the idea of a 'dignified death', or a 'death with dignity'. What exactly is meant by such phrases? Most of us have at least some understanding, albeit intuitive. We appreciate that a death of this kind is preferable to a death which is 'undignified' or 'lacking in dignity', and we understand that the reason for this has something to do with our feelings about what is a suitable or proper way for a human to act and to be treated. But beyond this our grasp of the idea of a dignified death and why it is important is slight. The problem is that dignity is an exceptionally slippery concept, and this allows both those for and against a right to assistance in dying to avail themselves of it.[308] So, for example, the Catholic bioethicist Luke Gormally has written:

> The justifications of both voluntary and non-voluntary euthanasia are incompatible...with recognition of the ineliminable dignity of every human being; voluntary and non-voluntary euthanasia are radically incompatible with what we need to acknowledge if we are to live well with each other. And since recognition of that dignity is necessary to the very existence of justice in society, the criminal law should not accommodate, either by statute or judicial decision, the practice of either voluntary or non-voluntary euthanasia. The significance of our equality-in-dignity as human beings for justice in society is the fundamental reason, also, for maintaining criminal sanctions on aiding and abetting suicide.[309]

By contrast, in his *Life's Dominion*, Ronald Dworkin argues:

> Because we cherish dignity, we insist on freedom, and we place the right of conscience at its centre, so that a government that denies that right is totalitarian no matter how free it leaves us in choices that matter less. Because we honour dignity, we demand democracy, and we define it so that a constitution that permits a majority to deny freedom of conscience is democracy's enemy, not its author. Whatever view we take about...euthanasia, we want the right to be able to decide for ourselves, and we should therefore be ready to insist that any honourable constitution, any genuine constitution of principle, will guarantee that right for everyone.[310]

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[308] H. Biggs, *Euthanasia, Death with Dignity and the Law* (Oxford: Hart, 2001), pp.11, 29, 122

[309] L. Gormally, 'Walton, Davies, Boyd and the Legalization of Euthanasia' in J. Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge: CUP, 1995), p.115.

[310] R. Dworkin *Life's Dominion: an Argument about Abortion and Euthanasia* (London: HarperCollins, 1993), p.239.

Can such antithetical views follow from one and the same idea? Is it really possible for dignity to bear the weight of both these arguments? To answer these questions we need to be much clearer about what we mean by the notion of dignity.

The word dignity is derived from the Latin *dignitās*, from *dignus*, meaning worthy, deserving or fitting. The *Oxford English Dictionary* defines dignity as 'the quality of being worthy or honourable; worthiness, worth, nobleness, excellence'. Perhaps a more helpful definition, however, is that given by the *Collins English Language Dictionary*. This tells us that dignity can be: '(i) behaviour which is serious, calm, and controlled; used showing approval; or (ii) the quality of being worthy of respect'. The merit of this definition is that it highlights the key distinction between dignity as a virtue and dignity as a value. It is this distinction that I cast off from in this chapter.[311]

A. The distinction between dignity as a virtue and dignity as a value

Some people seem to personify the idea of dignity. If one were asked to think of an adjective to describe someone like Gandhi or Nelson Mandela, 'dignified' would never be far from the front of the mind. If we look, too, to the world of literature there are certain characters who immediately stand out. In Solzhenitsyn's novel *One Day in the Life of Ivan Denisovich*,[312] in which the author describes a typical day in a Siberian labour camp, the dignity of the hero Shukhov seems to be all-pervasive. What is it about these people, though, that make them such exemplars of dignity? What traits and behaviour make them, more than others, synonymous with the concept?

We may start by noticing that it is actually behaviour that matters. In all these examples, the dignity we see is related to the way the people have acted or conducted themselves. This is the idea of dignity as a virtue, an idea captured in Blackie's aphorism that 'the real dignity of a man

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[311] At the outset I should say a word about sources. Had this chapter been written just a few years back, my task would have been a great deal more arduous, simply because there was not a lot of material on which to build. The literature on dignity was both thin and widely scattered, making it difficult to construct any sort of coherent analysis of the subject. In 2001, however, this changed. Given that the most significant contributions to the subject had, up to this point, come predominantly from the fields of philosophy and theology, it was perhaps a little surprising that what is unquestionably one of the most thoroughgoing treatments of dignity then came along from two academic lawyers, Beyleveld and Brownsword. Nevertheless, their treatise, *Human Dignity in Bioethics and Biolaw*, has now set the standard in this area, and no future examination of the idea of dignity will be adequate if it does not take into account their project and either build on it or show where it is flawed. Those who have read Beyleveld and Brownsword will be able to see for themselves how much my thinking has been influenced by them. Their ideas permeate much of this chapter, often more subtly than it is possible to give express acknowledgement to without becoming repetitive. So I would just wish to profess my indebtedness to their work from the start. Yet there are dissimilarities and divergences between their work and mine. Most obviously, I distance myself from the Gewirthian anchoring of their project. This is not because I feel this to be a weakness of their work, but rather because Beyleveld and Brownsword's objectives are quite different from—more ambitious than—my own. What they are seeking to do, among other things, is show that the injunction to respect dignity is categorically binding, as a matter of dialectical necessity. My aim, on the other hand, is simply to examine what—under the most coherent account of dignity—the injunction to respect dignity (which is simply presumed) would be likely to imply, specifically in the context of a dignified death. The other main difference between their work and mine is that I have expanded—even if just slightly—on Beyleveld and Brownsword's account of dignity as a value, principally by examining the idea of humans as beings with fundamental interests, but also by going into a bit more detail about what it is to be an end in oneself.

[312] A. Solzhenitsyn, *One Day in the Life of Ivan Denisovich* (Harmondsworth: Penguin, 1963).

lies not in what he has, but in what he is'. Here, according to Beyleveld and Brownsword, dignity is found 'in the character of humans wrestling with the limitations of human finitude and the problems of social order'.[313] In situations of adversity, some people seem better able than others to adopt an attitude which is expressive of a good balance between, on the one hand, submission, and on the other, struggle. We think of Gandhi as dignified because his advocacy of *Satyagraha* was at once both a powerful statement of resistance and a rational realisation that violent opposition to the might of the British Raj would have been disastrous. We think of Mandela as dignified because of the way he stoically served his sentence on Robben Island while at the same time never losing sight of his goal of seeing the fall of *apartheid*. The dignity of Solzhenitsyn's character lies in his refusal to be outraged by the harsh conditions he must endure; again and again we see the balance Shukhov strikes between acceptance and defiance, as when he remarks 'What had he eaten for eight, no, more than eight years? Next to nothing. But how much work had he done? Ah!'[314]

In each of these cases, it is not 'mere' adversity that the individuals are faced with. Crucially, as Beyleveld and Brownsword point out, the backdrop of injustice colours our thinking.[315] Whether because of the tyranny of Stalinism, the prejudice of *apartheid*, or the illegitimacy of imperialism, we think of our examples as 'oppressed victims'. But that we should do so is not necessary, for the virtue of dignity may also shine through in cases where adversity arises through nothing more unjust than the ordinary vicissitudes of life. Take Diane Pretty, for example. The fact that the adversity which she faced stemmed from her own motor neurone disease did not stop many people from thinking that her campaign was particularly dignified. The way she took her case first through the UK courts, and then, ultimately, to Strasbourg just weeks before she eventually succumbed to her illness, seemed to epitomise the equipoise between struggle and submission. She had made her point as forcefully as possible, exhausted all avenues of appeal, but when the decision finally fell against her, she retreated from the public eye to die the death she had fought so hard to avoid, in private.

As Beyleveld and Brownsword show us, the idea of dignity as a virtue is intimately connected to the existential anxiety that is part and parcel of the human condition. As humans, we are conscious that we are physically finite beings; we know that our bodies will die and decay and that there is nothing that we can do to change this. Unlike lower animals, we are aware of our fate and our powerlessness to alter it. But, equally, we cannot be sure that death in this world marks the absolute end of things. As Beyleveld and Brownsword remark, 'No amount of observation of what happens to physical bodies other than our own at bodily death can tell us anything about what happens to the psyches presumed to exist in those bodies, unless we identify the having of

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[313] D. Beyleveld and R. Brownsword, *Human Dignity in Bioethics and Biolaw* (Oxford: OUP, 2001) (hereinafter B&B), p.58.

[314] *op. cit.*, p.43.

[315] B&B, p.60.

the self with observable behaviour'.[316] Some people do precisely this, of course. They would assert that when we talk about the self, the psyche, or whatever we wish to call it, we are simply talking about certain kinds of brain activity that, just like everything else about us, will cease utterly at the moment we die. But the fact is, at the current state of knowledge, this position is no more reasonable—i.e. provable—than to say that we have a self which might transcend our earthly bodies; and indeed, for what I would suspect is a large majority of people, this latter position is a great deal more comforting. There are some who may be prepared to accept the indifference of mere physical existence, but even in our increasingly secular world they are probably rarer than we think. We do not need to believe in a divinity to hope that the universe might be divine.

At any rate, for Beyleveld and Brownsword, it is this uncertainty (and unprovability) as to whether the self is mortal or immortal that must lead us to what they call a 'radical agnosticism'. Via an analysis of Kant's Moral Argument for God and Immortality and Leibniz's Theodicy, they reach the conclusion that humans, when attempting to resolve their existential anxiety, may neither utterly put their faith in God and an afterlife, nor adopt an attitude of wholehearted acceptance of final extinction and the ultimate meaningless of all things. Instead, we are 'rationally required to accept a radical agnosticism or questioning stance that compels [us] to live with open-eyed fear of extinction and mere hope of immortality'.[317] Now, this may seem a tall order—Beyleveld and Brownsword believe that 'on overwhelming empirical evidence about human psychology' it is only certain 'heroic' individuals who will find such a strategy realisable.[318] But this gives us a clue as to why the virtue of dignity is so universally admired in people. For what is the virtue of dignity if not a practical attitude that reflects just such heroism? The person who is able to embrace 'radical agnosticism' is very likely to be just the sort of person who, when faced with terminal adversity, will be able to strike an appropriate balance between struggle and submission; his scepticism will compel the former, his hope the latter, and he will face his fate with equanimity.

Thinking about dignity as a virtue then—as a way of conducting oneself in a manner that bespeaks this heroism—we clearly shed some light on what we can sometimes mean when we talk about a 'dignified death'. A person may increase the dignity of his dying if he neither gives in to death too easily, nor rails against it too hard. He must both heed Dylan Thomas's injunction to 'not go gentle into that good night', but equally he must ignore the poet's plea to 'rage against the dying of the light'. There are certain consequences that attach to this view of a dignified death. Some writers have suggested that if it is only the character of the individual person that is important, his ability to face his end with a degree of dispassion, then a dignified death will not be something that others such as health care professionals will be able to bestow on a dying

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[316] B&B, p.116.
[317] B&B, p.137.
[318] B&B, p.135.

person.[319] A dignified death, these writers would say, is a goal to be accomplished, a matter of personal achievement, something to be aimed for but which few actually attain.[320] This last point is certainly true: not all people can have a dignified death, for any number of reasons.[321] However, do we really accept that the dignity of a person's death can only ever be affected by the dying person's own conduct? Is it really true that the dignity of someone's death cannot be improved by third parties?

Even to ask these questions is to realise that dignity as a virtue does not exhaust our understanding of the concept of dignity. Often, to say that someone has died an 'undignified death' is to comment not on the character of the dying person, but on the way he has been treated by others. It is to say that we feel the dying person has in some way been affronted or disrespected, as for example if an elderly incontinent person was left to die festering in his own mess, or was treated as if he were a child. This brings us to the notion of dignity as a value, the idea suggested in the second part of the *Collins Dictionary* definition, that humans possess some quality deserving of our veneration.

The idea of dignity as a value is a powerful one indeed. Beyleveld and Brownsword show us that it is the notion which lies behind both the principal post-war human rights documents and what they call the 'new European bioethics'.[322] In the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (ICCPR) (1966), and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966), human dignity is explicitly referenced as a foundational value, the preamble of each instrument providing that 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world'. The ICCPR and the ICESCR further acknowledge that 'these rights derive from the inherent dignity of the human person'. The European Convention on Human Rights (1950), another of the main post-war documents, is tied to dignity by way of its preambular recognition of the Universal Declaration, and the European Court of Human Rights at Strasbourg has said on more than one occasion that 'the very essence of the Convention is respect for human dignity'.[323] By the 'new bioethics', Beyleveld and Brownsword mean those international instruments that have sprung up in recent years in direct response to the advances which have been made in the sciences, particularly in the areas of reproductive technology and genetics. As in the above 'general' human rights documents, in specific instruments such as the Council of Europe's Convention on Human Rights and Biomedicine (CHRB) (1997) and UNESCO's Universal Declaration on the Human Genome

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[319] P. Allmark, 'Death with Dignity' (2002) 28 *JME* 255.

[320] Biggs notes that this is a view of dignified death which is common in Eastern religions: H. Biggs, *Euthanasia, Death with Dignity and the Law* (Oxford: Hart, 2001), p.154.

[321] Most often, that death comes suddenly and so the dying person has no opportunity to face his end with dignity.

[322] B&B, chs. 1and 2.

[323] D. Feldman, 'Human Dignity as a Legal Value—Part I' [1999] *PL* 682, p.689; *Pretty v UK* Appl. 2346/02, (2002) 35 EHRR 1, para. 65.

and Human Rights, dignity is explicitly name-checked as the underlying value, the deeper philosophical justification for the rights contained therein. For example, in the preamble to the CHRB it is stated that the signatory parties resolve 'to take such measures as are necessary to safeguard human dignity and the fundamental rights and freedoms of the individual in the application of biology and medicine'.[324]

But, in spite of its power—or perhaps because of it—dignity as a value can be highly divisive. Remember, when we talk of dignity as a value, what we are talking about is the quality that humans possess which makes them worthy of respect. The trouble is people disagree as to what precisely that quality is; this in turn leads them to different conclusions as to what the protection of dignity should imply.[325] Beyleveld and Brownsword show that even between the general founding human rights documents and the new bioethics there is some degree of discord.[326] For the bulk of this chapter, therefore, what I shall be concerned with is trying to determine whether there is one view of dignity as a value which is preferable to others—i.e. more defensible—and what this means both for the protection of dignity in general, and specifically for the idea of a dignified death and the right to assistance in dying. There are five main headings that I shall work under: humans qua humans, dignity as consensus, humans as ends in themselves, humans as beings with interests, and humans as autonomous beings.

B. Dignity as a value

Humans qua humans

To most people, a human is worthy of respect because of the simple fact that it is a human and not some other creature, be it an animal or whatever else. However, though this position may be an acceptable, even commendable, one to take in the course of everyday affairs (and no doubt the world would be a much better place if only everyone did subscribe to this view), it has to be accepted that it is a position which is liable, at least within the realm of moral philosophy, to the oft-laid charge of 'speciesism'; for as John Harris explains:

> When we ask what makes human life valuable we are trying to identify features, whatever they are, which both incline us and entitle us to value ourselves and one another, and which license our belief that we are more valuable (and not just to ourselves) than animals, fish or plants. We are looking for the basis of the belief that it is morally right to

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[324] Indeed, the full title of the CHRB is the *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine.*

[325] As is perfectly illustrated by Ruth Macklin's editorial in the BMJ, 'Dignity is a Useless Concept' (2003) 327 *BMJ* 1419, and the online rapid responses which this piece provoked at http://bmjjournals.com/cgi/content/full/327/7429/1419

[326] See chs. 1 and 2, where the authors set out their views on 'dignity as empowerment' and 'dignity as constraint'.

> save the life of a person rather than that of a dog where both cannot be saved, and our belief that this is not merely a form of prejudice in favour of our own species but is capable of justification. So the features we are looking for, although they will be possessed by normal adult human beings, will not simply catalogue the differences between such beings and other creatures. Rather they will point to features which have moral relevance, which justify our preference for ourselves and our belief that it is right to treat people as the equals of one another and as the superiors of other creatures.[327]

By identifying the value of humans with the human species *per se*, so the argument goes, we engage in the same sort of reasoning as the bigot who apportions value to a person simply because of the race or sex that they happen to belong to (and cannot help belonging to), something which we all ought to recognise as morally unacceptable. This line of argument, which is most closely associated with the Australian ethicist Peter Singer,[328] might seem slightly eccentric, perhaps even amusing. Even some distinguished philosophers have baulked at the concept of 'speciesism' as a form of unjustified prejudice.[329] But Singer's views must be taken seriously, for they are seemingly impossible to refute unless one is prepared also to accept the less palatable consequences of an ethics of valuing 'one's own kind'. As Harris has powerfully put it, we could be forced to acknowledge that people may prefer, as a matter of public policy, 'their own kind' even if that was men rather than women, whites rather than blacks, gentiles rather than Jews.[330] So, it is clear that dignity can have nothing to do with our membership of the species *Homo sapiens*—at least that is, if we are unwilling to compromise on issues such as racial and sexual equality. But then, what else might it be that gives humans their special value?

Dignity as consensus

We might suggest that the reason we respect humanity is not because we are human beings as such, but rather because, as humans, we are capable of constructing a *consensus* that we are valuable. This, apparently, is the thinking behind the conception of dignity which underlies the 'new European bioethics'.[331] According to Beyleveld and Brownsword, in documents like the CHRB and the UNESCO Declaration on the Human Genome, dignity seems to be largely a matter of what the signatory states agree it to be, or, more accurately, what the states agree to be infringements of human dignity. On this view, dignity is about constraining the actions of individuals for the sake of protecting and promoting a *communal* ideal of the value of humanity; it

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[327] J. Harris, *The Value of Life* (London, Routledge, 1985), p.9.

[328] See his *Practical Ethics* (2nd Ed.) (Cambridge: CUP, 1993), ch. 3 and 'All Animals are Equal' in P. Singer (ed.), *Applied Ethics* (Oxford: OUP, 1986).

[329] M. Warnock, '*In Vitro* Fertilization: the Ethical Issues (II)' (1983) 33 *The Philosophical Quarterly* 238, p.242.

[330] Harris, *op. cit.*, p.24.

[331] B&B, ch.2.

is about setting limits to what may and may not be done within the bounds of civilised society. A general view has emerged in Europe that certain practices and techniques—e.g. cloning, the commercialisation of body parts, sex-based embryo selection, germ-line interventions, and the creation of chimeras—simply should not be allowed because they would be so deeply detrimental to our common understanding of who we are and what we are about.

There is, clearly, widespread agreement on these particular issues. However, there are compelling reasons to resist any conception of dignity that grounds the value of humanity in common consent alone. First, societies will be less well positioned to castigate other societies for practices and beliefs that, although within those other societies may not be viewed as infringements of human dignity, nonetheless seem obvious and gross examples of a failure to respect the value of persons.[332] Secondly, there are good arguments to suggest that proper consensus rarely exists in reality; and when it does, it is a notion which is morally empty without further justification. Beyleveld and Brownsword quite rightly make the point that, often, societal consensus will mean little more than what Mill called the 'tyranny of the majority',[333] that is, the exercise of power by that class or portion of society which happen to be the most numerous, or at least the most active in putting forward their viewpoint. Though they acknowledge that there are, in theory at least, ways in which a consensus-based conception of human dignity could arise that might not be open to such criticism—as, for example, where a society had taken part in some Rawlsian-type consultation exercise, so that the conception had been arrived at in conditions where all who would be bound by it were informed, rational, and able to make their views and opinions heard on an equal footing, without fear of coercion—in reality, Beyleveld and Brownsword think that, 'the processes by which collective values are articulated are somewhat less attractive'.[334] The best we can hope for from consensus in the actual world is majoritarianism. But, as Beyleveld and Brownsword are quick to note, majoritarianism does not necessarily amount to a moral position, for the well-known reasons that have been set out by Dworkin.

Writing in reaction to the famous Hart/Devlin debate,[335] Dworkin has argued that in order for majoritarianism to rise above bare prejudice or a communal taste for or aversion to a particular practice or belief, and to qualify as a moral position that should be respected, it must first satisfy certain formal conditions.[336] These are, first, that there must be reasons for the consensus which are based neither on prejudice (i.e. an arbitrary bias for or against some morally irrelevant characteristic of the type already considered such as race or sex, etc.); nor emotional reactions

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[332] Although, for a view to the contrary, see Joseph Raz's 'social dependence thesis' in his *The Practice of Value* (Oxford: OUP, 2003).

[333] B&B, p.44.

[334] B&B p.45.

[335] P. Devlin, *The Enforcement of Morals* (Oxford: OUP, 1965); H.L.A. Hart, *Law, Liberty and Morality* (Oxford: OUP, 1967).

[336] R. Dworkin, *Taking Rights Seriously* (London: Duckworth, 1977), ch.10, pp.248-253.

(not because moral positions are supposed to be unemotional, but because a moral position is supposed to justify the emotional reaction, and not vice versa); nor propositions of fact that are so implausible that they challenge the minimal standards of evidence and argument that one generally accepts and imposes on others (e.g. lying makes one's nose grow); nor the mere parroting of others' views (though of course the reasons for a consensus can be taught and learnt). Secondly, the reasons given must, if they are not disqualified on any of the above grounds, presuppose some general moral principle or theory that is both sincerely held and consistently applied. This is not to say there can be no exceptions or qualifications at all to the general principle, but these will be different from outright inconsistency in that they can be supported by reasons which presuppose some other moral principle or position that can be properly held. To illustrate the point, Dworkin offers the example of a consensus which condemns homosexuality on Biblical authority, but has nothing to say about the question of fornication which is also supposed to be outlawed by scripture. He asks, what reasons can be offered for the distinction? If none can be produced to support it, then the consensus cannot claim to accept the general position of Biblical authority. But if reasons can be produced, then they too must stand up to the same questions that were asked about the original claim that homosexuality should be condemned, i.e. they must not be disqualified reasons, and they must presuppose some general moral principle or theory which is sincerely believed in and consistently applied.

Dworkin points out that it is of course not the case that the satisfaction of these conditions is something which either individuals or a society must think about consciously. We do not, he states, have to articulate the moral principles or theories to which we subscribe explicitly: very few people can, and the ability to hold a moral position is not limited to them alone. But still, our reasons for taking a position, either individually or collectively, must *at some level* be capable of justification. Where they are not, then ultimately they cannot be taken as more than a compound of prejudice and personal aversion, which need not in any way bind people. As Dworkin warns, we must not confuse the idea that the community's morality should count with what should count as the community's morality.[337]

Taken together, these reasons are sufficient for us to distance ourselves from a conception of dignity that sees the value of humanity as based solely on societal consensus. Although I do not suppose that the new bioethics are in any way seeking to impose the 'tyranny of the majority', or to dress up intolerance and bigotry as a concern for respect for human dignity—it is quite clear that the CHRB and the UNESCO Declaration are *bona fide* attempts to reflect the genuine and widespread public concern that surrounds the issues that are the focus of both those documents—we should nonetheless impugn the new bioethics because there is no solid foundation for them to be respected. If we apply Dworkin's conditions to the European scheme, we see that it is very probable that the new bioethics would fall foul of both of his criteria. First, we

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[337] *ibid*, p.255.

cannot suggest that the reasoning behind the consensus at the heart of the new bioethics is that there is a widespread belief that there are certain things that should not be done to human beings *simply because they are human beings*, for, as we have seen, without more, this is a mere bias towards our species, something which in itself is a morally irrelevant characteristic akin to one's race or sex; such a position thus falls foul of Dworkin's condition that our reasons must not be based on prejudice. Similarly, it could not just be said that the reasoning behind the consensus related to some sort of widespread emotional revulsion at certain practices or scientific techniques, for this again is disallowed under Dworkin's scheme. Secondly, however, even if to say that all human beings should be respected and protected simply because they are human beings did not violate Dworkin's injunction against relying on reasons based on prejudice or emotional reaction, in any case this would still presuppose a moral principle that European society does not apply consistently. For as Beyleveld and Brownsword are at pains to point out, a central line of thinking under the 'new bioethics' (at least as found in the CHRB) is that all human life *from the moment of conception* has a value which must be safeguarded.[338] Yet across Europe, women are free, to a greater or lesser extent, to terminate unwanted pregnancies. Now, there may of course be reasons presupposing other moral positions which would, in some instances, transform this apparent inconsistency into a justifiable qualification or exception (such as that, where an adult woman's and a foetus's life are in the balance the woman's life must be given precedence, or, that a woman may terminate a pregnancy where there is a risk that the child will be born with a very serious disability). But, there are also surely examples of permissible abortions that cannot be so easily squared with the view that life at all stages should be respected (such as where a woman chooses to abort a pregnancy for so-called life-style reasons, or because the child has some minor remediable defect such as a cleft palate).

Humans as ends in themselves

Another way of looking at dignity as a value is from a Kantian perspective. On this view, the reason that we respect humanity and set limits to the way we treat people is not because of any societal consensus which there may be on such matters, although there may in fact be such a consensus, but rather because humans are always to be treated as ends in themselves. The reason that I refer to this as a Kantian perspective of course is that the requirement that humans be treated as ends in themselves has its origins in Kant's Categorical Imperative, specifically in the Formula of the End in Itself, that is: 'Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end.'[339] But what exactly is meant by this? To understand the Kantian injunction, we have to find out a bit more about the notion of an 'end in itself'. Fortunately, we are

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[338] B&B, pp.31-33.

[339] I. Kant, *Groundwork of the Metaphysic of Morals* (trans. H.J. Paton) (London: Routledge, 1991), p.91 (429).

in a good position to do this, for the idea of the end in itself has recently been subjected to a thoroughgoing analysis by Professor Joseph Raz in his series of Seeley lectures.[340]

Raz begins by highlighting some previous, unsuccessful attempts to explain what it is to be an end in itself. He quotes the following explanation from Robert Nozick, which equates an end in itself with something that cannot be used instrumentally:

> Side constraints upon action reflect the underlying Kantian principle that individuals are ends and not merely means...There is no side constraint on how we may use a tool, other than the moral constraint on how we may use it upon others...there is no limit on what we may do to it to best achieve our goals. Now imagine that there was an overrideable constraint C on some tool's use. For example, the tool might have been lent to you only on the condition that C not be violated unless the gain from doing so was above a certain specified amount, or unless it was necessary to achieve a certain specified goal. Here the object is not *completely* your tool, for use according to your wish or whim. But it is a tool nevertheless, even with regard to the overrideable constraint. If we add constraints on its use that may not be overridden, then the object may not be used as a tool *in those ways. In those respects*, it is not a tool at all. Can one add enough constraints so that an object cannot be used as a tool at all, in *any* respect?[341]

Nozick's account fails because he seems to think that if something has enough constraints set on it so that it may not 'in any respect' be used as a tool, i.e. may not be used at all instrumentally, then this must make it an end in itself. But, as Raz points out, Kant never says that ends in themselves cannot be used instrumentally. He only says they may not be treated '*simply* as a means', that they must be treated 'always *at the same time* as an end'. Nozick's definition is thus unsuccessful because, by insisting on exclusivity—that an object has the standing of an end to the extent that it is not a means to anything—he does not allow that ends in themselves may also concurrently have instrumental value for something or someone else.

Next, Raz rejects the view that an end in itself is tantamount purely to something which has intrinsic value. Intrinsic value is value which does not derive from a thing's instrumental value, but from its value *for its own sake*. For example, it is often asserted that great works of art, although they do have an instrumental value in that they may evoke feelings of pleasure or other sensations in the viewer, also have intrinsic value because they are valuable for their own sake (which is not the same as a thing being valuable in itself). Even if no one ever saw the Mona Lisa again, because it was locked away in some vault beneath the Louvre, we would still think it wrong

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[340] Delivered at Cambridge and subsequently published as J. Raz, *Value, Respect and Attachment.* (Cambridge: CUP, 2001). The examination of ends in themselves is found in the fourth lecture, 'Respecting People'.

[341] R. Nozick, *Anarchy, State and Utopia* (New York: Basic Books, 1974), pp.30-31.

for it to be destroyed or damaged in any way, because it has an intrinsic value. We acknowledge it as an unequalled example of the technique of *sfumato* – the blurring of the outlines and use of mellow colours, particularly around the eyes and mouth – which gives the picture its famous quality of mystery. And although this quality of mystery evokes in the viewer certain feelings, thus being constitutive of the instrumental value of the picture, it is also valuable for its own sake as a manifestation of the skill and knowledge of Leonardo, particularly his knowledge of how the human eye actually sees.[342] It was Leonardo who discovered that, by modelling the areas around the corners of the eyes and the mouth with light and shade thus leaving the viewer with something to guess at, the facial expression seems to come to life, and the viewer is left wondering whether Lisa is happy or sad, mocking or sympathetic.[343] Other things which are often said to have intrinsic value apart from any instrumental value they may have include the natural environment, friendships and happiness. But, Raz believes that ends in themselves, 'even if they are valuable in the same ways that all intrinsically valuable objects (such as good works of art) are, are *also* valuable in a different way...having value in virtue of an intrinsic feature is not sufficient to characterise being an end in itself.'[344]

So what, then, is sufficient to characterise being an end in itself? Raz thinks that 'we tend to equate being an end in itself with being of value in oneself, and take that condition as a ground for a certain treatment, that is, with respect'.[345] Being of value in oneself is different from having intrinsic value because, as well as 'having intrinsic features which endow one with unconditional value', to be of value in oneself there must further be 'a complete reason for treating its possessor with respect'.[346] To understand what is meant by this, it is necessary to reflect for a moment on the nature of value, about which Raz has this to say:

> It is inherent in the nature of value that whatever is valuable is either valuable for something or someone of value, or is valuable in itself. Clearly, whatever is valuable instrumentally, that is, because of its consequences, or likely consequences, or (as with things like tools, which are means to ends) because of the use which can be made of it, is so valuable because of its contribution to something else which is valuable. The same is true of most intrinsic goods [for reasons we shall see below]. Good works of art, friendships, games of tennis (when all of these are judged apart from their instrumental value), are valuable because they can be good for people...Whenever one thing is

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[342] It is not a valid response to say that, if the painting was locked away never to be seen again, then the manifestation of Leonardo's skill could never be appreciated and thus would have no value, because of course there can be a million reproductions of the painting which are available to be seen at any time. It is precisely the intrinsic value of the painting which explains why we think it wrong or a shame for the real Mona Lisa to be damaged or destroyed, but we would not feel the same if my reproduction poster were damaged or destroyed. The instrumental value of the picture cannot explain these different reactions.

[343] E.H. Gombrich, *The Story of Art* (16th ed.) (London: Phaidon, 1995), pp. 300-303.

[344] J. Raz, 'Respecting People', p.143.

[345] *ibid*, p.144.

[346] *ibid*.

> valuable or good for another we can explain how it is so. Replacing engine oil is good for engines for it makes them function better, in specifiable ways. Replacing water in the vase is good for the flowers because it makes them look attractive for longer. Inoculating the cat is good for it for it protects it from illness, etc. The explanation often points to, or presupposes, that what the good is good for is itself good because it is, or can be, good for someone or something else. Changing the oil is good for the engine, because a well-functioning engine is good for...However, this chain has to stop somewhere for any of its links to make sense at all. The conditional must come to rest with some unconditional good, we might say. Otherwise it will all be good for nothing. Whatever is good unconditionally is good in itself.[347]

Something which is good or valuable in itself is different, therefore, from something intrinsically valuable because, as well as having intrinsic value, it will also be an end point of the value chain. Of most intrinsically valuable things we will not be able to say this. However, as Raz notes, this does not mean that they are thus relegated to the status of things of instrumental value. To paraphrase his words, something which is intrinsically valuable is valuable for us because it is *valuable*, not valuable because it is valuable *for us*. Yet it would not be valuable unless it *could* be valuable for us, and for this reason it cannot be regarded as something valuable in itself, it cannot be an end in itself.[348]

Formally, Raz stipulates that to show of anything valuable that it is of value in itself it is sufficient to show that: '(a) there are things which are good for it, but (b) their being good for it is not conditional on it contributing to the good of something else'.[349] But, who or what is capable of being of such ultimate value? Raz's answer is that valuers are,[350] and he has three reasons for saying this. First, he points to what he calls the 'mutual but asymmetrical dependence of intrinsic goods which are good for someone and those which are unconditionally good, that is, good in themselves'.[351] It is Raz's contention that it is in the nature of intrinsically valuable things that they are there to be engaged with by those who are of value in themselves. If we return to the Mona Lisa, Raz would say that, although it is accurate to say that even if it were to be locked away forever never again to be seen by human eyes, it would still have intrinsic value, nonetheless it is true that, in such a scenario, the value of the painting would go 'unrealised' or would be 'wasted' in some way.[352] This, for Raz, is enough to satisfy criterion (a) above: 'If there are intrinsic values

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[347] *ibid*, pp.146-147.
[348] *ibid*, p.149.
[349] *ibid*, p.151-152.
[350] Though he notes that it is conceivable that other things may also be, *ibid*, p.152.
[351] *ibid*, p.154.
[352] This is not the same as saying that the painting has only a potential value. To say that an unseen painting has potential value is to confuse the work's intrinsic value with its instrumental value. Potential value is related to the latter, that is, to the value in terms of the pleasure or happiness that the painting could evoke in the viewer if it were it to be seen. To say that the painting's value goes unrealised, however, is to

whose realisation requires recognition, a recognition which being valuers they can give, then there are things which are, assuming that the valuers are good, good for them'.[353]

Of course, there are many instrumentally valuable things that can be good for valuers; these too would be able to satisfy criterion (a). However, Raz chooses to rely on intrinsically valuable things because, unlike objects of instrumental value, these, crucially, will also be able to satisfy criterion (b), that is, they will be good for the valuer but their being good will not depend on their contributing to the good of something else. As Raz puts it, 'To show that valuers not only play the role of being of value in themselves in relation to goods which are good for others, but that they actually are of value in themselves one has, secondly, to show that their good does not matter simply because it is good for someone or something else'.[354] Intrinsically valuable things fulfil this ask. The intrinsic value of a great masterpiece like the Mona Lisa will be conditional solely on the valuer's ability to appreciate that value. Raz writes: 'When I think of the different things which are intrinsically good for people, and which their ability to recognise value enables them to engage in, I cannot think of a way in which being enriched by values in many of these ways can be accounted for by the use that people may be to others...The appreciation of the arts, of sports, of the pleasures of gourmet food, provides but a few examples.' [355] Hence, valuers not only fill the role of what is of value for its own sake, but they do so as ends in themselves, and not because they are of value or are good for something or someone else.

The third and final part of Raz's argument is not so much a reason showing why valuers are ends in themselves, as an explanation as to why valuers are valuable in themselves not only when they engage with value in the way outlined, but also when they do not. Put simply, it is the *capacity* to engage with value which matters. Just as having intrinsic value consists in the value of something which *may* be engaged with in the right way but which, if it is not so engaged, the intrinsic value remains unaffected (though, perhaps, wasted or unrealised), so to have the capacity to engage with value in the right way and to fail to exercise this does not diminish the status of being someone of value in oneself.[356]

I have, in the discussion till now, been tacitly assuming that valuers are humans—and there is nothing wrong in this. However, Raz himself equates valuers with those who are capable of intentional action. He writes, 'Intentional action is action for reasons, that is, action undertaken in light of an appreciation of oneself and one's circumstances. It is a response to the (perceived) normative aspects of the world as they relate to one. That is why agents (i.e. those capable of intentional action) are valuers'. Raz further notes that, a valuer will be capable of 'directing one's

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comment on the *actual* intrinsic value of the art, which, because it goes unseen, is, as Raz says, somehow wasted.

[353] *ibid*, p.156.

[354] *ibid*.

[355] *ibid*, pp.156-157.

[356] *ibid*, p.157-158.

conduct and one's life, in light of one's understanding of those features of the world which are reasons, rather than merely reflex-responses to factors which are in fact not reasons'.[357]

It has taken a while to get here, but I can now make the point I wish to. That is that, if an end in itself is someone or something of value in itself, which in turn, as we have seen, turns out to be a valuer, where such is defined as someone capable of directing one's conduct and one's life according to reasons, then what we seem to have here is a definition of an end in itself that looks very similar indeed to that of an autonomous being. Now, if in saying that humans are valuable because they are ends in themselves what we mean is that humans are valuable as autonomous beings, then this is one thing and I shall set out my views on this very shortly. However, the difficulty is that the Kantian demand to respect humans as ends in themselves seems to involve something more than just recognising and respecting human autonomy.

Let us reiterate the Kantian injunction: 'Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end'. The problem lies in the command to treat humanity *in your own person* as an end. If we accept the idea that humans are ends in themselves because they are autonomous beings, then the logical conclusion which would seem to follow is that to treat humans as ends in themselves we should respect their autonomous choices, at least insofar as these choices do not impinge on the autonomous choices of others. However, this is resolutely not Kant's view. Famously, he thought that there are certain things that, if we are to treat humanity in our person as an end in itself, we are under a duty to choose not to do:

> [A]s regards the concept of necessary duty to oneself, the man who contemplates suicide will ask 'Can my action be compatible with the Idea of humanity *as an end in itself*?' If he does away with himself in order to escape from a painful situation, he is making use of a person merely as a *means* to maintain a tolerable state of affairs till the end of his life. But man is not a thing—not something to be used *merely* as a means: he must always in all his actions be regarded as an end in himself. Hence I cannot dispose of man in my person by maiming, spoiling, or killing.[358]

Kant's comments on suicide are obviously of especial relevance for the present discussion. However, the point I wish to make here is one of more general application, about the very plausibility of owing duties to oneself. It has been argued by some commentators such as Marcus Singer[359] that the idea of owing a duty to oneself involves an ineluctable contradiction. What we

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[357] *ibid*, p.153.

[358] I. Kant, *Groundwork of the Metaphysic of Morals* (trans. H.J. Paton) (London: Routledge, 1991), pp.91-92 (429).

[359] M.G. Singer, 'On Duties to Oneself' (1959) 69 *Ethics* 202; this article prompted a flurry of five further pieces by other writers who criticised the arguments Singer had made: D. Kading, 'Are there really no Duties to Oneself?' (1960) 70 *Ethics* 155; W. Wick, 'More about Duties to Oneself' (1960) 70 *Ethics* 158; M.

call 'duties to oneself', Singer argued, are either not genuine moral duties at all, or, if they are, they are not duties to oneself. Singer's conclusion was based on the following three propositions. (1) If A has a duty to B, then B has a right against (or with respect to) A; (2) if B has a right against A, he can give it up or waive it and release A from the obligation; (3) it is essential to the nature of an obligation that one cannot release oneself from it by not wishing to perform it, or by deciding not to perform it, or indeed, in any other way—only another person can release one from an obligation. From this, Singer argued, it followed that if one could have a duty to oneself, then one would have a right against oneself, but, because one could waive that right at any time, one could release oneself from the obligation, meaning that the duty was only a duty insofar as one wanted it to be, which is tantamount to no duty at all. Singer concluded that to say someone has a duty to oneself to do a particular thing is no more than an emphatic way of asserting that he is free to do that thing, and that it might be foolish or imprudent for him not to. He noted, 'to suppose that one can actually have a moral duty to oneself, in any literal sense, is to confuse both a right to do something with a duty to do it, and an imprudent act with an immoral one'.[360]

In fairness, Kant had anticipated an argument such as Singer's.[361] But the way in which he refutes it will, I think, for many people be unacceptable. Basically, Kant thought that humans must be understood as dualistic beings, having both what he called a 'noumenal' and a 'phenomenal' aspect. According to Kant, duties to oneself are possible because the 'I' which imposes the duty is a perfectly rational being belonging to the 'intelligible world' (*Homo noumenon*), whereas the 'I' upon whom the obligation is imposed is an imperfectly rational being, subject to all of the impulses, desires and interests that ordinarily affect humans in the real or 'sensible world' (*Homo phaenomenon*). As Beyleveld and Brownsword put it, 'Kant holds that *homo noumenon* claims a right against *homo phaenomenon*, who is placed under a duty that *homo phaenomenon* cannot waive'.[362] Now, I do not intend to get into detailed arguments about Kantian dualism, which are best left to the Kant scholars; but I will say this much. Acceptance of Kant's thinking on duties to oneself seems to require acceptance of a very sterile and, still more, very staid view of human nature. The suggestion is that it is the task of the perfectly conformist, super-reasonable *Homo noumenon* to take the wayward, individualistic *Homo phaenomenon* firmly in hand and subject it to strict rational control. But, do we really want to go along with this? Are we really prepared to dismiss our flesh and blood phenomenal selves as merely the impetuous child in constant need of reining-in by his serious elder brother, the ideally rational self? It seems to me, and other commentators such as Michael Neumann,[363] that if we agree with this then we surrender almost

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Mothersill, 'Professor Wick on Duties to Oneself' (1961) 71 *Ethics* 205; F.H. Knight, 'I, Me, My Self, and My Duties' (1961) 71 *Ethics* 209; W. Wick, 'Still More about Duties to Oneself' (1961) 71 *Ethics* 213. To these, Singer powerfully replied in 'Duties and Duties to Oneself' (1963) 73 *Ethics* 133.

[360] (1959) 69 *Ethics* 202, p.203.

[361] I. Kant, *The Metaphysics of Morals* (trans. M. Gregor) (Cambridge: CUP, 1996), pp.173-174.

[362] B&B, p.109.

[363] M. Neumann, 'Did Kant Respect Persons?' (2000) 6 *Res Publica* 285.

everything about us that makes us truly human. As Neumann remarks, 'Rational selves [*Homo noumenon*] are, for all practical purposes, rational automata...Dissent and diversity, different drummers and different goods, are not part of the agenda. Each person is self-legislating, but the self-legislated rules are always the same'.[364]

There are at least doubts, then, about the view that humans should be respected because they are ends in themselves—at least where this is taken to imply that humans owe a duty to respect humanity in their *own* person and must thus be constrained in respect of certain self-regarding actions. The implications of these doubts could, potentially, be very far-reaching. Were they substantiated, not only would the Kantian objection to suicide and assisted dying fall, but so too (were they to be interpreted in a Kantian rather than a consensus-based light) would certain provisions of the 'new European bioethics', for example the ban on the commercialisation of human body parts.[365] But, alas, these are matters for others, for we presently need to move on to consider the view that the value of humanity might lie not in the fact that humans are ends in themselves, but rather in the fact that humans are beings with certain fundamental interests.

Humans as beings with interests

The interest theory of human dignity associates the value of humanity with the fact that humans have certain fundamental interests, interests that ought to be respected and protected via certain fundamental rights. The interest theory has its powerful advocates,[366] most of whom view themselves as opponents of what they take to be the rival, and less satisfactory, 'autonomy-based' account of dignity and rights. But against the interest theory it is possible to raise several important objections.

To start with, an interest theorist has to specify exactly which interests should matter to dignity. In other words, which interests will be deemed sufficiently weighty to warrant being called fundamental, in consequence of which they must be respected and protected by rights? Clearly not just any old interest will do. I cannot, for example, say that my interest in travelling in an empty tube carriage in which I can quietly read my book is sufficient to entitle me to a right to travel in such fashion, so that all other passengers would be obligated to me to move into another carriage. As much as I might like this, such an entitlement would of course be absurd. To recognise that such an interest could ground such a right would be to embark on the short and straight path to the trivialisation of rights which, as I remarked in the introductory chapter, I am so keen to avoid.

While some particularly austere interpretations of the interest theory might deny that the theory needs to be specific in this way, stating that it is enough to know only that some interests will be

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[364] *Ibid*, p.295.
[365] On which see B&B, pp. 33-38.
[366] Among them Neil MacCormack, Matthew Kramer and, in his own way, Peter Singer.

weighty enough to ground rights,[367] most interest theorists, finding such an approach unacceptably formal and insubstantive, tend to suggest that an interest will ground a right only if the interest is one which correlates to some sort of basic human need. This rules out the prospect that trivial interests might ground rights because, as James Griffin has put it:

> One can distinguish adventitious needs that persons acquire in virtue of their choosing one particular goal rather than another (if I were to decide to plant a bomb, I should need cool nerves) from needs that arise from goals that in a sense are not chosen but are characteristic of human life generally. As human beings, we need food simply in order to survive. Though in special circumstances survival can become subject to choice, in normal circumstances it is not; survival is, rather, what human life characteristically aims at. Human beings, as such, need air, food, water, shelter, rest, health, and companionship.[368]

Clearly, though, the essential problem remains. We have merely reformulated the question 'what *interests* will be sufficient to ground rights?' as 'what *basic needs* will be sufficient to ground rights?' The difficulty is, one man's basic need is another man's luxury. Griffin wonders 'Is interesting work a basic need? Well, without it, alienation, a kind of social pathology, results. Is education? Well, without it one's intellect will atrophy. And how much education is a basic need?'[369] The risk of trivialisation has not gone away. To say this is not to conclude that the rights to interesting work and a decent education are trivial—though they certainly are contestable—but simply to suggest that the idea of basic necessity is one that is too malleable, too open to subjective construction, even when what we are talking about are goals that are characteristic of human life generally.[370]

But even if we could adequately delimit the scope of basic needs in such a way as to avoid the risk of trivialisation, the interest theory would not be without other problems. One consequence of linking dignity to the fact that humans have certain fundamental interests is that, in rare circumstances, some humans will have no dignity, because they have no interests, and this is

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[367] See M.H. Kramer, 'Rights without Trimmings' in M.H. Kramer, N.E. Simmonds and H. Steiner, *A Debate over Rights: Philosophical Enquiries* (Oxford: Clarendon, 1998), especially at p.79.

[368] J. Griffin, 'Do Children Have Rights?' in D. Archard and C. Macleod (eds.) *The Moral and Political Status of Children* (Oxford: OUP, 2002), p.25. See also Martha Nussbaum's so-called 'capabilities approach' (which, though not identical to the interest theory, is very closely related to it). See in particular her *Women and Human Development: the Capabilities Approach* (Cambridge: CUP, 2001) and 2002 Tanner Lectures, which have subsequently been published as *Frontiers of Justice: Disability, Nationality, Species Membership* (Cambridge, Ma: Belknap, 2006).

[369] J. Griffin., *op. cit.*

[370] The point would have been better made, perhaps, if Griffin had focused instead on the basic need for health. How much health is a basic need? What would a right grounded in this need entail? While those in some developing countries might be content to an entitlement to penicillin and other such basic medicines, those in Beverly Hills might protest if such a right did not allow them access to botox injections, on the ground that having wrinkles could have a serious deleterious effect on their psychological well-being.

true even if they do still have certain basic bodily needs such as those for food and water, which is another reason to doubt the value of relying on the idea of basic necessity. Consider for example the deep persistent vegetative state (PVS) cases such as that of Anthony Bland. With characteristic insight, Lord Mustill penetrated to the heart of the matter when, in considering whether it could be said to be acting in Bland's best interests to withdraw the artificial nutrition and hydration by which he was being kept alive, he noted that:

> [Anthony Bland] feels no pain and suffers no mental anguish. Stress was laid in argument on the damage to his personal dignity by the continuation of the present medical regime, and on the progressive erosion of the family's happy recollections by month after month of distressing and hopeless care. Considerations of this kind will no doubt carry great weight when Parliament comes to consider the whole question in the round. But it seems to me to be stretching the concept of personal rights beyond breaking point to say that Anthony Bland has an interest in ending these sources of others' distress. Unlike the conscious patient he does not know what is happening to his body, and cannot be affronted by it; he does not know of his family's continuing sorrow. By ending his life the doctors will not relieve him of a burden become intolerable, for others carry the burden and he has none. What other considerations could make it better for him to die now rather than later? None that we can measure, for of death we know nothing. The distressing truth which must not be shirked is that the proposed conduct is not in the best interests of Anthony Bland, for he has no interests of any kind.[371]

On the other hand, when the case was before the Court of Appeal, Hoffmann LJ had noted that such a view of Bland's interests was 'seriously incomplete'. He thought it 'demeaning to the human spirit to say that, being unconscious, [Bland] can have no interest in his personal privacy and dignity'. But the trouble with Hoffmann LJ's analysis is that, by his own admission, this view of the interests of those in PVS rests on nothing more than 'most people's intuitive feelings about their lives and deaths'. His Lordship was not 'concerned to analyse the rationality of these feelings', it was, he thought, 'enough that they are deeply rooted in our ways of thinking and that the law cannot possibly ignore them'.[372]

As we shall see shortly, the criticism that some individuals, by virtue of their mental incapacitation, can have no dignity does not only arise in relation to the interest theory; similar concerns also occur where dignity is linked to autonomy (although, as we shall see when we come to consider these concerns in the autonomy context, it may be that there are strategies which allow us to get around them; such strategies, if successful, would also militate against the

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[371] *Airedale NHS Trust v Bland* [1993] 1 AC 789, p.897.
[372] *Ibid*, p.829

same criticism in the context of the interest theory). And yet, it is an oddity of the interest theory that whilst it cannot secure dignity for all humans, it nonetheless seems to ascribe dignity to most animals; for as someone like Peter Singer would suggest, an animal has as much of an interest in, say, avoiding pain and suffering as any human—more so where the human in question is insentient, as in the case of a PVS patient like Bland.[373]

For many people, this makes the interest theory unsupportable. The implications of its acceptance—vegetarianism, a ban on all vivisection—are simply too broad to admit. However, I am loath to allow too much to rest on this particular criticism because, following Singer, I would argue that if we accept that dignity cannot be based solely on membership of the human species, because this on its own is morally irrelevant, then, whether we choose to view dignity as based on interests, autonomy, the fact that someone is an end in themselves, or indeed on any other morally relevant criterion—if animals then meet that criterion, then this is not so much a reason to abandon the criterion because it does give animals dignity, as a reason to question the prevailing view that animals cannot possess dignity. In other words, the thinking of those who would level this criticism seems to be back to front; as Singer would say, they should be more willing to follow the arguments where they logically lead, without any prior assumptions about what can and cannot be accepted as part of the outcome. I shall return to the issue of the dignity of non-human animals below.

Humans as autonomous beings

Finally then, we arrive at the idea that humans are valuable and have dignity because they are autonomous. According to Beyleveld and Brownsword, this is the conception of dignity underlying such principal human rights documents as the Universal Declaration of Human Rights, the ICCPR, the ICESCR and the European Convention on Human Rights.[374] The view that dignity can be linked to autonomy is one which has fairly widespread support, not least amongst the international judiciary. For example, Beyleveld and Brownsword highlight the judgment of the German Federal Constitutional Court in its well-known *Life Imprisonment Case*, where it was noted that 'the dignity of the human being as a person which cannot be lost consists exactly of the maintenance of his recognition as an autonomous personality'.[375] We find similar remarks in the jurisprudence of the Israeli Supreme Court. Justice Shamgar for one, the former president of the court, has commented that 'Human dignity is reflected, *inter alia*, in the ability of the human being as such to forge his personality freely, as he wishes, to give expression to his aspirations and to choose ways to fulfil them, to make free choices...'[376] Justice Shamgar's successor, Justice Barak, has similarly explained that 'Underlying [the concept of dignity] lies recognition of

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[373] P. Singer, *Practical Ethics* (2nd. Ed.) (Cambridge: CUP, 1993), ch. 3.
[374] B&B, ch.1.
[375] BVerfGE 5 (1977) 187, p.228, cited in B&B at p.14.
[376] *Ploni v Almoni* (1992) 48(3) PD 837, p.843.

man as a free being, who develops his body and spirit according to his will within the social framework with which he is connected and on which he is dependent'.[377] And the president of the South African Constitutional Court, Arthur Chaskalson, has written extra-judicially that 'In a broad and general sense, respect for dignity implies respect for the autonomy of each person'.[378]

These practitioners' pronouncements chime in with much of the academic thinking on the subject of dignity. If we look again to the work of Joseph Raz, we see that, for him, 'Respecting human dignity entails treating humans as persons capable of planning and plotting their future...respecting people's dignity includes respecting their autonomy, their right to control their future'.[379] In similar vein Michael J. Meyer has put the matter thus: 'A person who has human dignity is fundamentally a person who is self-possessed; he at least has the capacity to give direction to his own life.'[380] And for Robert Young, 'autonomy seems crucial to our conception of moral agency...since being able to choose and act so as to make one's own lot in life is obviously connected in some way with personal dignity and self-esteem'.[381] In a particularly influential paper, though he pointedly avoided using the word 'autonomy', Harry Frankfurt wrote that: 'It is my view that one essential difference between persons and other creatures is to be found in the structure of a person's will. Human beings are not alone in having desires and motives, or in making choices. They share these things with the members of certain other species, some of whom appear to engage in deliberation and to make decisions based upon prior thought. It seems to be peculiarly characteristic of humans, however, that they are...capable of wanting to be different, in their preferences and purposes, from what they are'.[382] Frankfurt famously labelled this capacity the capacity for 'second-order desires', which he contrasts with the capacity for 'first-order desires' that, as he states, humans share with animals from other species. The capacity for first-order desires is the capacity merely to want or to choose, to be moved to this or that action by, for example, fear, hunger, pleasure or some other such immediate motive. But it is the human ability to think beyond this, to form and to hold higher-order desires which have as their object not actual actions of the agent but lower-order desires themselves, a desire *to have or not to have desire X* or *Y*, that, in Frankfurt's opinion, gives man his uniqueness—what makes a human pre-

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[377] *Vickselbaum v Minister of Defence* (1992) 47 PD (2) 812, p.827. Both these Israeli cases are cited in D. Kretzmer, 'Human Dignity in Israeli Jurisprudence' in D. Kretzmer and E. Klein (eds.), *The Concept of Human Dignity in Human Rights Discourse* (The Hague: Kluwer, 2002).

[378] A. Chaskalson, 'Human Dignity as a Constitutional Value' in D. Kretzmer and E. Klein, *op. cit.*, p.134.

[379] J. Raz, *The Authority of Law* (Oxford: Clarendon, 1979), p.221. See also, *The Morality of Freedom* (Oxford: Clarendon, 1986), p.190: 'The capacity to be free, to decide freely the course of their own lives, is what makes a person. Respecting people as people consists in giving due weight to their interest in having and exercising that capacity. On this view respect for people consists in respecting their interest to enjoy personal autonomy'.

[380] M.J. Meyer, 'Dignity, Rights and Self-Control' (1989) 99 *Ethics* 520, p.533.

[381] R. Young, 'The Value of Autonomy' (1982) 32 *The Philosophical Quarterly* 35, p.39.

[382] H.G. Frankfurt, 'Freedom of the Will and the Concept of a Person' (1971) 68 *J of Philosophy* 5, pp.6-7.

eminently important is his capacity for reflective self-evaluation, 'the capacity to raise the question of whether I will identify with or reject the reasons for which I now act'.[383]

We can see from this that, if it is autonomy that marks humans out as especially valuable, then this distinctive property has more to it than is often realised. For autonomy is a word which is frequently used, particularly in common parlance, simply to express the idea that people have choice and should be allowed to act upon that choice. But this understanding of autonomy comprises only the so-called first-order desires, and, as these sorts of desires are also found in some non-human animals, this would provide no sound basis for thinking humans to be anything particularly estimable. Rather, then, when we think about autonomy, we ought to think of it as a complex association of capacities which allows a person to develop; to form and to act upon successive wants and desires, both of the long-term and the short-term kind, the higher and the lower order; and to self-critically evaluate these wants and desires, balancing and ordering them in the manner which he believes best accords with his evolving life as it continually relates both to his own self-consciousness and to the world around him. As David A.J. Richards has put it, these capacities 'enable persons to call their life their own', 'to establish various kinds of priorities and schedules' so that some first-order desires (such as the desire to eat or sleep) may be regularised, while others (such as the desire to purchase an especially sought-after item) will be postponed till later; some self-criticised desires (such as smoking) may over time be eliminated altogether; and yet others will be encouraged (e.g., cultivating one's currently undeveloped desire to view and appreciate certain types of contemporary art).[384] As well as self-consciousness (where this is taken to mean merely an awareness of one's awareness of oneself as a being existing over time), numbered among the principal capacities which are probably constitutive of autonomy are: language (to communicate one's desires and choices), memory (allowing one to recall the choices one has made in the past and whether one will make them again or choose differently), and the ability to understand, to a greater or lesser degree, empirical information and to make logical connections (to know that if I choose this, such and such will or might happen), using all this as the basis for the choices we make.[385]

As with all of the other views of dignity as a value that have been considered, however, the idea that humans are valuable because they are autonomous is not without its problems. I noted in the

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[383] Frankfurt's theory of higher and lower-order desires has since been built upon, and its implications for a full theory of autonomy have been worked out by, Gerald Dworkin in his *The Theory and Practice of Autonomy* (Cambridge: CUP, 1988). This last quotation appears at p.15 of this work, where Dworkin elaborates by saying that 'A person may identify with the influences that motivate him, assimilate them to himself, view himself as the kind of person who wishes to be moved in particular ways. Or, he may resent being motivated in certain ways, be alienated from those influences, prefer to be the kind of person who is motivated in different ways.'

[384] D.A.J. Richards, 'Rights and Autonomy' (1981) 92 *Ethics* 3, p.6.

[385] Richards, *ibid*, p.7; see also M.S. Pritchard, 'Human Dignity and Justice' (1972) 82 *Ethics* 299, p.302; J. Christman, 'Constructing the Inner Citadel: Recent Work on the Concept of Autonomy' (1988) 99 *Ethics* 109, pp.115-116. On the specific capacity for language, see John Harris's *The Value of Life* (London, Routledge, 1985), pp.19-21.

previous section that where dignity is linked to autonomy similar concerns will arise as those that exist in relation to the interest theory and its inability to ascribe dignity to individuals who, through incapacitation, can be said to have no interests. The worry is that an autonomy-based account of dignity will be just as incapable of universally ascribing dignity, if not more so. If it is the capacity for autonomy that gives humans their special value, then it looks as if it will be difficult to attribute dignity not only to patients in PVS, but also to infants, young children, and those suffering from certain mental impairments that, though they might not be as total as PVS, nonetheless have a serious deleterious impact on the various capacities that taken together do constitute autonomy. This is a grave objection indeed, and one which must be overcome if the autonomy account is to have a chance of being viewed as a feasible way of thinking about human dignity. How, though, are we to get around it?

One tactic would be to suggest that it is not only actual autonomous beings that have dignity, but also all *potentially* autonomous beings. This would of course allow us to ascribe dignity to all children (or at least all children who are not born with some sort of mental impairment or disability which will prevent them from growing into fully autonomous persons) and also to all persons suffering from some sort of temporary mental incapacitation from which they could in the future recover (e.g. someone with a treatable mental illness such as schizophrenia). But that still leaves us with a large number of people—i.e. all those who are born, or through illness or injury, become permanently incapacitated—who would be left without dignity. In itself this provides us with a good reason to doubt the tactic of relying on potentiality. But, as John Harris has explained, the biggest difficulty with the potentiality argument is that it leads down a road where dignity would have to be ascribed backwards to an unacceptable degree. Foetuses, embryos, fertilised eggs, unfertilised eggs, sperm—all these have the potential, if certain things happen and certain things do not happen, to become autonomous persons. But even if some of us think that some of these things should be assigned dignity, we surely would not want to say that about all of them. For if we did, as Harris remarks, the obligation to actualise all human potential and the procreative imperative implied by this, would mean we should all be in for a highly exhausting time, one where our efforts to respect dignity would ultimately become self-defeating.[386] Thus we need to look elsewhere for a solution to the problem of non-autonomous beings.

At this point many are tempted to say that, although it is the capacity for autonomy which will *normally* give a being its dignity, where this capacity is lacking, we must instead look to the fundamental interests of the being. However, this suggestion seems to me to be fatal to the autonomy account. For unless we can show why, where the capacity for autonomy does in fact exist, this should take precedence, it seems as if ultimately the interest theorists are right and that the reason humans have dignity is not because they have the capacity for autonomy, but rather because they have fundamental interests. In short, we can either say people have dignity

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[386] J. Harris, *op. cit.*, pp. 11-12.

because they are autonomous, or because they have certain interests. But we cannot say that where the former is missing the latter comes to the rescue, without utterly undermining the conceptual integrity of the autonomy account.

This has led some to frankly admit that if non-autonomous beings do have dignity, then they do so only because autonomous beings deem them to have it, as a matter of charity or compassion.[387] Yet this seems not so much to affirm the dignity of non-autonomous beings as to slight it. So where else have we to go? In their book, Beyleveld and Brownsword consider the merits of two other tactics. I shall here look at only the more plausible of these: the principle of precautionary reasoning *vis-à-vis* other minds.[388]

Because the capacities that are constitutive of autonomy are, as we have seen, largely mental capacities that cannot be directly observed in other persons, although I can be certain that I am autonomous, I cannot be sure that anyone else is, and hence I cannot say definitively that anyone other than myself has a dignity which must be respected and protected. The best I can do, as Beyleveld and Brownsword suggest, is to construct a model of behaviour to be expected of someone who is autonomous, and to gauge people's behaviour by the side of this. However, even if a particular person acts precisely as my model would have an autonomous person act, this is no guarantee that the person in front of me is in fact autonomous. It is theoretically possible that he could be nothing more than an extremely life-like programmed robot, or simply a non-autonomous person whose behaviour just for the moment happens to coincide with that of someone who is autonomous. However much I observe, nothing can prove to me that the other being is anything more than *ostensibly autonomous*. Of course, our automatic response would be to claim that such solipsism is absurd; we would want to retort something like 'If it looks like a duck, and it quacks like a duck, well...' But this does not deal with the philosophical problem.

The 'Problem of Other Minds', as this difficulty is known to philosophers, is clearly an exceptionally abstruse one.[389] Fortunately, it is not an area in which we need to become too embroiled. For as Beyleveld and Brownsword show us, though it may be true to say that the propositions 'X is autonomous' and 'X is not autonomous'[390] are on a par with respect to our ability to demonstrate categorically the *truth* of either, these propositions are not on a par *morally*. And this, for us, is what matters. The argument is essentially this: it is normally worse to treat an autonomous person as if he were non-autonomous, than it is to treat a non-autonomous person as if he were autonomous. Hence, where a person displays all the behaviour expected of one

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[387] See, for example, Martha Nussbaum's discussion of the way the non-autonomous are dealt with by the social contract theorists: *Frontiers of Justice: Disability, Nationality, Species Membership* (Cambridge, Ma: Belknap, 2006).

[388] B&B pp.119-134. The other tactic, which Beyleveld and Brownsword show to be less feasible, relies on the Gewirthian argument that persons can be ascribed dignity (and therefore rights) proportionately to the degree that they may be *partially* autonomous (or 'partial agents' in Gewirth's language). This is discussed at pp.117-119 of B&B.

[389] For an overview of this area, see A. Avramides, *Other Minds* (London: Routledge, 2000).

[390] Within a Gewirthian framework, 'X is an agent' and 'X is not an agent'. B&B p.121.

who is autonomous, i.e. he is ostensibly autonomous, there has to be a presumption that he is in fact autonomous, and thus he should be ascribed with dignity. But now, suppose that we are faced with someone whose behaviour suggests that they are able to exercise the relevant capacities to a degree less than those of someone who is ostensibly autonomous, by virtue of which this second person can be said to be either *ostensibly partially autonomous* or *ostensibly non-autonomous*. Just as I cannot say with certainty that a person who is ostensibly autonomous is in fact autonomous, so I cannot say that a person who is ostensibly less than autonomous is definitely not autonomous. In both the case of the ostensibly partially autonomous person and the ostensibly non-autonomous person there is a chance (however remote it might be) that what we are dealing with is in fact an autonomous person; and because this is so, and because it is normally worse to treat an autonomous person as non-autonomous than it is to do vice versa, then, again, there must be a presumption in the first instance that both the ostensibly partially autonomous person and the ostensibly non-autonomous person are in fact autonomous, and that they therefore have dignity.[391]

Having said this, given that X's display of behaviour consistent with all the capacities of autonomy must, under precautionary reasoning, be viewed as sufficient evidence that X is autonomous, it follows that if X displays behaviour which is inconsistent with these capacities or is only partially consistent with them, then this must be viewed as *less than sufficient* evidence that X is autonomous. In other words, where X is ostensibly autonomous, the probability that X is autonomous must be taken to be 1; but where X is ostensibly only partially autonomous, the probability that X is autonomous must be taken to be greater than 0 but less than 1 in proportion to the capacities of autonomy that X displays; where X is ostensibly non-autonomous, the probability that X is autonomous cannot be taken to be 0 (because of the precautionary principle, i.e. that it is normally worse to treat an autonomous person as non-autonomous than it is to do vice versa) but must be taken to be the lowest possible positive value.[392]

Now, let us stand back for a moment and think about what we have here. For it seems to me that Beyleveld and Brownsword have arrived at a conceptual scheme of thinking about the dignity of the non-autonomous that not only allows us to view these people as having a genuine dignity

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[391] B&B p.122. Again, bear in mind that Beyleveld and Brownsword talk in terms of Gewirthian 'agency' rather than autonomy. Also, I should note here that I have adapted Beyleveld and Brownsword's terminology to remedy what seems to me a minor discrepancy. When they talk of an agent who acts in all the ways one would expect an agent to act, they call this person an 'ostensible agent' (viz. someone who is 'ostensibly autonomous' in the terms I am using). Yet, when they talk of someone who behaves in a manner which suggests they are less than an ostensible agent, they call this person an 'apparent partial agent' rather than an 'ostensible partial agent'. It may seem pedantic, but I think that in this difficult area the fewer words we use to describe things that are the same, the more comprehensible we can make things. Thus, if we choose to use the adjective 'ostensible' to indicate the fact that we are unable to be certain, because of the problem of other minds, about whether a person is in fact autonomous, then we should also use this same word (and not a different word like 'apparent', even though it is a synonym) to indicate our uncertainty as to whether a person is someone who is less than autonomous.

[392] Here, again, I have slightly modified the position of Beyleveld and Brownsword (at p.123). In particular, I have added the final clause concerning where X is ostensibly non-autonomous.

of their own[393] (as opposed to a dignity which results purely from the charity or compassion of autonomous beings), but also which has a remarkable degree of congruence with the way we actually think about and treat the non-autonomous in real life. To take first the mentally incapacitated. If we look, for example, at the law relating to the ability of persons in this group to determine what shall happen to their own bodies (a key concern of all dignitarians, whatever conception of dignity they may subscribe to) we can see that there exists a presumption that every adult has both the capacity and the right to consent to or refuse almost any invasion of his bodily integrity whatsoever, even medical treatment which will save his life[394]—*which is just to say, at least on my understanding, that there should be a presumption in the case of all ostensibly autonomous persons that they are in fact autonomous and must thus have their dignity respected by not having their autonomous choices overridden.* However, this legal presumption can be set aside—*as can Beyleveld and Brownsword's conceptual presumption*—where there is evidence that the person concerned does not have the requisite capacity—*viz. where a person exhibits behaviour which suggests he is less than ostensibly autonomous, that is, where he is ostensibly partially autonomous or ostensibly non-autonomous.* The legal test for establishing capacity is that which was set out by Butler-Sloss LJ in the case of *Re MB*[395] and which has recently been codified in ss.2 and 3 of the Mental Capacity Act 2005. According to this, a person will be held to be incapacitated if he is found to be suffering from some impairment or disturbance of mental functioning which impacts upon his ability either (a) to comprehend and retain information relevant to the choice he has to make, or (b) to use this information and weigh it in the balance as part of the process of arriving at a decision. Now, it is a feature of this test that, under it, capacity is assessed 'functionally' or 'task-specifically', that is to say, what matters is the person's capacity to comprehend, retain, and use information, not in general, but relative to the particular decision or choice that the person is faced with—*which is a lot like Beyleveld and Brownsword's idea that evidence of autonomy is a matter of degree, something which is to be determined proportionately to the capacities of autonomy that a person displays.* But—and this is crucial—we can note that, even if a person is found to be legally incapacitated and thus does not have the right to determine what shall be done to himself, this does not then mean that he can be treated in just any fashion; for whatever is to be done to a person adjudged mentally incapacitated, it has to be done for the sake of that person's best interests.[396] Why? *Ultimately, it can only be out of a concern to exercise precautionary reasoning vis-à-vis other minds, i.e. we cannot say definitively that the person is not autonomous.* Though in some cases it might seem more natural to say that we are acting in an incapacitated person's best interests because of the possibility that he may in the

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[393] I realise that in saying that non-autonomous beings do have 'a genuine dignity of their own' I am drawing a conclusion which Beyleveld and Brownsword would probably want to add some clarifying remarks to.

[394] *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All ER 649, at p.661. The presumption of capacity has of course recently been put on a statutory footing in s.1 of the Mental Capacity Act 2005.

[395] (1997) 38 BMLR 175, p.186

[396] *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1; s.1(5) of the Mental Capacity Act 2005.

future regain capacity, this cannot be the real reason why we do so, for if it was, it would not explain why we also ought to act in the best interests of those who are permanently incapacitated.

Beyleveld and Brownsword's scheme also seems to fit fairly well with the law concerning the right of self-determination of children (I am referring here only to children who will in due course mature normally, i.e. those who do not suffer from any mental impairment). If we consider the notion of '*Gillick* competence',[397] we can see that the approach of the courts is to say that, save where a statute expressly provides otherwise, a child's right to make his or her own decisions will normally depend on whether the child can be said to have attained sufficient maturity to understand what the particular decision entails. *Here, too, then we see rights being attributed proportionately to the capacity for autonomy being displayed.* But, again, as with the mentally incapacitated, even where a child is found not to be of sufficient maturity, and thus does not have the right of self-determination, all decisions regarding the child must be made (usually by the child's parents) out of a concern to further the child's best interests.[398]

It is important, as Beyleveld and Brownsword warn, for us to be clear about what the precautionary argument does and does not establish. What it does not establish is that autonomous beings owe duties to non-autonomous beings in proportion to the degree to which they *approach being autonomous.* Rather, it establishes that autonomous beings owe duties to all creatures *whose capacity for autonomy is uncertain in proportion to the degree to which they display evidentially the necessary capacities for autonomy.* As the authors note, on the assumption that those such as children and the mentally incapacitated are not autonomous beings, they are owed no duties. But, the point is that autonomous beings cannot know that such individuals are non-autonomous with sufficient certainty to risk offending against the principle that, normally speaking, it is morally worse to treat an autonomous being as non-autonomous than it is to do vice versa.[399]

The precise implications of the precautionary argument are worked out by Beyleveld and Brownsword in much more detail than it is possible to do here. However, the following points, which come out fairly clearly from the argument, ought to be made explicit. First, it is apparent that the logic of precautionary reasoning is such that, not only does it allow us to say that *all* members of our own species have dignity, but also that all non-human animals have dignity, as, indeed, does all plant life, at least to some degree.[400] Secondly, and contrary to what initially

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[397] *Gillick v West Norfork and Wisbech AHA* [1986] AC 112.

[398] *ibid.*

[399] B&B, pp.125-126, again I have made terminological adjustments.

[400] I am conscious that in saying this I am diverging slightly from Beyleveld and Brownsword, who seem to take the view that although the precautionary principle can be used to ascribe 'intrinsic moral status' to non-autonomous beings, it is only ostensibly autonomous beings who can be said to possess dignity proper. They write, at p.126: 'Does this mean that marginal groups [i.e. young children, the mentally incapacitated, animals, plants] as well as ostensible agents are to be considered as having dignity? If we regard possession of intrinsic moral status as possession of dignity, then marginal groups must be held to have

looked to be the case, the potential for autonomy does seem to matter. This is not because the potential for autonomy in itself allows us to say a being has dignity, but rather because evidence that a being is a potential autonomous being is evidence relevant to the probability that the being is autonomous.[401] Thirdly, what follows from the precautionary argument is 'an entirely relative ordering' of dignity, according to which even the lowliest form of life ought to be respected, *unless* to do so would require denial of the dignity of a being of higher standing, that is, a being more approximate to an ostensibly autonomous being. In a footnote that really ought to be a part of the main text,[402] Beyleveld and Brownsword explain that, in principle, conflicts between duties owed to ostensibly partially autonomous beings and duties owed to other beings will be decided by use of a needs calculus that weighs the risk of relevant harm to the ostensibly partially autonomous being of action to protect the relevant needs of the conflicting party (or parties) (taking into account the relevant 'utility' of such action to the conflicting party) against the risk of relevant harm to the conflicting party of action to protect the relevant needs of the ostensibly partially autonomous being (taking into account the relevant utility of such action to the ostensibly partially autonomous being). Hence it would appear that, notwithstanding precautionary reasoning, practices such as contraception, abortion, embryonic research, and vivisection could all be permissible for some reasons, though not others, depending on what will result in the greatest insult to dignity *overall*. So again then there seems to be convergence between theory and practice.

It is time now to try to draw some conclusions about dignity as a value, and to look at what these mean for the idea of a dignified death and the right to assistance in dying. However, before I do this I will just say a few words about the relevance of the precautionary argument to the interest theory. For it seems to me that if the precautionary argument is accepted as a sound tactic for dealing with the problem of ascribing dignity to individuals who, because of their incapacitation, cannot be said to be autonomous, then there is no good reason why it cannot also

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dignity—which, furthermore, will vary in degree. However, if we think of dignity as the property by virtue of which beings have generic rights (and this is the primary way in which we are approaching the matter), then marginal groups (human or not) are not to be thought of as possessing dignity (only as possibly possessing it); and dignity so viewed does not vary in degree. A distinction must, then, be drawn between possessing intrinsic moral status and possessing dignity.' Quite simply, I do—and have done all the way through the analysis of this chapter—regard dignity (at least where it is considered as a value as opposed to a virtue) as possession of intrinsic moral status.

[401] Beyleveld and Brownsword thus believe precautionary reasoning supports the following two claims: (1) Evidence that E is a potential ostensible agent [in my terms, a potential ostensible autonomous being], *by itself*, requires agents to grant E moral status [in my terms, dignity] (in proportion to the strength of this evidence); (2) Evidence that E is a potential ostensible agent adds to the moral status secured by E by the degree to which E exhibits the characteristics and behaviour expected of an agent. Thus, if F is apparently only a partial agent with f moral status (by virtue of the extent to which F displays the characteristics and behaviour expected of an agent) *but not apparently a potential agent*, and E is apparently a partial agent with e moral status *and also apparently a potential agent*, then agents must take more seriously the possibility that E is an agent than that F is an agent, by virtue of which their duties of protection to E are greater than their duties of protection to F. B&B p.125. It is on this basis that Beyleveld and Brownsword believe the decision in the conjoined twins case, *Re A (Children) (Conjoined Twins: Surgical Separation)* [2000] 4 All ER 961, can be justified by a dignitarian: p.255.

[402] B&B p.124, note 15.

be used to ascribe dignity to those who, under the interest theory, for similar reasons of incapacitation, cannot be said to have interests. In spite of Lord Mustill's confident assertion that Anthony Bland had no interests of any kind, and in spite of the weight of the scientific evidence to support this claim, the truth is that, ultimately, it is difficult to know whether patients in deep PVS can hold interests, and we should therefore acknowledge this fact in the way we treat such people.[403] To say this is not to conclude that their Lordships' decision in *Bland* was wrong and that we must do all that is possible to maintain the lives of those in PVS at all costs; it is just that this is what is required of us when there are no good countervailing considerations.[404]

C. Dignity and a dignified death

The preceding pages have covered much ground and gone into some quite recondite arguments. But this has been absolutely essential, for we cannot hope to understand the idea of a dignified death unless we have a good grasp on the concept of dignity. This, as we have seen, is no straightforward matter. First, we have to be aware of the distinction that exists between dignity as a virtue and dignity as a value, that is, the distinction between dignity as a practical attitude which one adopts in one's conduct or behaviour, and dignity as a quality that humans possess by virtue of which we deem them worthy of our respect. Secondly, we have to keep in mind that there are a variety of different interpretations that people give to the idea of dignity as a value, i.e. people disagree as to which quality it is precisely that makes human life important. There are, we saw, basically five different views, some of which it will now be apparent are more defensible than others.

The view that humans are valuable simply because they are members of the human species seems indefensible. To treat humans as deserving of respect simply because we ourselves happen to be human and we believe that we ought to look out for our own kind is no better than to treat men as more deserving of respect simply because we happen to be a man, or white people as more deserving of respect simply because we happen to be white. It is quite dangerous to allow the value of humanity to rest on a morally irrelevant characteristic such as membership of species *per se*.

Likewise, the idea that dignity is a social construct, something which derives from communal consensus, is open to challenge. If dignity is based on no more than a majority of the population's prejudice, or emotion, or some other such disqualified reason, then the fact that it is generally assented to does not in itself add anything to the equation. The fact that most people do believe

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[403] As Beyleveld and Brownsword would no doubt grant if they were to talk in terms of interests, B&B p.252.

[404] Beyleveld and Brownsword believe that there are essentially three such considerations which could justify a decision to withdraw life-support from a PVS patient: (1) that we are fulfilling an obligation undertaken to the previously ostensible agent/autonomous being/interest holder; (2) that we are fulfilling a preference that we can justifiably assume the previous ostensible agent/autonomous being/interest holder would have had, even though he never actually stated it explicitly; or (3) that we are reallocating scarce resources in order to protect the dignity of ostensible agents/autonomous beings/interest holders, which the relative ordering which follows from the precautionary argument would seem to allow. B&B p.253.

humans have value simply because they are human does not alter the fact that such a belief is one that ought not to be relied on, because of its underlying acceptance of a morally dubious bias in favour of our own species. Thus, consensus alone does not explain why humans have dignity, for we are still required to justify the ultimate reasons upon which any consensus is based.

The view that humans have value because they are ends in themselves seems to hold more promise. Following Professor Raz's analysis, we found that an end in itself is something or someone of value in itself, which, in turn, we saw can be a valuer, i.e. someone capable of directing one's conduct and one's life according to reasons. From this, I suggested, it followed that when we say humans are valuable because they are ends in themselves this is tantamount to saying that humans are valuable because they are autonomous. However, we also saw that, usually, the idea of treating people as ends in themselves is interpreted, after Kant, as imposing certain duties on oneself—which, by definition, will conflict with or restrict individual autonomy, e.g. the duty not to commit suicide. But, we further saw that the notion of duties to oneself is controversial, and some have argued convincingly that such duties are conceptually impossible for they entail a person being, at one and the same time, both obligator and obligatee. Kant of course denied this; yet in order to do so, he had to rely on the view that humans are fundamentally split beings, having, on the one hand, an intelligible rational aspect, and on the other, a phenomenal, more animalistic side. Such dualism I suggested was a high price to pay, for it rejects as irrelevant much of what in reality makes us human: our flesh and blood, vulnerable, passionate, temptable, spontaneous life. And so, while we should not be utterly dismissive of the view that humans have dignity because they are ends in themselves, I do think we need to be careful about how exactly we interpret such a view. If, by it, we only mean to say that humans are valuable because they are autonomous, then this seems to have some merit. But we should be cautious about accepting interpretations that go beyond this.

When we turn to the interest theory of dignity I think we are on much safer ground. True, there are some difficulties with the theory, but they do not seem to be insurmountable. As we have just seen, the objection that some individuals, because of incapacitation, will have no interests and therefore have no dignity, can be overcome by utilising Beyleveld and Brownsword's argument for precautionary reasoning *vis-à-vis* other minds: because we cannot ever know with certainty that a being does not have interests, all things being equal, it is better to err on the side of safety and assume that he does. Similarly, I do not think it is completely inconceivable that someone could come up with a list of fundamental interests or basic needs which would not run the risk of trivialising rights. Martha Nussbaum seems to be on the right track with her 'Ten Central Human Capabilities'.[405] So, in principle at least, I can accept that the interest theory probably is a feasible way of thinking about dignity as a value, even though there may still be some work to be done.

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[405] See note 368.

Which leaves us with the autonomy account, which for me stands as the most convincing of the views discussed. If one accepts—as I do—that Beyleveld and Brownsword's precautionary argument provides a satisfactory reply to the objection that the autonomy account cannot adequately deal with those who appear to be less than autonomous, then what the account seems to offer is a conceptual framework for the value of humanity which is not only rationally defensible, i.e. not based on morally irrelevant considerations such as membership of species, but is also fairly in tune with how we think about and treat humans and other forms of life on a day to day basis. Of course, some might wonder why, if I do accept that the interest theory can be a feasible way of thinking about dignity, I believe the autonomy account to be the more convincing view. In truth, my reasons are probably, as one commentator would put it, a matter of my subscribing to a pre-rational paradigm of thought.[406] But, if I do try to reason about it, what sways it for me is the fact that the interest theory seems to have grown up as an alternative to the autonomy account, precisely because of the difficulties that the latter had in ascribing dignity universally. However, if we now have a way of getting around this problem within the autonomy framework, then this seems to make the interest theory, if not entirely redundant, then certainly a second fiddle.

So what, then, does all this mean for the idea of a dignified death and the right to be assisted in dying? For those heroic individuals replete with the virtue of dignity, as I said towards the beginning of this chapter, a dignified death will be a death that is neither succumbed to too easily, nor fought against too hard, one which is faced with an equal measure of hope and acceptance, dread and anticipation. On this view, we saw, a dignified death will be a matter of personal achievement, something that results from one's character and which others are not much able to influence; it was noted that a dignified death was not something that others such as health care professionals could bestow on a dying individual. At first sight, this seems to point us away from the right to assistance in dying. But let us think about this a bit more closely. For whilst it might be true to say that others cannot bestow a dignified death on a dying person to the extent that they cannot alter the dying person's character, i.e. they cannot alter whether or not he will approach death in balance between struggle and submission, it is not true to say that others cannot bestow a dignified death on a dying individual full stop. Consider the following: a person is dying (and will certainly die within a fairly short time) from an illness such as motor neurone disease, which has robbed him of all physical ability. As someone in whom the virtue of dignity is strong, our dying individual has decided that, though he fears his extinction and cannot be certain of anything beyond his physical existence, because he agnostically hopes in his immortality, he would rather take his own life now than continue on with no prospect for recovery and the possibility of a more painful and distressing death a little way down the line. He has weighed the prospects and come to the conclusion that, for him, the dignified balance between the struggle for life and acceptance

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[406] D. Dwyer, 'Beyond Autonomy: The Role of Dignity in "Biolaw"' (2003) 23 *OJLS* 319, p.322.

of one's fate will only be struck if he now takes active steps to end his life. But, he is prevented from doing this, because of his physical disability. It seems to me that here we have a prime example of where a third party will be able to bestow a dignified death on a dying individual. Not through anything he can do to influence the dying individual's character, but simply because he can help the dying person to put his character's resolve into effect. Undoubtedly there will be some who will say that to decide on ending one's life before one's time is naturally up (with or without assistance) is always to die an undignified death, because such a decision always shows an over-eagerness to capitulate. I cannot agree with this for the simple reason that, surely, it must only be the dying individual himself who can properly decide on the right balance between struggle and submission. But, anyway, as I hope will be clear by now, we should not think that a dignified death is the preserve only of those who are able to attain this balance, for this would be to acknowledge but a part of how we think about dignity.

If my examination of dignity as a value is correct, then a dignified death will also be a death where either we respect the fact that the dying individual is a being with certain fundamental interests, or we respect the fact that he is an autonomous being. Now, on either of these accounts a right to assistance in dying has to be admitted. Obviously this is so with the autonomy account, for, as we have seen, autonomy is about reflective self-evaluation; about being able to establish one's own priorities in life; about forming higher and lower order desires, including, logically, the higher order desire that it is better to die now rather than later. Again then, if we are faced with a dying individual who is physically incapable of putting his desires into effect on his own, it seems to me that to respect his dignity we must be prepared to allow others to help him. As to the interest theory, it is enough to say this: any credible list of fundamental interests which ought to be respected and protected is going to have to include not only an interest in being able to exercise autonomy (in which case the right to assistance in dying follows as per the autonomy account), but also an interest in being free from unnecessary pain and suffering (which, as we saw in the previous chapter, is an interest that in spite of the best palliative care it is sometimes only possible to satisfy by allowing for assistance in dying).[407]

That, really, is the whole of the argument: on any coherent account of the concept of dignity, we are bound to accept that a dignified death will entail a right to assistance in dying, at least in certain circumstances. But now, to end this chapter, let me briefly return to something which was discussed in the previous chapter: that is, the hospice movement's policy of an open confrontation with death. For it will be recalled that I questioned whether this policy was compatible with the idea of a dignified death. The problem seemed to be that patients were being kept on the open ward to die, not so much out of consideration for their own interests, but to further the hospice philosophy that witnessing the death of a patient provides reassurance and comfort to those other patients remaining on the ward. Is this an insult to dignity?

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[407] Both of these interests are included in Nussbaum's capabilities approach.

Before answering this, let me first clarify the criticism. For the suggestion is not that *competent* patients are being compelled to die in public where they are explicitly able to say this is not what they want; clearly, to go against a competent patient's wishes like this would be a most blatant affront to his dignity, and this would be so regardless of any attendant benefits to others (although, even here, the matter is complicated somewhat by the issue of resources; though a shortage of bed space should not prevent at least minimal measures being taken to give the patient privacy, even if this is just drawing the curtains around the patient's bed). Rather, the suggestion is that *incompetent* patients are being made to die openly, even when it is not certain that this is what they themselves would have chosen had they been competent. So, is this compatible with dignity?

Well, clearly not—because the precautionary argument makes it plain that, even though a patient may be incompetent, this fact does not license hospice staff to go ahead and simply choose an open death for the patient. When Lawton notes that 'Most of the staff I observed and interviewed in the hospice seemed to make the implicit assumption that when a dying patient ceased to be aware of their environment (such as when they slipped into a coma) their surroundings meant little to them',[408] what we are being told is that the implicit assumption of staff is that the incompetent are non-autonomous/non-interest-holding beings to whom we owe no duties. But, as we have seen, such an assumption is impermissible. We simply cannot know with sufficient certainty that those individuals that are *ostensibly* non-autonomous/non-interest-holding beings are in fact non-autonomous/non-interest holding beings. And thus we are required to act always in their best interests. What does this mean in practice? Simply that, exercising precautionary reasoning, hospice staff could only choose an open death for an incompetent patient where there were no good countervailing considerations. What are we to count as 'good countervailing considerations'? Either: (1) a preference against open dying which the patient actually expressed whilst he was still competent, or (2) a preference against open dying that we may justifiably assume the patient would have held, even though he never actually expressed it. Where either an incompetent patient's previously expressed wishes or implied preferences indicate that he would rather not die on the open ward, such preferences can only be ignored at the cost of affronting the patient's dignity (although, again, we may note that there is always the matter of resources to factor in; but fundamentally a shortage of resources can only excuse an affront to dignity, it cannot not justify it). In short, then, the hospice movement's policy ought to be reconsidered. The wisest move would seem to be for hospice staff only to elect for an open death when that is what the patient has explicitly said he or she would prefer.

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[408] J. Lawton, 'A Room with a View' (1997) 93(34) *Nursing Times* 53.

PART III: THE RIGHTS ANALYSIS

5. ARTICULATING THE RIGHT

The aim of this chapter is to articulate the right to assistance in dying. By this I do not mean to define what it actually entails to be assisted in dying. On this, I do not propose to say more than was offered in my introduction, i.e. that assistance in dying should be understood as referring to a broad range of activities including what would ordinarily be termed euthanasia, assisted suicide and double effect cases, but with the crucial proviso that the person being assisted must be competent and consenting. Rather, my concern is to clarify the right itself; and this involves us in two issues. First, what can we say about what might be called the *analytic* right to assistance in dying? This, really, is a question of what type of right the right to assistance in dying is or can be. In chapter 2 I mentioned in passing that the Suicide Act 1961 does not grant people a *right* to commit suicide. The reason the offence of self-killing was abrogated was not to acknowledge that people should be entitled, if they wish, to choose suicide, but simply to acknowledge the inappropriateness of punishing suicide attempts. Nonetheless, as I explained in a footnote, the Suicide Act does allow us to say that there is a *liberty* to commit suicide. What we need to know now, however, is what it would mean to say that there exists a fundamental right to assistance in dying of the sort that is protected by international convention or national constitution: would this be a right or a liberty?

The second question that needs to be addressed—and that which takes up the largest part of this chapter—is: what is the legal basis for the right to assistance in dying? Here, the concern is to discover from which positive human rights the right to assistance in dying can be most comfortably derived; in other words what are the substantive provisions within whose ambit the right to assistance in dying can best be said to fall? The approach taken to this question is a comparative one. Though, for obvious reasons of relevance, the main focus of the discussion will be the substantive rights guaranteed under the European Convention on Human Rights, I hope that by looking at certain Canadian and American provisions, as well as the odd provision from other jurisdictions, the analysis presented in this (and the following) chapter will have a potentially very broad application. It is not so much my objective to examine the right to assistance in dying vis-à-vis the provisions of any specific system of rights protection, as to examine the right vis-à-vis such provisions as they appear in rights guarantees generally.[409] Having said this, we must of

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[409] Of course, there are dangers in taking such an explicitly comparative approach. Different systems of rights protection evolve from different circumstances and conditions and are tailored to deal specifically with these circumstances and conditions. On this view, the value of comparative analyses of rights is highly questionable. However, there is an alternative view to this, and this states that fundamental rights issues are a set of global issues to be resolved by courts around the world in colloquy with one another. This common enterprise does not 'obviate cultural differences', as one commentator has noted, 'but it assumes the possibility that generic legal problems such as the balancing of rights and duties, individual and community interests, and the protection of individual expectations, may transcend those differences'. A-M. Slaughter, 'A Typology of Transjudicial Communication' (1994) 29 *U Richmond L Rev.* 99, 127. For a good overview of the phenomenon of comparative rights analysis and the problems raised by it, see C. McCrudden, 'A

course remain alert to the risk of distortion and trivialisation of specific provisions (which was discussed in the introduction when we looked at the drawbacks of rights analyses).

A. The analytic right: liberty or right?

Although for some commentators the analytic right[410] to assistance in dying might be formulated in a number of different ways,[411] I prefer to adhere to the classic Hohfeldian rights typology, and consider that there are essentially only two types of 'right' that a right to assistance in dying might be: either a *right* proper, or a *liberty*.

In his *Fundamental Legal Conceptions*,[412] Hohfeld does not attempt to define these terms by way of formal definition—such definitions, according to Hohfeld, being 'always unsatisfactory and altogether useless'—but by a purely analytical scheme of 'correlatives' and 'contradictories'. Although well-known, it is worth setting out the scheme for ease of reference.

Right	Liberty	Power	Immunity
Duty	No-Right	Liability	Disability

Hohfeld tells us that each of the four columns consists of a pair of 'jural correlatives', that is, two concepts that entail each other. Thus, if X has a right, Y will be under a duty; if X has a liberty, Y has a 'no-right'; if X has a power, Y is under a liability; and if X has an immunity, Y will be under a disability. By contrast, the diagonal pairs in the first two columns (right/no-right and liberty/duty) and the diagonal pairs in the last two columns (power/disability and immunity/liability) each consist of 'jural contradictories',[413] that is, two concepts that negate each other. For present purposes, we can ignore the last two columns.

From this scheme we can see that the reason we can be sure that the Suicide Act does not grant people a right to commit suicide is that, for there to be such a right there would also have to be a corresponding duty on others to not interfere with suicides, a state of affairs which clearly does not obtain: else how could the policeman persuade down the person threatening to jump

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Common Law of Human Rights? Transnational Judicial Conversations on Constitutional Rights' (2000) 20 *OJLS* 499.

[410] I use the term 'analytic right' in this section because I am dealing with the form of the right to assistance in dying at the theoretical/abstract level, not the form of the right at the level of the positive law.

[411] P. Lewis, 'Rights Discourse in Assisted Suicide' (2001) 27 *American J of Law and Medicine* 45, p.50, citing M. Pabst Battin, *Ethical Issues in Suicide* (London: Prentice-Hall, 1982), pp.184-185.

[412] W.N. Hohfeld, *Fundamental Legal Conceptions as applied in Judicial Reasoning* (D. Campbell and P. Thomas eds.) (Aldershot: Ashgate, 2001).

[413] Hohfeld actually used the term 'jural opposites' to express the diagonally related concepts, but, as has been recognised for a long time, a more accurate way of describing them is as 'contradictories' or 'negations': M.H. Kramer, 'Rights without Trimmings' in M.H. Kramer, N.E. Simmonds and H. Steiner, *A Debate over Rights: Philosophical Enquiries* (Oxford: Clarendon, 1998), n.1.

from a bridge? How could the commuter on the underground platform hold back the person who dashes to throw himself under a rush-hour tube train? Much more accurate is to say that the Suicide Act, by abrogating the offence of suicide, created a *liberty* to commit suicide. To have a liberty in the Hohfeldian sense is to be free from any duty either to do or not to do the thing to which the liberty pertains; others have *no right* either to demand that you do or refrain from doing whatever it is that the liberty relates to. People have no right to demand that a person not commit suicide; there is no duty to not commit suicide. There must therefore be a liberty to commit suicide. At the same time, however, others can clearly interfere with suicidal actions. How? Because, according to the Hohfeldian scheme, those others may themselves have a liberty to interfere with suicides—indeed, there is nothing to say that they could not have a duty to interfere (as clearly some people do, e.g. the police and prison authorities in relation to prisoners who are known to be at risk of attempting suicide, and medical staff in relation to patients at such risk[414]), because duties and liberties do not correlate to one another, and they only negate each other when they are held by the same person.

All of this is fairly uncontroversial, and the same conclusions have been drawn by another commentator who has conducted a Hohfeldian analysis in this area, Antje Pedain.[415] However, what is less clear is the issue with which we are centrally concerned: what sort of 'right' a fundamental human right to assistance in dying would or can be? Pedain has this to say on the matter:

> Usually a Hohfeldian liberty is easily removed from the legal order. The legislator need only create a legal duty upon the liberty-holder to do—or, as the case may be, refrain from doing—the very act the liberty had him free to do or not to do, and the liberty is no more. But in the context of human rights law, Hohfeldian liberties can acquire a new significance. They can come to possess what one may call protected status. As liberties with a protected status, they cannot be removed from the legal order without justification. This statement needs some explanation. From the perspective of human rights law, it is possible to distinguish between 'simple' and 'protected' Hohfeldian liberties. A simple liberty exists in any given legal situation in which the legal subject is neither under a duty to perform a certain act nor under a duty not to perform this act (for example, A is at liberty to walk across a field if he is neither under a duty to walk across it nor under a duty to keep off it). This is the concept of a legal liberty which the Hohfeldian scheme employs. A protected liberty is a Hohfeldian liberty with a special quality, which is external to the features of legal liberties the Hohfeldian model can take into account: liberties whose

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[414] *Kirkham v Chief Constable of Greater Manchester Police* [1990] 2 QB 283; *Reeves v Commissioner of Police of the Metropolis* [1999] 3 WLR 363; *Selfe v Ilford & District Hospital Management Committee* (1970) 114 SJ 935.

[415] A. Pedain, 'The Human Rights Dimension of the Diane Pretty Case' (2003) 62 *CLJ* 181, p.185.

> exercise falls within the sphere of personal freedom protected by a fundamental right. Within the Hohfeldian scheme, the question whether a given liberty is a simple or a protected one cannot be answered. Hohfeld gives us only what may be called the two-dimensional perspective of the law. He describes legal relations as they emanate from a particular set of norms which happen to be in existence at the time of the analysis on what might be called a horizontal plane of legal relationships. His fundamental legal relations between individuals are like lines between dots criss-crossing a plane. They exhaustively account for what they purport to describe—the pattern on the plane—but there is much of legal relevance which necessarily remains outside the picture, without however challenging its validity or completeness as far as it goes. Hohfeld tells us what we find on the legal flatland, on which all relations which individuals have with other individuals are mapped out. What he does not give us—nor does he purport to do so—is the third dimension: the principles, concepts, interests, values, etc, which generate many of the concrete bipolar legal relationships between persons which we find on the Hohfeldian plane, comparable to the way in which drawings on a map are based on and reflect an explorer's knowledge of the course he has taken and the observation of natural features he has made.[416]

I have quoted Pedain at some length because she concisely sums up much of what needs to be said with clarity. She is clearly right that Hohfeld's scheme cannot answer the important question of whether a right such as the right to assistance in dying will or should be a fundamental human right of the sort protected by convention or constitution (i.e. whether it is what she would call a 'protected liberty'). That is a question which can only be answered by reference both to the sorts of value considerations seen in chapters 3 and 4 (is the right to assistance in dying necessary to avoid pain and suffering/promote dignity?) and the interpretative considerations with which the remainder of this chapter is concerned (can the right to assistance in dying be derived from substantive rights without distorting or trivialising them?). But what I think is less helpful is the terminology that Pedain chooses to employ. By talking of 'simple' and 'protected' *liberties* she makes things more confusing than they need to be. For it seems to me that the latter term is something of a misnomer. A 'protected' Hohfeldian liberty is surely just a freedom either to do or not do a particular thing which it is the duty of the state to not interfere with, in which case it is not really a liberty at all but a *right*, at least on a Hohfeldian account of things.

This might seem a rather pedantic point to make, because in essence I think that Pedain and I are largely in agreement. But it is important, because to say that there is a liberty to commit assisted dying (even when we qualify what we mean by saying that there is a 'protected liberty') is more likely to be misinterpreted as not entailing a correlative duty on the state to not interfere

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[416] *ibid.*, pp.185-186.

with assistance in dying; but it is precisely such a duty that fundamental rights have to entail. As Robert Alexy—who Pedain states to be the 'inspirational basis' of her discussion of the relationship between Hohfeld's scheme and fundamental rights—notes: 'Every constitutional liberty is a liberty at least in relation to the state. Every constitutional liberty held in relation to the state is directly and subjectively protected by at least one subjectively equivalent right that the state should not prevent the liberty-holder from doing what he is constitutionally free to do'.[417] So there is just something odd, then, in the way that Pedain insists on talking about 'protected *liberties*' when she is referring to fundamental human rights, for it is surely more appropriate to say that such rights are in fact *rights* proper, i.e. entailing a duty, without however denying that the reason that they are or should be fundamental rights is because they involve freedoms that, by reference to pre-Hohfeldian value considerations, we consider to be 'protected' and which 'cannot be removed from the legal order without justification'.

Perhaps a clue as to why Pedain chooses the terminology she does is to be found in the following extract, where she applies her analysis to the *Pretty* case. She writes:

> We can now understand Mrs Pretty's case at a more sophisticated level: first of all, what Mrs Pretty wants to have is not a right to commit suicide (which would impose a corresponding duty upon others to refrain from saving her from death), what she wants is to be at liberty (in the Hohfeldian sense) to commit that act. She wants to be free to do it or not to do it at her pleasure. Secondly, she argues that this liberty has protected status under certain human rights norms and can therefore not be taken away from her and other persons without justification...[418]

Note that Pedain thinks that the case is centrally about whether Mrs Pretty ought to be permitted to commit suicide, *not* whether she ought to be permitted to receive assistance in dying. This is crucial as to why Pedain gets involved in the splitting of liberties into those which are 'simple' and 'protected'. Because Pedain knows she cannot commit herself to the conclusion that there is a *duty* on others to refrain from interfering in all suicides, she has to say that what Mrs Pretty was wanting was a Hohfeldian liberty to commit suicide; consequently she has to divide liberties into those which are 'simple' and 'protected' in order to preclude the situation where the state could simply legislate to remove such a liberty. But this can all be avoided if, instead of focusing on the permissibility of suicide, we focus on the permissibility of assistance in dying. If we say that what Mrs Pretty wanted was to be permitted to receive assistance in dying, then we can phrase this as a Hohfeldian *right* because the duty which this entails would not be a duty on others to refrain from interfering with all suicides, but only a duty on the state to refrain from interfering with those

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[417] R. Alexy, *A Theory of Constitutional Rights* (trans. J. Rivers) (Oxford: OUP, 2002), p.149.

[418] A. Pedain, *op. cit.*, p.187.

cases of assistance in dying that fall within the protected sphere of freedom covered by the right, which of course is determined by value considerations and arguments outside of the Hohfeldian picture. The right to assistance in dying and the right to commit suicide are distinct; by conflating them Pedain has got herself into a muddle which she can only get out of by creating unnecessary sub-categories of the Hohfeldian concepts.

All of this is to say that, to me, analytically, a fundamental right to assistance in dying has to be a Hohfeldian right proper, not a liberty. As long as the purpose of fundamental rights is to prevent the state from interfering with freedoms which the individual ought normatively to be allowed to exercise, such rights have to entail a duty on the state to refrain from such interference. In the case of the right to assistance in dying this does not mean that there is a duty on the state (or indeed on anyone else) to not interfere with suicides generally—quite clearly this would have unacceptable consequences—it only means that there is a duty on the state to not interfere in those cases of assistance in dying which would be covered by the right, the scope of which would be determined pre-analytically. The analytical right to assistance in dying and the analytical right to suicide are not equivalent, and the duties they entail will therefore be quite different.

B. The legal basis of the right: deriving the right from substantive provisions

A survey of the leading cases in the field reveals that, whichever convention or constitution the petitioner might be relying on to argue for a right to assistance in dying, he will ultimately be attempting to derive the right from one or more of the substantive provisions—however those particular provisions might be formulated under a particular convention or constitution—that protect the following handful of fundamental rights: the right to life, the right not to suffer certain types of treatment, the right to freedom of conscience, the right to autonomy and the right not to be discriminated against on the basis of an irrelevant characteristic. Although scholars have occasionally argued that the right to assistance in dying can be derived from certain other rights, for example an individual's right of property in his own body,[419] such attempts are rare and they have not found their way into the courts—presumably because the right to property in one's body is not a right that is explicitly recognised by constitutions and conventions, even though such a right might underlie certain provisions.

The right to life

Arguments which attempt to derive the right to assistance in dying from substantive provisions protecting the right to life might seem perverse, but they have been around for some time and

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[419] See P. Lewis, *op. cit.*, p.50, citing R.F. Friedman, 'It's my Body and I'll Die if I want to: a Property-Based Argument in Support of Assisted Suicide' (1995) 12 *J of Contemporary Health and Policy* 183. Lewis notes that the philosophical ancestry of the property argument can be traced to the writings of John Locke, who contended that: 'Though the earth and all inferior creatures be common to all men, yet every man has a property in his own person; this nobody has a right to but himself'.

have been raised by petitioners in several of the cases. In *Rodriguez v British Columbia (AG)*,[420] a case factually very similar to the Diane Pretty case involving a 42 year-old woman suffering from amyotrophic lateral sclerosis, the petitioner had argued in the Canadian Supreme Court that s.241 of the Canadian Criminal Code (the effect of which is to prohibit assisted suicide in much the same way and to the same degree as our own s.2(1) of the Suicide Act) infringed her rights under s.7 of the Canadian Charter of Rights and Freedoms ('the Charter'). S.7 provides that:

> Everyone 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.

Ms Rodriguez had argued that s.241 interfered with both her liberty and the security of her person; but she herself had not intended to pray in aid the right to life under s.7. Nevertheless, Sopinka J, who authored the majority opinion of the Court, noted that though Ms Rodriguez had wished to rely on just two of the interests under s.7, a consideration of these could not be divorced from the third interest, the interest in the sanctity of life.[421] He then proceeded to argue that the 'right to life' element of s.7 meant that the Court had to weigh Ms Rodriguez's interests in the liberty and security of her person against the *societal* interest in protecting the sanctity of life. One of the dissenting judges, Corey J, disagreed with the majority approach. For him, the right to life under s.7 was purely an expression of the individual's entitlement to live his life without state interference, including, according to his Honour, the entitlement to live out the final moments of his life as he wished:

> The life of an individual must include dying. Dying is the final act in the drama of life. If, as I believe, dying is an integral part of living, then as a part of life it is entitled to the constitutional protection provided by s.7. It follows that the right to die with dignity should be as well protected as is any other aspect of the right to life.[422]

Now, Corey J's interpretation of the phrase the 'right to life' is not beyond challenge, as will be seen below. However, what can be said about his Honour's understanding of s.7, is that he is almost certainly right to intimate that s.7 is, and has always been understood as being, all about the *individual's* interests and not, as the majority opinion suggests, society's interests. Of course societal interests are taken into account; but not within the confines of s.7. As with all human rights documents, the assessment to be made is a two-stage process. First, it is determined whether the petitioner has discharged the burden of showing whether there has been a breach of his rights; then—and only then—is it proper to look at whether the breach is nevertheless saved

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[420] [1993] 3 SCR 519.
[421] *ibid.*, p.584.
[422] *ibid.*, p.630.

because of the necessity of protecting important societal interests. In the context of Canadian Charter law, this second stage should normally take place in s.1 of the Charter, which states that:

> The [Charter] 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.

This point, about the proper place for consideration of societal interests, is one which has been forcefully made both by Mclachlin J,[423] another of the dissenting judges in *Rodriguez*, and certain academic writers. For example, Lorraine Eisenstat Weinrib has written that, by importing societal values into s.7, the majority of the court marked 'a dramatic contraction of Charter protection' because it imposed on the rights petitioner a burden of disproving justification that had, until *Rodriguez*, rested as a positive burden on the state under s.1. She asks whether, given this new formulation, the s.1 justification should remain available to the state after a finding of a s.7 violation.[424]

This is not a question we need to answer. The important thing is that, for at least one of the judges in *Rodriguez*, a right to assistance in dying could be extracted from a provision protecting the right to life. But was Corey J correct in his view? Diane Pretty thought so; and in her case, contrary to Ms Rodriguez, she specifically invoked the right to life as this is set out in Article 2 of the European Convention on Human Rights (hereinafter 'the Convention'). This provides that:

> 1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
> 2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
> (a) in defence of any person from unlawful violence;
> (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
> (c) in action taken for the purpose of quelling a riot or insurrection.

The parallel between Mrs Pretty's submissions on the right to life under Article 2 and Corey J.'s reading of the right to life under s.7 of the Canadian Charter should be clear to anyone. Mrs Pretty argued that Article 2, at its essence, was about protecting, not the right to life, but rather the right to self-determination over life, the right whether to live or not. This meant that though the state was obliged to protect individuals against unwanted death by attack, it was not obliged to

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[423] *ibid.*, p.621-22, citing the dicta of Lamer CJ in the case of *R v Swain* [1991] 1 SCR 933.

[424] L. Eisenstat Weinrib, 'The Body and the Body Politic: Assisted Suicide under the Canadian Charter of Rights and Freedoms' (1994) 39 *McGill LJ* 618, p.628.

force life upon a person who did not want it. The right to life, according to Mrs Pretty, included its natural corollary, the right to die, and the state had an obligation to protect both.

When Mrs Pretty's case was before the House of Lords,[425] to a point their Lordships had agreed with this. The judges accepted that, it was true, the state was not obliged to force life upon one who did not want it. Thus, if he wished, a person could perfectly lawfully end his life by, e.g. committing unassisted suicide (i.e. exercising his Hohfeldian liberty to commit suicide) or by refusing life-sustaining medical treatment. This, however, the Law Lords thought only took Mrs Pretty's argument so far. All this meant was that the state, if it wished, *could* permit assisted suicide without being in breach of Article 2; but this was quite different from saying that Article 2 *obliged* the state to do so. As Lord Bingham noted, 'It is not enough for Mrs Pretty to show that the United Kingdom would not be acting inconsistently with the Convention if it were to permit assisted suicide; she must go further and establish that the United Kingdom is in breach of the Convention by failing to permit it'.[426] In the opinion of their Lordships, this she could not do. The view that the corollary of life is death and thus the corollary of the right to life is the right to die was unconvincing. Far from being its corollary, if anything, the right to die was the antithesis of the right to life.

Against this, and again echoing Corey J's analysis, it had been argued by A.C. Grayling, a philosopher who helped Mrs Pretty's lawyers with the ethical aspects of her case, that although death is indeed the antithesis of life, dying is not:

> Dying is an act of living; it is indeed one of the most important events in life, and because it can be pleasant or painful, timely or untimely, tragic or desired, it is central to the character and quality of a person's life as he himself experiences it. We do not experience death, which is not an activity or state—a state of non-existence indistinguishable from being unborn. But we very much experience dying, and just as we hope that most of our acts of living will be pleasant, we likewise desire that the act of dying should be so too—or, if not pleasant, at very least not frightening, painful or undignified. 'Life' in the phrase 'the right to life' is not mere existence. It is existence with at least a minimum quality and value.[427]

This is a neat argument; at least it is ethically neat. However, in the context of European human rights law, ultimately it is of little import. This is because the 'right to life', as manifested in Article 2, is not a general ethical concept (even though, of course, it is based on one), but rather a specific legal idea with a precise nature and meaning. The point here is one that I have been at

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[425] *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61; [2001] 3 WLR 1598; [2002] 1 All ER 1.

[426] *ibid.* [9].

[427] A.C. Grayling, 'A Good Death' *The Guardian* (Saturday Review), 27 October 2001.

pains to accent from the outset: that, in interpreting the right to life (or any other right for that matter), the House of Lords (or any other court) does not have free rein to do as it likes. Both the text of the right itself and the conclusions which previous courts have reached on it significantly limit the scope of the judges' interpretative freedom; and this must be so, to guard against the undue expansion and trivialisation of fundamental human rights.

The text of Article 2 has been interpreted by the Strasbourg authorities (both the ECtHR and the European Commission on Human Rights) on a number of different occasions. On none of these, however, has it ever been indicated that the right to life covers such expansive notions as those suggested by Grayling.[428] In assessing Mrs Pretty's case, the ECtHR thought that this was crucial. Surveying its previous case law, the ECtHR found that the consistent emphasis in all Article 2 cases had been the obligation of the state to protect life; there was nothing to suggest the provision was concerned with issues to do with quality of living or what a person chooses to do with his or her life.[429] Indeed, it may be noted that, as long ago as 1979, it was remarked by the Commission that Article 2 exists to 'primarily provide protection against deprivation of life only'.[430] The conservative interpretation of the right to life thus has a remarkably long pedigree. But, what is the underlying rationale for this restrained approach?

The main reason why Article 2 must be interpreted narrowly relates, it seems, to a desire on the part of the Strasbourg authorities not to undermine its supreme and fundamental position *vis-à-vis* the other Convention rights. As the ECtHR noted, being the most important right of all, the pre-requisite to all other human rights, the view taken is that the right to life must be construed strictly, in terms which allow the taking of life only in the limited circumstances set out in the second paragraph of the provision, i.e. when lethal force is absolutely necessary for one of the three listed exceptions.[431] For the ECtHR, the problem with interpreting the right to life as Mrs Pretty wished was that, by implication, it would have to add to these exceptions, when time and again they have been stated to be 'exhaustive'.[432] It is for this reason, principally, that Mrs Pretty's claim under Article 2 failed before the ECtHR.

But perhaps this is too legalistic an analysis. For the European judges were in large part guided by the same common sense approach taken by the House of Lords. They asked, simply, whether the right to life plausibly could include a right to die—and they concluded that it could not: 'Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die'.[433] It is the same conclusion that has been independently reached by

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[428] See C. Ovey and R.C. White (Jacobs & White), *The European Convention on Human Rights* (3rd ed.) (Oxford: OUP, 2002), at p.56: 'the Strasbourg institutions have not, to date, given any recognition to the principle that the "quality" of the life to be preserved is a relevant factor'.

[429] *Pretty v United Kingdom* [2002] ECHR 427 (App. No. 2346/02) [39].

[430] *X v Austria* Appl. 8278/78, 18 D&R 154, p.156.

[431] [2002] ECHR 427 (App. No. 2346/02) [37].

[432] See, *e.g.*, *Stewart v UK* Appl. 10044/82, 39 D&R 162, p.169.

[433] [2002] ECHR 427 (App. No. 2346/02) [39].

constitutional courts in countries as far apart as India and Ireland,[434] and one which I think is utterly correct. The plain fact is: the right to die is indeed the antithesis of the right to life. Semantically, to state otherwise is a nonsense. As numerous commentators have pointed out,[435] Article 2, if anything, is more likely to be invoked as an argument against the right to assistance in dying, such a right being incompatible with the state's obligation to protect life. So Mrs Pretty, then, in the end, probably failed under her Article 2 arguments for very simple reasons: as a matter of ordinary, everyday understanding, the right to life just does not connote a right to *end* life.[436] This probably holds true for all respectable formulations of a fundamental right to life.

The right to be free from certain types of ill-treatment

Given that a crucial part of the justification for the right to assistance in dying must—as I have insisted throughout—centre on humanitarian concerns related to the avoidance of pain and suffering, it should come as little surprise that petitioners have appealed to those substantive rights provisions that protect individuals against certain types of ill-treatment likely to cause pain and suffering. More surprising, however, is the complete lack of success that has resulted from this tactic. The difficulties faced by petitioners stem, once again, from the risk of trivialisation and over-extension of rights: the type of treatment being complained of simply does not come within the range of ill-treatments that are within the imagination of most fundamental human rights

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[434] In *Gian Kaur v State of Punjab* (1996) 22 *CLB* 749, where the central question facing the Indian Supreme Court was whether the right to life under Article 21 of the Indian Constitution included the right to die, Verma J noted that to read the latter into the former would mean 'effacing the right itself. The "right to die", if any, is inherently inconsistent with the "right to life" as is death with life. (Full text of the judgment is available at the Supreme Court of India website; quote found at para. 20.) It has been suggested by some that the contrary argument, i.e. the argument put forward by Grayling, was accepted by the Irish Supreme Court in the case of *Re a Ward of Court (Withholding Medical Treatment)* (1999) 50 BMLR 140. This was a case involving a patient who for over twenty years had existed in a state which was described as 'nearly, but not quite, PVS'. The patient's family wanted the patient to be allowed to die, and to this end had asked for a declaration that it would be lawful to withdraw the artificial nutrition and hydration by which she was being kept alive. One of the questions which the Court had to address was whether such a declaration would be compatible with the right to life under Article 40.3 of the Irish Constitution. Hamilton CJ considered that: 'As the process of dying is part, and an ultimate inevitable consequence, of life, the right to life necessarily implies the right to have nature take its course and to die a natural death...' (p.172) However, all this case really decides—and this is a point which was accepted by both the UK courts and the ECtHR in *Pretty*—is that the right to life cannot be interpreted in a way which would deny people the right to refuse life-sustaining medical treatment, forcing them to go on living longer than nature intended (the right to refuse of course being exercised by the patient himself if he is competent, but by others if the patient is incompetent and the treatment is thought to be both futile and not in the patient's best interests). But the case certainly does not decide that the right to life includes a right to die whenever one wants. As Hamilton CJ went on, 'This right [the right to life] does not include the right to have life terminated or death accelerated and is confined to the natural process of dying.' (p.172).

[435] M. Blake, 'Physician-Assisted Suicide: a Criminal Offence or a Patient's Right?' (1997) 5 *Med L Rev* 294, p.306; H. Nys, 'Physician Involvement in a Patient's Death: a Continental European Perspective' (1999) 7 *Med L Rev* 208, pp.214-15; M. Freeman, 'Death, Dying, and the Human Rights Act 1998' (1999) 52 *CLP* 218, p.221.

[436] On the importance of interpreting the terms of the Convention according to their ordinary meaning, see C. Ovey and R.C. White (Jacobs & White), *op. cit.*, pp.31-32, where the authors note that in the *Johnston* case, (1986) Series A no. 112, the ECtHR ruled that the ordinary meaning of the words 'right to marry' under Article 12 did not include a right to divorce.

documents. We see this most clearly from the judicial consideration given to Mrs Pretty's arguments under Article 3 of the Convention. This Article states:

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Under Article 3, states are both negatively and positively obliged to protect individuals within their jurisdiction from the ill-treatments proscribed. Not only must states not *subject* individuals to torture or inhuman and degrading treatment, but also they must take adequate steps to *prevent* individuals being subjected to such treatment. Mrs Pretty did not argue that the state had failed in its negative obligation—there was no question that the UK Government had itself inflicted any ill-treatment upon her. Instead, Mrs Pretty concentrated on what she saw as the state's failure under its positive obligation: by preventing her husband from assisting in her suicide, the state would, by exposing her to the pain and distress which inevitably would befall her in the terminal stages of the disease, fail in its obligation to *prevent* her suffering inhuman and degrading treatment.

Assessing this claim in the House of Lords, Lord Bingham started out by acknowledging that the prohibition of the proscribed treatment in Article 3 was cast in absolute terms, without exception or proviso. This observed, however, he then proceeded to deny that it could apply in Mrs Pretty's case for the following reason:

> [T]he absolute and unqualified prohibition on a member state inflicting the proscribed treatment requires that 'treatment' should not be given an unrestricted and extravagant meaning. It cannot, in my opinion, be plausibly suggested that the Director [the DPP] or any other agent of the United Kingdom is inflicting the proscribed treatment on Mrs Pretty, whose suffering derives from her cruel disease.[437]

In an attempt to counter this reasoning, Mrs Pretty relied on the decision of the ECtHR in *D v UK*.[438] This case concerned the proposed expulsion to St Kitts of an alien drug courier suffering in the later stages of AIDS. The Convention challenge was that the decision to deport D would have been in breach of Article 3 because the receiving country could not afford him the treatment and medication that was necessary for his condition. The ECtHR found in D's favour. In its judgment it commented that, although breaches of Article 3 would usually arise in relation to intentionally inflicted acts of public authorities, the Court nevertheless was not precluded from 'scrutinising an applicant's claim under Article 3 where the source of the risk of proscribed treatment...stems from

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[437] *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61[13].

[438] (1997) 24 EHRR 423.

factors which cannot engage either directly or indirectly the responsibility of the public authorities'.[439]

Mrs Pretty claimed that this case provided clear authority that, even though the proscribed treatment stemmed from her illness (a factor which could not engage the responsibility of the state), nevertheless the state could be held liable under Article 3, since by failing to allow her assistance in death, it would, in just the same way as it would have done had it managed to deport D, be condemning her to suffer inhuman and degrading treatment.

Both their Lordships and the ECtHR, however, took a different view. For them, the two cases were simply not comparable. The ECtHR noted that in order for Mrs Pretty's claim under Article 3 to succeed, it would have to place 'a new and extended construction on the concept of treatment'.[440] This was because, in Mrs Pretty's case, in contrast to *D*, the positive obligation on the part of the state did not just involve the mitigation of harm by, for instance, preventing ill-treatment or providing improved conditions of care. Instead, what it involved was the sanctioning of actions which ordinarily would be unlawful, an obligation which could not be derived from Article 3.[441]

It is difficult to disagree with the ECtHR's reasoning on this point. For if the word 'treatment' is interpreted too broadly then the danger is that, potentially, very many criminal law provisions could fall foul of Article 3. This was a point which was made by Sopinka J in *Rodriguez*. Discussing the meaning of 'treatment' under the Canadian equivalent of Article 3, s.12 of the Charter,[442] his Honour noted:

> In the present case, the appellant is simply subject to the edicts of the Criminal Code, as are all individuals in society. The fact that, because of the personal situation in which she finds herself, a particular prohibition impacts upon her in a manner which causes her suffering does not subject her to 'treatment' at the hands of the state. The starving person who is prohibited by threat of criminal sanction from 'stealing a mouthful of bread' is likewise not subjected to 'treatment' within the meaning of s.12 by reason of the theft provisions of the *Code*, nor is the heroin addict who is prohibited from possessing heroin by the provisions of the *Narcotics Control Act*.[443]

Mrs Pretty failed under Article 3, then, because she could not show that the UK Government's actions amounted to treatment of any kind. However, even if she had succeeded on this point, it is still very unlikely that the judges would have accepted that she had been subjected to *inhuman*

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[439] *ibid.*, [49].

[440] *Pretty v United Kingdom* [2002] ECHR 427 (App. No. 2346/02) [54].

[441] *ibid.*, [55].

[442] S.12 of the *Charter* provides: 'Everyone has the right not to be subjected to any cruel and unusual treatment or punishment'.

[443] *Rodriguez v British Columbia (AG)* [1993] 3 SCR 519, at pp.611-612.

and degrading treatment. This is because, according to convention case law, ill-treatment will only be held in breach of Article 3 if it attains a 'minimum level of severity'.[444] In Mrs Pretty's case, whether this was so was questioned by Lord Hope in the House of Lords when he suggested, in effect, that Mrs Pretty could have mitigated the severity of her suffering.

> As for the question whether the consequences of not giving the undertaking will attain the minimum level of severity, the facts must be seen in their whole context. Mrs Pretty cannot be forced to accept medical treatment for her condition as it reaches the terminal stages, but it is relevant to her case to see what is on offer...Your Lordships were informed that nursing care and palliative treatment is already being provided to Mrs Pretty and that it will continue to be available. The use of drugs such as opiates in the form of morphine may be helpful in the terminal stages in relieving the distress of breathlessness and the sensation of choking. It has not been possible in these proceedings to examine the facts in detail. But there is enough information available to us to cast serious doubt on the question whether the consequences of the refusal, taken as a whole, in the context of the treatment available, attain the minimum level of inhuman or degrading treatment within the meaning of the article.[445]

It is easy, of course, to argue that this was not the point for Mrs Pretty, and to suggest that the whole purpose for her was to have control over her death, to be able to say goodbye while she was alert, not while sedated and overcome by drugged stupor. This is true. But the fact is, again, this can have no bearing on Convention arguments, at least under Article 3 where the concern is only to ensure the individual is not *subjected* to inhuman and degrading treatment, not necessarily to give a *choice* over the methods used to ensure this. According to current Strasbourg jurisprudence—which requires that any assessment of whether the minimum severity has been reached take into account 'all the circumstances of the case, such as the nature and context of the treatment'[446]—what the state had done in refusing to grant Mrs Pretty's husband immunity from prosecution,[447] just could not, given the existence of an adequate and available palliative care regime, be considered severe enough ill-treatment to be labelled 'inhuman and degrading'. Something more would have been required from the state: for instance, as Lord

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[444] See, *e.g.*, *A v UK* (1998) 27 EHRR 611[20]; *Ireland v UK* (1976) Series A no. 25 [162]; *Tyrer v UK* (1978) Series A no. 26 [29]; *X v UK* Appl. 9261/81, 28 D&R 177, para. 1.

[445] *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61 [91].

[446] *A v UK* (1998) 27 EHRR 611 [20].

[447] Remember, Mrs Pretty had asked the DPP for an undertaking that, if her husband were to assist in her suicide, the DPP would refuse to grant his consent to a prosecution under the Suicide Act. The legal basis of Mrs Pretty's claim is set out in detail at Introduction, Opening remarks.

Bingham suggested, a public official denying access to pain-killing and palliative drugs.[448] This of course had never happened.

The right to freedom of conscience

The right to freedom of conscience is the right of each person to make the final judgment on a moral issue in accordance with the verdict of his own conscience, including the right to disagree with the judgment of anyone else on that same issue. The case for basing the right to assistance in dying in the right to freedom of conscience has been stated by Penney Lewis thus: 'In general terms, the argument would be that for the state to interfere in the *moral* decision of an individual to take her life violates the right to freedom of conscience. One might argue that, as is the case with abortion, the decision whether or not to commit suicide is essentially a matter of conscience'. Although Lewis talks only of individuals taking their own lives, it is clear that she also believes the same argument applies in the case of assisted dying, for she goes on to note that the basic position of freedom of conscience proponents can be thought of as the flipside to arguments opposing assistance in dying that rely on the sanctity of life. 'Although such [sanctity of life] arguments can be formulated in ostensibly secular terms, their religious origins are still present in many modern uses, arguably reflecting the underlying belief that suicide is a sin. For freedom of conscience proponents, such an argument must be recognised as representative of only one conscientiously-held view [the opposite conscientiously-held view being that assistance in dying ought to be legalised]'.[449]

Lewis's assessment of matters is fair and certainly not unrepresentative—but yet, it is not the whole story. For when looking at attempts to base the right to assistance in dying in freedom of conscience it is imperative to distinguish between the underlying moral right to freedom of conscience and those concrete legal provisions which protect this right. It has to be understood that with the latter—but not necessarily the former—there has to be a clear delineation between, on the one hand, the right of individuals to hold a sincere and deep belief in something, and on the other, the right to manifest that belief in practices and behaviour. Thus we find the New Zealand Bill of Rights Act grants individuals two separate rights: the right to freedom of thought, conscience, religion and belief under s.13; and the right to manifest such beliefs under s.15. Similarly, the Canadian Supreme Court has stated that the right to freedom of conscience under s.2(a) of the Charter 'demands that every individual be free to *hold* and to *manifest* whatever beliefs and opinions his or her conscience dictates...'[450] Under the European Convention, Article 9 provides:

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[448] *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61[14].

[449] P. Lewis, *op. cit.*, pp.60-61.

[450] *R v Big M Drug Mart Ltd* [1985] 1 SCR 295, p.346, emphasis added.

> 1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in a community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.
> 2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

That Article 9(1), like its equivalents, establishes the two different rights—to hold beliefs and to manifest beliefs—has long been acknowledged.[451] Article 9, however, is the only substantive rights provision protecting freedom of conscience which has actually been tested as a basis for a right to assistance in dying, in the Diane Pretty case. Yet this only serves to show how the divide between the right to hold and to manifest one's beliefs will almost certainly always be fatal to attempts to derive the right to assistance in dying from a right to freedom of conscience.

In the ECtHR, Mrs Pretty's arguments under Article 9 were considered in light of the leading case of *Arrowsmith v UK*.[452] The applicant in this case was a convinced pacifist who, in protest at UK policy in Northern Ireland, had distributed leaflets to British soldiers endeavouring to persuade them to go absent without leave or to refuse to accept tours of duty in the province. After being convicted under the Incitement to Disaffection Act 1934, and exhausting domestic remedies of appeal, the applicant claimed that her conviction and sentence interfered with her right to manifest her pacifist belief as guaranteed by Article 9. The Commission found against the applicant. Although it was of the opinion that pacifism was protected under the right to freedom of thought and conscience, where the Commission was not so convinced was with the claim that the leaflets had actually been a manifestation of the applicant's pacifist beliefs. The Commission commented that:

> Article 9.1 enumerates possible forms of the manifestation of a religion or a belief, namely, worship, teaching, practice and observance...and the applicant submits that by distributing the leaflets she 'practised' her belief. The Commission considers that the term 'practice' as employed in Article 9.1 does not cover each act which is motivated or influenced by a religion or belief. It is true that public declarations proclaiming generally the idea of pacifism and urging the acceptance of a commitment to non-violence may be considered as a normal and recognised manifestation of pacifist belief. However, when the actions of individuals do not actually express the belief concerned they cannot be

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[451] D. Harris *et al*, *Law of the European Convention on Human Rights* (London: Butterworths, 1995), p.360.
[452] Appl. 7050/75, 19 D&R 5.

> considered to be as such protected by Article 9.1, even when they are motivated or influenced by it.[453]

The Commission decided on this basis that, because certain aspects of the leaflets had suggested that in some circumstances fighting could be appropriate, instead of expressing beliefs about pacifism as the applicant had claimed, what the leaflets actually expressed were objections to UK policy. The applicant was thus not entitled to say she was practising—and neither was she manifesting—her belief in pacifism. Applying this decision to Mrs Pretty's arguments, although the ECtHR could not be guided by the Commission's ultimate reason for dismissing the case (there can be no doubt that, by committing assisted suicide, Mrs Pretty would have been expressing her belief in the virtue of it), nonetheless the ECtHR thought that the Commission's dicta offered valuable advice as to how wide the term 'practice' could sensibly be interpreted. The ECtHR agreed that the term 'practice', as employed in Article 9.1, does not cover each act which is motivated by a conscientiously-held view or belief.

The justification for this narrow reading is not difficult to see. Quite simply, in a civilised society there have to be reasonable limits to what people may do in the name of their personal convictions. Thus, the religious terrorist cannot justify his actions by appealing to the right to freedom of conscience. Similarly, the pro-life campaigner cannot kill or injure doctors who offer women abortions and say he is practising his beliefs and should therefore be protected. Of course, under Article 9 there is always the second paragraph to guard against such arguments. However, the fact is the Strasbourg authorities appear to believe that, even in the absence of the second paragraph, such actions would not fall within the scope of the right to freedom of conscience and religion. What the Strasbourg authorities consider a 'practice' or a 'manifestation' is some sort of expression of belief that is fairly innocuous. One may be free to *hold* any conscientiously-held view one wants—even views as extreme as those of the religious terrorist or pro-life campaigner—but when it comes to *manifesting* those views, the manifestation cannot be anything so egregious. Had Mrs Pretty, for example, been denied the freedom to publish pamphlets espousing her support for the right to assistance in dying, then almost certainly the ECtHR would have found an interference with her right to manifest her beliefs. But Mrs Pretty had wished to go much, much further than this. On the spectrum of manifestations of a belief in the morality of assistance in dying, for the ECtHR, Mrs Pretty was up at the more inordinate end. At any rate, the ECtHR thought that, to the extent that Mrs Pretty's views reflected her commitment to, and desire to practise, the principle of personal autonomy, the case would be better dealt with under another provision of the Convention, Article 8.[454]

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[453] *ibid.*, paras. 70,71.

[454] *Pretty v United Kingdom* [2002] ECHR 427 (App. No. 2346/02) [82].

The right to autonomy

No good constitution or convention can ignore the right to autonomy; and we are now better placed to understand why. If, as we saw in the previous chapter, the foundational value of all human rights documents is the protection of human dignity, and one of the most coherent accounts of dignity we have is one which emphasises the value of humans as autonomous beings, then the right to autonomy must be *primus inter pares* in the rights hierarchy. Tribunals might state the right to life to be the *sine qua non*, the right without which 'any of the other rights and freedoms are rendered nugatory',[455] but insofar as this is a view which fails to take into account what it is about life that actually makes life valuable, it is mere rhetoric. There is nothing inherently estimable about life *per se*; it is only the capacity for autonomous life—or, to be more accurate, the *possibility* of the capacity for autonomous life—that we can defensibly argue to be worth our worry.

The right to autonomy is protected by substantive provisions that vary widely between the different rights documents. Sometimes the right will be expressed as a component of the right to privacy; other times it will be protected as a right to security of the person; in some documents the right to autonomy appears as a right to liberty. But however it might be articulated, fundamentally we are concerned with the same thing: that is, the right of individuals to be free to self-critically consider whether the reasons for which they act are ones with which they would want to identify or reject, and not to suffer compulsion to act in accordance with those reasons which they would reject. It is from this right and the provisions which protect it that petitioners for a right to assistance in dying have found their greatest succour. As we shall now see, we can say that it is certainly the case that it is the right to autonomy from which the right to assistance in dying can be most comfortably derived.

In Canada, the right to autonomy is protected by the substantive right to security of the person found under s.7 of the Charter. In the *Rodriguez* case, the majority of the court found that previous case law established that 'personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity is encompassed within security of the person'.[456] However, the question for the court was still: does the right to autonomy grant individuals a right to assistance in dying? The court's answer was emphatic, with five of the seven judges holding that the right to autonomy did indeed give individuals this right. For the majority, Sopinka J noted: 'the prohibition [on assisted suicide] in s.241 deprives the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person'.[457]

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[455] *ibid.*, [37].

[456] [1993] 3 SCR 519, p.588.

[457] *ibid.*, p.589.

The same basic conclusion was reached by the US Ninth Circuit Court of Appeals in its *en banc* judgment in *Compassion in Dying v State of Washington.*[458] Here the petitioners were a coalition of three terminally ill patients, four physicians who treated the terminally ill, and Compassion in Dying, a not-for-profit organisation providing support and advice to mentally competent, terminally ill adults wishing to commit assisted suicide. The question for the court was whether Washington's anti-assisted suicide law (RCW 9A.36.060(1)) violated the US Constitution's Fourteenth Amendment, which in pertinent part provides that no state shall 'deprive any person of...liberty...without due process of law'.

The liberty interest protected by the Fourteenth Amendment has long been seen as being intimately connected with individual autonomy. Beginning with the groundbreaking judgments of the 1960s on questions such as contraception[459] and the right of individuals to marry across the races,[460] through the right of men to engage privately in homosexual relations[461] and the right of women to abortions,[462] US Constitutional law had developed to a point where, in *Planned Parenthood of Southeastern Pa v Casey,*[463] the Supreme Court was able to state confidently:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the state.[464]

For the Ninth Circuit Court of Appeals, this line of cases provided not only 'strong general support for [the] conclusion that a liberty interest in controlling the time and manner of one's death is protected by the Due Process Clause of the Fourteenth Amendment', but also, in the above dicta

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[458] (1996) 79 F 3d 790.

[459] *Griswold v Connecticut* (1965) 381 US 479. Although it is recognised that this decision was not based in the liberty interest of the Fourteenth Amendment—Justice Douglas instead preferring to extract the right to practise contraception from the penumbras of various other provisions of the constitution—*Griswold* is nevertheless generally recognised as the progenitor of the line jurisprudence concerning the right to autonomy.

[460] *Loving v Virginia* (1967) 388 US 1.

[461] *Bowers v Hardwick* (1986) 478 US 186. Although in this case the Supreme Court rejected the argument that such a right could be protected by the liberty interest, *Bowers* has long been viewed as a constitutional aberration (see D. Richards, 'Constitutional Legitimacy and Constitutional Privacy' (1986) 61 *NYU L Rev* 800; J. Rubenfeld, 'The Right of Privacy' (1989) 102 *Harv L Rev* 737; D.O. Conkle, 'The Second Death of Substantive Due Process' (1987) 62 *Ind L J* 215), and was finally overruled in *Lawrence v Texas* (2003) 123 S Ct 2472. In a sweeping judgment delivered by Justice Kennedy, the court noted '*Bowers* was not correct when it was decided, and it is not correct today. It ought not to remain binding precedent. *Bowers v Hardwick* should be and now is overruled.'

[462] *Roe v Wade* (1973) 410 US 113.

[463] (1992) 505 US 833.

[464] *ibid.*, p.851.

from *Casey*, it found reasoning which was 'highly instructive' and 'almost prescriptive'.[465] The court noted that:

> Like the decision of whether or not to have an abortion, the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime', a choice 'central to personal dignity and autonomy'. A competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent...Surely a person's decision whether to endure or avoid such an existence...implicates a most vital liberty interest.[466]

So one would think. But when the *Washington* case was appealed to the US Supreme Court, it took rather a different view. First, as we have seen in Chapter 2, it disagreed with the Ninth Circuit Court's reading of the historical record, finding 'a consistent and almost universal tradition that has long rejected the asserted right, and continues to explicitly reject it today, even for terminally ill, mentally competent adults'.[467] But the Supreme Court also disagreed with the lower court's interpretation of the dicta in *Casey*. Chief Justice Rehnquist remarked for the majority that 'the Court's opinion in *Casey* described, in a general way and in light of our prior cases, those personal activities and decisions that this Court has identified as so deeply rooted in our history and traditions, or so fundamental to our concept of constitutionally ordered liberty, that they are protected by the Fourteenth Amendment'. But, His Honour warned, 'that many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected'.[468]

The Chief Justice's remarks have been interpreted by many as sounding the death knell for arguments of a right to assistance in dying based in the Due Process Clause;[469] and, given the Supreme Court's apparently crushing 9-0 vote against the existence of such a right, this is not unreasonable. But the unanimity of the *Washington* verdict is deceptive, and it is worth pointing out that although Chief Justice Rehnquist's opinion was concurred with by a majority of the Court, five of the Justices in the case took care not to foreclose the constitutional debate over whether such a right might in future be recognised as part of the liberty interest. For example, Justice Stevens explained that the only reason why he had been unable to hold that the liberty interest protected the right to determine the time and manner of death was a procedural one to do with

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[465] (1996) 79 F 3d 790, p.813.

[466] *ibid*. p.814

[467] *Washington v Glucksberg* (1997) 521 US 702, p.723

[468] *ibid*., p.727.

[469] G. J. Annas, 'The Bell Tolls for a Constitutional Right to Physician-Assisted Suicide' (1997) 337(15) *NEJM* 1099.

the fact that, by the time the case was heard by the Ninth Circuit Court, the three terminally ill patients had all died and thus the court did not have before it any individual plaintiff seeking to hasten death, or any doctor who was threatened with prosecution for assisting in the suicide of a particular patient. His opinion left little doubt that in an appropriate case, his vote would have gone the other way. He noted, 'there are situations in which an interest in hastening death is legitimate. Indeed, not only is that interest legitimate, I am also convinced that there are times when it is entitled to constitutional protection'.[470] A little later he affirmed the Ninth Circuit Court's interpretation of *Casey* when he noted 'Avoiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly "[a]t the heart of [the] liberty...to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life"'.[471] Similarly, Justice Souter's opinion stressed that his vote was only 'at this time'. Justices O'Connor and Breyer each said that changed circumstances might cause them to reconsider their position. And Justice Ginsburg concurred with Justice O'Connor.[472]

A similar pattern of recognition and rejection occurred in the *Pretty* case. First, the Divisional Court held that the right to assistance in dying could be derived from the right to autonomy; the House of Lords however reversed this. Mrs Pretty's autonomy arguments were based on Article 8(1) of the European Convention, which states that:

> Everyone has the right to respect for his private and family life, his home and his correspondence

Article 8(1) is intended to protect individuals against arbitrary interference by the state in any of the four protected areas set out, i.e. private life, family life, home or correspondence. But of these, and notwithstanding that it is undoubtedly the case that in many instances the four areas may interconnect and overlap,[473] it is the protection afforded to the 'private life' which protects the right to autonomy. Yet, privacy and autonomy may seem to be entirely unrelated concepts; whereas rights that protect liberty or security of the person probably automatically cause one to think of the right of individuals to exercise some control over their lives, this is not necessarily the case with privacy rights. So it is perhaps worth spending some time on the development of the right to respect for private life.

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[470] *Washington v Glucksberg* (1997) 521 US 702, pp.741-742,

[471] *ibid.*, p.745.

[472] For a detailed examination of these aspects of the judgment, see R. Dworkin, 'Assisted Suicide: what the Court really said' (1997) *New York Review*, 25 September.

[473] See, *e.g.*, *X v Switzerland* Application No. 8257/78, 13 D.R. 248, a case involving both private life and the family life.

In 1973, Jaques Velu expressed the view that the right to respect for private life under Article 8 was 'in effect a miscellany of rights covering a wide field of individual activities'.[474] This definition is vague; but in the years that have since passed no one seems to have been able to offer anything more articulate. There are, commentators suggest, two main reasons for this.[475] First, neither the Commission nor the ECtHR have attempted comprehensively to elucidate on what interests are covered by the private life.[476] As just mentioned, in many Article 8 cases that have come before the Strasbourg authorities, the issues raised have fallen under more than one of the protected heads (i.e. private life as well as either family life, the home, or correspondence); the ECtHR and Commission have thus not been required to define the exact parameters of each of the heads. The second reason for the imprecision surrounding the right relates to the evolutionary and dynamic nature of the Convention rights. It has long been established that the Convention 'is a living instrument which...must be interpreted in the light of present-day conditions'.[477] What this means is that interests will be recognised and protected by the right to respect for private life as and when they are required by the civic life, its progressive social ideals and changing perceptions.[478]

The private life of course concerns privacy. This may seem a trite observation, but the point in making it is to draw attention to the distinction that exists between what is commonly or conventionally thought of as privacy, and other, broader aspects of privacy that the Strasbourg authorities also believe to be encompassed by the private life. Conventional understandings of privacy, i.e. what most ordinary people believe privacy to be about, relate to ideas of private space and the right to have personal information kept secret. In their seminal 19th century article in the *Harvard Law Review*, Warren and Brandeis talked of this notion of privacy as a right to be 'let alone', a right of individuals to a refuge from the prying eyes of the rest of mankind.[479] The Strasbourg authorities have long regarded this conventional understanding of privacy as fundamental to the private life. Thus from very early in the history of the Convention, interferences with Article 8(1) were found in cases involving, e.g. lawful searches of individuals' homes[480] and places of work,[481] the 'tapping' of private telephones,[482] the photographing of individuals,[483] and

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[474] J.Velu, 'The European Convention on Human Rights and the Right to Respect for Private Life, the Home and Communications' in A.H. Robertson (ed.), *Privacy and Human Rights* (Manchester: MUP, 1973), p.92.

[475] P.J. Duffy, 'The Protection of Privacy, Family Life and Other Rights Under Article 8 of the European Convention on Human Rights' (1982) 2 *Yearbook of European Law* 191, p.192.

[476] This was expressly acknowledged by the Commission in *X v Belgium*, Application No. 8707/79, 18 D&R 255, p.257, and by the ECtHR first in *Niemietz v Germany* (1992) Eur Court HR, Series A No. 251-B [29], and more recently in *Mikulic v Croatia* (2002) Application No. 53176/99 [58].

[477] *Tyrer v UK* (1978) Eur Court HR, Series A No. 26 [31].

[478] In *Marckx v Belgium* (1979) Eur Court HR, Series A No. 31, for example, the ECtHR and Commission found breaches of Article 8 and 14 in relation to Belgian laws on illegitimacy. This judgment was delivered in spite of the fact that twelve years previously a similar complaint had been rejected at the admissibility stage. Application No. 2775/67 (unreported).

[479] S.D. Warren and L.D. Brandeis, 'The Right to Privacy' (1890) 4 *Harv L Rev* 193.

[480] *X v Germany*, Application No. 6794/74, 3 D&R 104.

[481] *Niemietz v Germany* (1992) Eur Court HR, Series A No. 251-B.

the collection[484] and retention and subsequent use of personal information.[485] However, the private life goes far beyond this. From the outset it was determined by the Strasbourg authorities that respect for private life requires much more than the mere protection of individuals against traditional invasions of privacy. In *X v Iceland*, a case involving a challenge to a law which prohibited the keeping of dogs except in limited circumstances, it was noted by the Commission, in its first authoritative analysis of the of the private life, that:

> For numerous anglo-saxon and French authors the right to respect for 'private life' is the right to privacy, the right to live, as far as one wishes, protected from publicity...In the opinion of the Commission, however, the right to respect for private life does not end there. It comprises also, to a certain degree, the right to establish and to develop relationships with other human beings, especially in the emotional field for the development and fulfilment of one's own personality.[486]

The significance of this statement cannot be overestimated. At a stroke, what the Commission had done was to take the immeasurably important step of recognising a second aspect of the private life. It had acknowledged that, as well its role regarding the right to be 'let alone', there was also another equally, if not more important function of the right to respect for private life: that is, to promote and protect the free development of individual personality.

Since the *Iceland* case, the Strasbourg authorities have made many pronouncements on the importance of personality to the right to respect for private life.[487] In *Brüggemann and Scheuten v Germany*, for example, the Commission stated that the right was of 'such scope as to secure to the individual a sphere within which he can freely pursue the development and fulfilment of his personality'.[488] Similar sentiments are also echoed in its decisions in *Deklerck v Belgium*[489] and *X v Germany*.[490] The jurisprudence of the ECtHR, too, is equally accepting of the idea of a link between the private life and personality. Although for a long time there was only implicit recognition of this,[491] in *Botta v Italy*, it forthrightly stated that 'the guarantee afforded by Article 8

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[482] *Klass and Others v Germany* (1978) Eur Court HR, Series A No.28; *Malone v UK* (1984) Eur Court HR, Series A No. 82; *Kruslin v France* (1990) Eur Court HR, Series A No. 176-A; *Hulvig v France* (1990) Eur Court HR, Series A No. 176-B.

[483] *Murray v UK* (1994) Eur Court HR, Series A No. 300-A; *McVeigh, O'Neill and Evans v UK*, Application Nos. 8022, 8025, 8027/77, 25 D&R 15; *cf.*, *Friedl v Austria* (1995) Eur Court HR, Series A No. 305-B (though photograph taken in public place).

[484] *X v UK* Application No. 9702/82, 30 D&R 239; *X v Belgium* Application No. 9804/82, 31 D&R 231.

[485] *Leander v Sweden* (1987) Eur Court HR, Series A No. 116; *N v UK* Application No. 12327/86, 58 D&R 85; *Chave née Jullien v France* Application No. 14461/88, 71 D&R 141.

[486] Application No. 6825/74, 5 D&R 86, p.87.

[487] For a general survey and commentary, see L.G. Loucaides, 'Personality and Privacy under the European Convention on Human Rights' (1990) 61 *BYIL* 175.

[488] Application No. 6959/75, 10 D&R 100 [55].

[489] Application No. 8307/78, 21 D&R 116.

[490] Application No. 8741/79, 24 D&R 137.

[491] See, *e.g.*, *Gaskin v UK* (1989) Eur Court HR, Series A No. 160 [39], [49].

of the Convention is primarily intended to ensure the development, without outside interference, of the personality of each individual'.[492]

It is within this personality function of the right to respect for private life that the right to autonomy rests. One cannot possibly hope to develop one's individual personality unless one has a right to autonomy. If individuals do not at the very least have a *prima facie* freedom to act only in accordance with reasons with which they would identify, then they cannot be said to be acting in accordance with their own personalities, but rather with that of someone else—usually the state. This, for Mrs Pretty, meant that the right to respect for private life ought to include a right to decide when and how to die, including the right to decide to die with assistance.

In the Divisional Court, as already stated, the judges were prepared to accept Mrs Pretty's argument. The court noted that 'Article 8(1) protects the moral and physical integrity of the individual...It is possible to spell out of the right to bodily integrity the right of a competent person to refuse life-prolonging or even life-sustaining treatment...We are even prepared to assume, for the purpose of this argument, that it could include the right to be allowed to take one's own life...'[493] Moreover, the court specifically acknowledged that its decision was based on recognition of Article 8's concern with individual autonomy. It stated: 'It is not for third parties to make judgments about the quality of anyone else's life. Only that person can know what is or is not tolerable for them. The reason we might wish to respect their right to die is that we wish to respect their right to their own values and choices, provided always that these are freely made'.[494] But when the case came before the House of Lords, their Lordships could not agree with this proposition. For them, although the right to respect for private life offered protection to autonomy during life, it did not say anything about the right of individuals to autonomy over their deaths.[495]

At first sight, this may seem not unreasonable—it is true that by the very words 'private *life*' Article 8 does seem to rule out any consideration of matters relating to death. However, there are good reasons why this interpretation should be questioned. Let us remind ourselves of just what Mrs Pretty was arguing. It is apt here to refer again to the passage by A.C. Grayling set out above. To reiterate, the point is that Mrs Pretty was not asking for autonomy over her death, but only her dying, which as Grayling rightly notes *is* an act of living, as much as any other part of life. Now, in relation to Article 2 and the right to life of course, it was seen that this was of no consequence to Mrs Pretty's case. But the same is not true here. If dying is part of living, then there is nothing in principle to exclude it from the protection guaranteed by Article 8(1). Lord Hope at least recognised this (although somehow he was still able to deny that it could affect whether the Article was engaged),[496] but it was not until the *Pretty* case actually got to Strasbourg that it was finally accepted that, quite obviously, prohibitions on assisted dying do engage the right to

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[492] (1998) 26 EHRR 241 [32].
[493] [2001] EWHC 788 [53].
[494] *ibid.*, [60].
[495] *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61 [23], [61], [100].
[496] *ibid.*, [100].

respect for private life. Quoting Lord Hope, the ECtHR noted that 'the way she [Mrs Pretty] chooses to pass the closing moments of her life is part of the act of living, and she has a right to ask that this too must be respected'.[497] The ECtHR thought that Mrs Pretty had been prevented by law from exercising choice to avoid what she considered to be an undignified and distressing end to her life, and the court was 'not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8(1)'.[498]

Yet even had this not been the case—even if the ECtHR had not thought dying to be part of life—Mrs Pretty would still have been able to rely on Article 8 by virtue of the fact that, contrary to the opinion of their Lordships, the provision does in fact apply in some circumstances to protect 'posthumous autonomy'. This much is clear from the decision of the Commission in *X v Germany*,[499] a case in which the applicant claimed that the state had interfered with his Article 8 rights by not allowing him to have his ashes scattered on his own land. Here it was noted that:

> It may be doubted whether or not this right [to respect for private life] includes the right to choose the place and determine the modalities of his burial. Whilst those arrangements are made for a time after life has come to an end, this does not mean that no issue concerning such arrangements may arise under Article 8 since persons may feel the need to express their personality by the way they arrange how they are buried. The Commission therefore accepts that the refusal of the German authorities to allow the applicant to have his ashes scattered in his garden on his death is so closely related to private life that it comes within the sphere of Article 8 of the Convention.[500]

Clearly then, there was no justification at all for the conclusion reached by the Law Lords. Given the *X v Germany* judgment, their ruling in relation to the right to respect for private life was, with all due respect, plainly not in the spirit of Article 8.

In summary therefore we can say this. Of those courts of final jurisdiction that have considered the question of whether a right to assistance in dying can be derived from provisions protecting the right to autonomy, it is only the House of Lords and the US Supreme Court that have provided negative answers. But, in both these instances the courts' judgments have been doubtful: the House of Lords was subsequently told by the ECtHR that its ruling on Article 8(1) was wrong; and five of the judges on the Supreme Court panel which heard the *Washington* case were not at all sure about whether, had a case with different circumstances come before them, they would have been able to reach the conclusion which they did. So it is plain that the right to autonomy has

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[497] *Pretty v United Kingdom* [2002] ECHR 427 (App. No. 2346/02) [64].
[498] *ibid.*, [67].
[499] Application No. 8741/79, 24 D&R 137.
[500] *ibid.*, [2].

been the right which has provided petitioners for a right to assisted dying with the greatest degree of success. However, there is also one other category of rights which calls for examination.

The right to equality/not to be discriminated against

Equality rights, or non-discrimination rights, aim to treat like cases alike and to treat different cases differently, and in the context of the assistance in dying debate have been used to forward two similar, but distinct, arguments. The first is that which was in issue in the companion case to the *Washington* litigation, *Quill v Vacco,*[501] where a challenge was mounted by terminally ill patients and their doctors against New York's assisted suicide laws. In this case the petitioners had contended that the New York laws were in violation of the Equal Protection Clause of the Fourteenth Amendment, which commands that no state shall 'deny to any person within its jurisdiction the equal protection of the laws'. Put shortly, the argument was that, although in New York individuals are prevented from assisting suicide, they are not prevented from withdrawing life-sustaining medical treatment, and this amounted to unequal treatment of like cases:

> The removal of a life support system that directly results in the patient's death requires the direct involvement of the doctor, as well as other medical personnel. When such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live. Their doctors do a careful clinical assessment, including a full exploration of the patient's prognosis, mental competence to make such decisions, and the treatment alternatives to stopping treatment. It is legally and ethically permitted for physicians to actively assist patients to die who are dependent on life-sustaining treatments...Unfortunately, some dying patients who are in agony that can no longer be relieved, yet are not dependent on life-sustaining treatment, have no such options under current legal restrictions. It seems unfair, discriminatory, and inhumane to deprive some dying patients of such vital choices because of arbitrary elements of their condition which determine whether they are on life-sustaining treatment that can be stopped.[502]

The Second Circuit Court of Appeals accepted this line of reasoning, holding that a right to assistance in dying could be derived from the Equal Protection Clause. Miner J, who authored the majority opinion, wrote: 'New York law does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for

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[501] (1996) 80 F 3d 716.

[502] Declaration of Dr Timothy Quill, *ibid.*, p.721.

the previous attachment of life-sustaining equipment, are not allowed to hasten death by [assisted suicide]'.[503]

However, as in the *Washington* case, the US Supreme Court disagreed with the Circuit Court's ruling; again, the Supreme Court's opinion was delivered by Chief Justice Rehnquist. The Chief Justice began by noting that, on their face, neither New York's ban on assisted suicide nor its laws permitting patients to refuse medical treatment treated anyone differently from anyone else. '*Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted medical treatment; *no one* is permitted to assist suicide'.[504] His Honour was perfectly correct, of course; but his banality has not addressed the Circuit Court's central point: that is that, fundamentally, withdrawals of life-sustaining medical treatment are 'nothing more nor less than assisted suicide' and, as such, banning one but allowing the other results in similarly circumstanced people (i.e. those who are terminally ill but are on life-sustaining treatment and those who are terminally ill but are not on life-sustaining treatment) being treated differently. So the Chief Justice was forced to consider the merits of this argument. His analysis began with his conclusion: 'we think the distinction between assisting suicide and withdrawing life-sustaining medical treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational'.[505]

The Chief Justice based his conclusion on familiar common law distinctions relating to causation and intention. He wrote:

> The distinction comports with fundamental principles of causation and intent. First, when a patient refuses life sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication...Furthermore, a physician who withdraws, or honours a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes... The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, 'must necessarily and indubitably intend primarily that the patient be made dead'.[506]

Now, I have said from the outset that such distinctions as these are unimportant in a rights analysis of assistance in dying, because they tend to focus on the assister's conduct rather than on the person wishing to be assisted. I suggested that if there is a fundamental right to be

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[503] *ibid.*, p.729.
[504] *Vacco v Quill* (1997) 521 US 793, p. 800.
[505] *ibid.*
[506] *ibid.*, pp.801-802.

assisted in certain circumstances, such a right ought to be respected, regardless of what we can say about the assister's conduct, unless there are countervailing concerns for the rights of others. I stand by this. But the Supreme Court's judgment in *Vacco* makes it clear that, at least where the argument is made that a right to assistance in dying ought to be recognised because of its equivalence to the already recognised right to withdraw life-sustaining medical treatment, it is impossible to escape the common law problems altogether.

So, let us face them head on. Is there a difference between the cause of death in a case of assisted suicide and a case of withdrawing life-sustaining medical treatment? Well, if there is it certainly is not that which was put forward by the Chief Justice, that in the latter, but not the former case, the patient dies from the underlying disease. In many cases of treatment withdrawals the patient is not dying at all. For example, in *Bouvia v Superior Court*,[507] the patient, although suffering from severe cerebral palsy and being quadriplegic, could easily have lived for a further 15-20 years, had the court not agreed that she had the right to withdraw a feeding tube which had been inserted into her against her will. Even when the patient is dying, however, and the underlying disease can be said to be what the patient ultimately *dies of*,[508] this does not equate with being the *cause* of the patient's death for the purpose of attributing moral and legal responsibility. We would no more want to say, in the case of e.g. a stabbing, that the victim's cause of death was internal bleeding, even though that might be what he ultimately died of. Why? Because, for the purpose of attributing responsibility, we usually look for voluntary human actions, not mere conditions or scientific descriptions of causal connections.[509] Just as in the stabbing case it is the voluntary human action of the knifeman that has caused the death of his victim, so in the case of a patient requesting discontinuation of life-sustaining medical treatment it is the voluntary act of the doctor withdrawing the feeding tube or the respirator that has caused the patient's death. If, instead of stabbing his victim, the killer were to enter the hospital and *he* were to disconnect the patient's life-support machine, we would certainly want to say that *he* had caused the patient's death. So what is the difference between the actions of the killer and those of the doctor? The answer, of course, is that there is none—at least not in terms of causation. The only reason we distinguish between the doctor and the criminal interloper is that, while the former acts with the patient's consent or in his best interests, the latter does not.[510] Of course, this is not to say that there can never be situations when the cause of the patient's death is the underlying disease or condition. This will be the case where, for example, the patient suffers from a terminal disease or condition and either is not placed on life-sustaining medical treatment, or

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[507] (1986) 225 Cal Rptr 297.

[508] Although, strictly speaking, even this is not accurate, for the reason highlighted by the Second Circuit Court of Appeals: 'The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation beings on death by respiratory failure'. (1996) 80 F 3d 716, p.729.

[509] H.L.A. Hart and T. Honoré, *Causation in the Law* (2nd ed.) (Oxford: Clarendon, 1985),pp.33-44

[510] The example of the criminal interloper is taken from the judgment of Lord Goff in *Airedale NHS Trust v Bland* [1993] 1 AC 789.

refuses such treatment.[511] But by intervening, first, to install such life-sustaining treatment and measures, and secondly, to remove them, the doctor relegates the underlying disease or condition to a background position. As two of our most eminent thinkers on causation would put it, the doctor's deliberate human intervention is both our 'barrier and goal' in tracing backwards from the end result of the patient's death.[512]

The courts, as is well known, have tried to deny this by relying on the legal doctrine of acts and omissions, which states that individuals should only be legally held to be the cause of a harm when their conduct amounts to a positive commission or an omission to do an act which they are under a legal duty to do.[513] In the case of *Bland*,[514] the House of Lords decided that a doctor's conduct in removing life-sustaining medical treatment should be classified as an omission. But, we have to ask whether it is not the case that we do a serious violence to our language and understanding by describing the withdrawal of medical treatment as an omission, for surely the removal of a feeding tube or a respirator involves a most positive form of action. In *Bland*, Lord Browne-Wilkinson conceded this point but for him:

> in neither case should the act be classified as positive, since to do so would be to introduce intolerably fine distinctions. If, instead of removing the nasogastric tube, it was left in place but no further nutrients were provided for the tube to convey to the patient's stomach, that would not be an act of commission. Again...if the switching off of a ventilator were to be classified as a positive act, exactly the same result can be achieved by installing a time-clock which requires to be reset every twelve hours: the failure to reset the machine could not be classified as a positive act. In my judgment, essentially what is being done is to omit to feed or to ventilate: the removal of the nasogastric tube or the switching off of the ventilator are merely incidents of that omission.[515]

This is sensible enough. But, obviously, doctors would normally be liable for omissions to feed and to ventilate, because of the duty which arises out of their assumption of responsibility towards the patient. *Bland* decides, however, that this duty ends either where a competent patient refuses to continue with treatment or, in the case of an incompetent patient, where a responsible body of professional opinion agrees that continuation of the treatment is no longer in the patient's best interests because it is futile;[516] once the doctor is released from his duty, of course, he can no

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[511] Biggs suggests that, where a patient declines to accept medical treatment, death is caused by the underlying medical condition combined with the treatment refusal: H. Biggs, *Euthanasia, Death with Dignity and the Law* (Oxford: Hart, 2001), p.48.

[512] H.L.A. Hart and T. Honoré, *op. cit.*, pp. 42-44.

[513] For general surveys of this area, see J.C. Smith, 'Liability for Omissions in the Criminal Law' (1984) 4 *LS* 88; A. Ashworth, 'The Scope of Criminal Liability for Omissions' (1989) 105 *LQR* 424.

[514] [1993] 1 AC 789.

[515] *ibid.*, p.882.

[516] *ibid.*, e.g. at pp.864-865, 882-884, 897.

longer be liable for omissions to feed and to ventilate, which again seems sensible enough, because it would be absurd to have doctors owing a duty to do that which their patients did not want them to, or which was not in their patients' interests. Yet, I fear we have slightly got away from the point, because all *Bland* really does is to provide a legal defence to a doctor who withdraws life-sustaining medical treatment.[517] But the case does not—and nor can it—dispose of the central problem which is our concern: that is that, by withdrawing the life-sustaining treatment, the doctor still *causes* the patient's death insofar as it is his voluntary conduct which is responsible for that outcome; this remains the case regardless of whether the law excuses what the doctor does. And for us, this is the crucial thing. For we have to remember that the question we are seeking to answer is not whether withdrawals of life-sustaining medical treatment and assisted suicides are *legally* considered as equivalents (quite obviously they are not); it is whether these two activities are *in actuality* so similar that to permit one but not the other would be to treat similarly circumstanced persons (i.e. those who are terminally ill and on life-sustaining treatment and those who are terminally ill but are not on life-sustaining treatment) differently, in violation of their right to equality. In terms of causation, there simply is no difference in actuality between cases of assisted suicide and withdrawals of life-sustaining medical treatment. Indeed, if there is a difference at all, it would be one which would seem to justify banning withdrawals of treatment but permitting assisted suicide. For in most cases of assisted suicide the doctor's conduct will be one step further removed from the patient's death than in cases of treatment withdrawals. The doctor will have provided the means or know-how for the patient to end his life, but it will be the actions of the patient himself that will be the responsible cause of death, because we should not trace back beyond the patient's own voluntary actions (even if these only amount to the swallowing of drugs or the plunging of a syringe). So it cannot be causation that justifies the law's difference in treatment between those who wish to commit assisted suicide and those who wish to withdraw life-sustaining treatment. But what about Chief Justice Rehnquist's other ground for the distinction: the difference in intention in the two cases?

If we are unable to distinguish between assisted suicide and withdrawals of treatment on the basis of causation, then to do so on the basis of intention seems an even shakier tactic. The Chief Justice contended that a doctor who withdraws life-sustaining medical treatment purposefully intends only to respect his patient's wishes, whereas a doctor who assists in a patient's suicide must indubitably intend primarily that the patient be made dead. Yet this is simply not true, as even a cursory analysis reveals. In treatment withdrawals, even if the doctor's direct intention is only to respect his patient's wishes, since the doctor knows with absolute certainty that his actions will result in the patient's death, morally and legally, it is perfectly

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[517] As was admitted by Lord Browne-Wilkinson when he said, 'where the charge is one of murder by omission to do an act and the act omitted could only be done with the consent of the patient, refusal by the patient of consent to the doing of such act does, indirectly, provide a defence to the charge of murder': *ibid.*, p.882.

possible to say—indeed we ought to say—that the doctor's intention was that the patient die. This is sometimes referred to by lawyers as the doctrine of 'oblique intention', and it is a doctrine that reflects the common sense notion that in cases where a foreseen though undesired consequence is inseparably bound up with a desired consequence, it would simply be outrageous to say that the undesired consequence was unintended, thereby allowing the actor to evade responsibility. Consider the following well-known example: suppose a man plants a powerful time-bomb in an aircraft with the desire to blow it up in flight so that he can collect the proceeds of insurance on the cargo. Although he has a purpose other than killing the passengers on board (namely, the recovery of the insurance money), it is clear from the circumstances that it would be obscene to say that he did not intend them to perish, thus allowing him to escape liability for their deaths. Public opinion would rightly be appalled if the bomber could get away with his crime by saying that he would not have minded if all the passengers on board had survived, provided he got his money.[518]

Moreover, it is not at all clear that in cases of assisted suicide the doctor does indubitably and primarily intend that the patient should die. It could instead be argued that the intention of the doctor is primarily to help. It would not be completely inconceivable to imagine a doctor saying to his patient: 'Look, I do not want you to die, and I hope that you decide to change your mind, but since you are ill and cannot manage to take your own life, and because I believe that each individual should be able to control his own destiny, as your physician, I am prepared to give you the assistance you require.' Here, it is not the direct intention of the doctor that the patient should die—but of course this hardly matters, because the doctor would yet have *obliquely* intended the patient's death, as he would know with certainty that this would be the upshot of his assistance. So there is no difference, also, in terms of the intention of a doctor who assists in suicide and one who withdraws life sustaining treatment. The honest truth is, in either case, a doctor may directly intend the patient's death, or he may obliquely intend the patient's death, but either way the intention is that the patient will die. Chief Justice Rehnquist would have known this: indeed, he said as much when he noted that 'a physician who withdraws...life-sustaining medical treatment purposefully intends, *or may so intend*, only to respect his patient's wishes'.[519]

Thus it appears that, on analysis, the Second Circuit Court of Appeals was correct in its conclusion that New York law did not treat similarly circumstanced persons alike. In terms of both causation and intention, a withdrawal of life-sustaining treatment *is* 'nothing more nor less than assisted suicide'.[520] It is hard to see how, when compared with those individuals who are

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[518] G. Williams: 'Oblique Intention' (1987) 46 *CLJ* 417, p.423.

[519] *Vacco v Quill* (1997) 521 US 793, p. 801, emphasis added.

[520] Does this mean that a patient who refuses life sustaining medical treatment commits suicide? The answer is no, because withdrawals of life sustaining medical treatment and assisted suicides are only equivalent in terms of causation and the intention of the *doctor*, not the patient. The intention of the patient may very well be not to die, but only to let nature take its course and to no longer be subjected to a regime of treatment which he finds objectionable. Yet even if this is the patient's intention, a doctor who withdraws

terminally ill and on life sustaining-treatment, those who are terminally ill but are not on such treatment are treated any way but unequally.

But I said above that equality rights, or non-discrimination rights, had been employed to forward two different arguments. The second argument is that which was advanced in the *Pretty* and *Rodriguez* cases. Here, the heart of the matter was not that the law treated similarly circumstanced persons differently; rather, it was that the law failed to treat differently persons whose circumstances were significantly different. For both Mrs Pretty and Ms Rodriguez, the key issue was that provisions which prohibit assisted suicide are discriminatory since they fail to take into account the fact that the disabled (i.e. those whose circumstances are significantly different) are not capable in the same way as the able-bodied of exercising their right to commit suicide: whilst a physically mobile individual is perfectly able to jump off a bridge, or to obtain a lethal quantity of drugs to overdose on, for the disabled individual—particularly someone like Mrs Pretty, who was so physically incapacitated that she could barely control her voice, let alone her limbs—these are just not going to be viable options.

In *Pretty*, where the submissions were made under Article 14 of the Convention,[521] the Law Lords dismissed this line of reasoning by appealing to the distinction, already noted in our examination of the analytic right, between the *right* to commit suicide and the *liberty* to do so. Lord Bingham stated:

> The Law confers no right to commit suicide. Suicide was always, as a crime, anomalous, since it was the only crime with which no defendant could ever be charged. The main effect of the criminalisation of suicide was to penalise those who attempted to take their own lives and failed, and secondary parties. Suicide itself (and with it attempted suicide) was decriminalised because recognition of the common law offence was not thought to act as a deterrent, because it cast an unwarranted stigma on innocent members of the suicide's family and because it led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success. But while the 1961 Act abrogated the rule of law whereby it was a crime for a person to commit (or attempt to commit) suicide, it conferred no right to do so. Had that been its object there would have been no justification for penalising by a potentially very long term of imprisonment one who aided, abetted, counselled or procured the exercise or attempted exercise by another of that right. The policy of the law remained firmly adverse

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treatment at the patient's request will still intend that the patient dies. The intention of the patient and the doctor are quite separate, and they do not have to coincide with each other.

[521] Article 14 provides that, 'The enjoyment of the rights and freedoms set forth in this 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'.

> to suicide, as s.2(1) makes clear...The criminal law cannot in any event be criticised as objectionably discriminatory because it applies to all.[522]

His Lordship's reading of the background to the introduction of s.2(1) of the 1961 Act is, of course, quite correct. As we know from chapter 2, Parliament had no intention of creating a right to commit suicide when it changed the law; at best, we can say the situation changed so that people are now at liberty to commit suicide, insofar as others have no right to demand that they refrain from doing so. However, does all this really matter for present purposes?

I do not think it does—for the same reason that the distinction which the law draws between assisted suicide and withdrawals of life-sustaining treatment did not matter for present purposes either. Remember, equality and non-discrimination rights are not about legal or analytical distinctions, but about how things are on the ground. The fact that the law does not grant people a right to commit suicide but only a liberty is neither here nor there if the practical upshot is that, as the law stands, a certain group of people are denied an opportunity or advantage which is available to the majority. As Antje Pedain has put it, 'When the standard is one of ensuring non-discriminatory treatment both in law and in fact—as, surely, in the context of human rights law it is because otherwise granting human rights to persons would be no better than a sham—rules with discriminatory effects stand in need of separate and particular justification to the extent to which they typically affect a sub-group of persons much more harshly than other subjects of the law'.[523]

The point being made here is the very simple one, that, in relation to the freedom to commit suicide, individuals who are severely physically disabled are being indirectly discriminated against in a way which in no other area of life we would find acceptable. If, in providing employment, facilities, services, or any other advantage or benefit, a person or organisation was to adopt a rule or standard which on its face was applicable to all but which had a disproportionately adverse impact on one particular group of society, such impact being due to a particular characteristic of that group such as race, sex, religion, or, indeed, disability, then prima facie the person or organisation adopting the rule or standard would be in breach of our anti-discrimination laws. For example, we do not usually allow employers to have blanket bans on part-time working, because we know that this has a disproportionately adverse impact on women as a group due to the fact that women are statistically more likely to be primary child-carers than men.[524] Similarly, we would question an employer who had a policy that all members of staff should be clean-shaven and have short hair, because this could have a disproportionately adverse impact on, for example, Sikhs as a group.[525] So why then do we allow a law to stand that although seemingly applicable to all has a disproportionately adverse impact on the severely physically disabled as a

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[522] [2001] UKHL 61[35], [36].

[523] A. Pedain, *op. cit.*, pp.197-98.

[524] *Home Office v Holmes* [1984] ICR 678.

[525] *Singh v Rowntree Mackintosh Ltd* [1979] ICR 554; *Panesar v Nestlé Co Ltd* [1980] ICR 144n.

group?[526] It cannot be for the facile reason that the freedom to commit suicide is not an advantage or benefit, because, as Chief Justice Lamer noted in *Rodriguez*, the advantage which is being claimed is not the advantage of committing suicide as such, but rather the advantage in having the *choice* to do this.[527]

There has to be another explanation. Again, it is enough to look for it in our ordinary anti-discrimination law principles: since it is clear that, in some cases, indirect discrimination may be justifiable. In *Bilka Kaufhaus GmbH v Weber von Hartz*,[528] it was held that an indirectly discriminatory rule or policy will be justified if, among other things, it objectively relates to a ground other than a characteristic of the employee such as sex or race; corresponds to a real and reasonable need on the part of the employer; and is both appropriate and necessary to meet that real need. So, for example, a ban on unshorn beards and long hair may be justified on the grounds of hygiene, as long as the employer is in the business of food manufacturing and such a ban is absolutely necessary.[529] And thus it is with prohibitions on assisted suicide: it may be that they, too, are capable of objective justification, as indeed was found to be the case by the ECtHR in *Pretty* (this justification is the subject of the final chapter). But the point is, it is not adequate for a court glibly to state that because, legally speaking, there is no right to commit suicide there can never be discrimination against those who because of their disability are unable to do what most others can. This is to miss the crucial point about the right not to be discriminated against—that is, it is the right not to be discriminated against not just in law, but in fact. The House of Lords realised this, I think, because their Lordships do also refer to a possible objective justification.[530] However, by introducing the analytical distinction between rights and liberties—trying to secure their opinion by belt and braces—their Lordships have probably done more to confuse than to clarify the law.

For all of the above reasons, whether one chooses to focus on the inequality of treatment between those who are terminally ill and on life-sustaining treatment and those who are terminally but not on such treatment, or, indeed, on the indirect discrimination suffered by those too disabled to be able to exercise the same degree of freedom to commit suicide as the non-disabled majority, there does seem to be good reason to conclude that equality and non-discrimination rights could yet prove to be the kind of substantive provisions within whose ambit a right to

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[526] It is sometimes suggested that, if the right to assistance in dying is framed as a right not to be discriminated against, it follows that the right must be granted not only to those who are severely physically disabled, but also to those who are disabled in another sense, insofar as they lack the strength of will to carry through their desire to die. I may be perfectly capable of jumping of a bridge, but simply could not bring myself to do it, preferring instead the less harrowing option of a lethal injection carried out by an obliging doctor. Can the right not to be discriminated against be taken this far? I do not think so, but I struggle to find a reason why—except to say that a disability of will may be indicative of ambivalence on the part of the person requesting death. But, cf. the discussion of first and second order desires in Chapter 4.

[527] [1993] 3 SCR 519, at pp.552-554.

[528] [1987] ICR 110.

[529] *Singh*; *Panesar*, *op. cit.*

[530] *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61 [36], [64].

assistance in dying might fall—even if, ultimately, the unequal or discriminatory treatment might be capable of objective justification. Yet, there is perhaps one other type of argument that needs to be considered here: and this is that provisions which protect equality and the right not to be discriminated against are simply not meant to be applied to problems such as assistance in dying.

This was the point made by McLachlin J in *Rodriguez*. Ms Rodriguez had argued that the prohibition on assisted suicide under s.241 infringed her rights under s.15 of the Charter, which states that: 'Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability'. The Chief Justice Lamer, Corey J, and the majority had all agreed with Ms Rodriguez (although only the Chief Justice and Corey J held the infringement could not be justified). However, McLachlin J wrote: 'I am of the view that this is not at base a case about discrimination under s.15 of the Canadian Charter of Rights and Freedoms, and that to treat it as such may deflect the equality jurisprudence from the true focus of s.15—"to remedy or prevent discrimination against groups subject to stereotyping, historical disadvantage and political and social prejudice in Canadian society"...I see this rather as a case about the manner in which the state may limit the right of a person to make decisions about her body under s.7 of the Charter [on which see above]'.[531]

Throughout this work the need for sensitivity toward the natural parameters of substantive provisions has been consistently emphasised; and it is this rather than anything else that should now cause pause before concluding that a right to assistance in dying can be derived from equality and non-discrimination rights. For while, intellectually speaking, I can accept that prohibitions on assisted dying may be framed as problems for equality and discrimination, I am less certain that they ought to be, as a matter of practice. I think McLachlin J has a valid point. Equality and non-discrimination provisions do exist principally to combat bias and unfairness against groups subject to stereotyping, historical disadvantage, etc; and the terminally ill—even the physically disabled terminally ill—are not, and never have been, on the receiving end of such treatment, at least not on any systematic basis.[532] So it does seem, therefore, that by admitting the issue of assisted dying into the area of equality and discrimination, we are deflecting the jurisprudence from its real area of concern. Now, of course, I realise that in saying this I may appear to some to be exhibiting a fundamental misunderstanding. They would suggest that if I only looked at a provision such as Article 14 of the Convention, I would see that equality and anti-discrimination provisions do not have to be concerned only with stereotyped and historically disadvantaged groups. Article 14, they would point out, comes into play whenever one of the other Convention rights is engaged. If, in line with the analysis in the previous section, a right to

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[531] [1993] 3 SCR 519, at p.616.

[532] Although, as was discussed in chapter 3, the terminally ill can often feel stigmatised because of their condition.

make choices about the time and manner of death falls within the right to autonomy in Article 8, then under Article 14 this right has to be secured equally for all, irrespective of whether the terminally ill have historically been discriminated against. This is true enough. But I nonetheless think that the principal route of argument for those petitioning for a right to assistance in dying still ought to be via substantive provisions that protect the right to autonomy—for in the end, claims of discrimination or inequality will always be 'parasitic' to the autonomy arguments,[533] as is reflected in the fact that Article 14 has no independent existence, i.e. it cannot be invoked without either Article 8 or one of the other Convention rights first being engaged.[534] There are then at least reasons to wonder whether equality and anti-discrimination provisions are the 'best fit' for a right to assistance in dying.

C. Conclusion

We need to take stock of where we are, to be clear about exactly what has been achieved so far; because there is perhaps a risk that the reader may assume we have gone further than we actually have, and that it has already been established that prohibitions on assisted dying must fall because they are in violation of certain fundamental rights. This, we have not yet established. All that has been accomplished in this chapter is to *articulate* the right to assistance in dying: that is, to voice it in the language of those substantive rights provisions that are found in constitutions and international conventions. In doing so, we have found that certain of the substantive provisions are better able to accommodate the right to assistance in dying than others. In particular—unsurprisingly—provisions that protect the right to autonomy are especially amenable, for example Article 8 of the European Convention, s.7 of the Canadian Charter and the Due Process Clause of the Fourteenth Amendment to the US Constitution. But we also saw that the right to assistance in dying may be derivable from provisions protecting equality and the right not to be discriminated against—although, as said above, there are perhaps problems with these provisions in terms of their natural parameters. Yet, all of this does not really amount to very much, because being able to voice the right—being able to say there is a right to be assisted in dying, and being able to point to its location in some substantive provision—is not at all the same as being able to say that the right must be protected and respected to the extent that legislation such as s.2(1) of the Suicide Act, or s.241 of the Canadian Criminal Code, or the various US state bans on assisted suicide, cannot remain in force. As I have said throughout, a right to assistance in dying need only be respected and protected to the extent that it can exist alongside countervailing concerns for the rights of others. It is to these countervailing concerns that we must now turn.

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[533] Insofar as that the terminally ill who are severely disabled and the terminally ill who are not on life-sustaining treatment are unable to put their autonomous choices into effect to the same degree as either the able-bodied or those who are on life-sustaining treatment.

[534] For an overview of how Article 14 works, see S. Livingston, 'Article 14 and the Prevention of Discrimination in the European Convention on Human Rights' [1997] 1 *EHRLR* 25.

6. INTERFERING WITH THE RIGHT

The writings of J.S. Mill[535] teach us that the state has a fundamental obligation to manage, so far as it can, people's competing claims to liberty, so that the greatest degree of freedom is permitted to each individual as is compatible with the same degree of freedom for all. It is in fulfilment of this obligation that the state must balance the arguments of the individual asserting a right to assistance in dying against those arguments that are opposed to such a right—the latter, because of their collective nature, usually being referred to as 'state interests' (although, of course, it is crucial to remember that it is equally an interest of the state to protect the individual who is asserting the right to assistance in dying).

There are a variety of interests to which the state may appeal to limit or prevent recognition of a right to assistance in dying and, in this chapter, I will examine, often by reference to the evidence presented to the recent House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill,[536] each of these interests with a view to establishing both their relative strengths, and the precise concerns which are encompassed by them. In turn, I shall look at the interest in upholding the sanctity of human life, the interest in preventing suicide, the interest in protecting dependants, the interest in preserving the integrity of the medical profession, the interest in not demeaning the disabled, and the interest in protecting the lives of those who do not want to die. These interests are sometimes referred to as the legislative objectives, or ends, for which the state may prohibit assistance in dying. However, in determining whether a state is justified in interfering with a fundamental right, it is necessary to look not only at the legislative ends, but also at the means chosen to achieve those ends. This is the issue to which the final part of this chapter is given over, and here, essentially, we are interested in proportionality. How far does the state have to go to achieve its ends? Is total prohibition of assistance in dying necessary, or can the state secure its interests by some lesser interference?

A. The legislative ends: state interests

The interest in upholding the sanctity of human life

For many people, assistance in dying ought not to be sanctioned because to do so would undermine the principle of the sanctity of human life, i.e. the idea that all human life is inviolable. This principle usually derives from the religious view that life is a God-given gift over which humans are to exercise stewardship, but not dominion. Life is not ours to dispose of as we wish; that is a matter for which only the Almighty is qualified. On this understanding, to end one's life or to assist in the ending of another's life is the ultimate act of defiance—the assertion of self over

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[535] J.S. Mill, *On Liberty and Other Essays* (Oxford: OUP, 1991).

[536] HL Paper 86 (London: HMSO, 2005) (hereinafter, HL 86 I, II or III)

divine authority.[537] Other versions of the sanctity of life principle are more secular. Ronald Dworkin, for example, has suggested that reverence for the intrinsic value of human life can be based on our awe for the creativity of evolutionary biology, or on individual human endeavour.[538] Moreover, people can simply believe that the taking of a human life is always wrong no matter what, and they need not derive this view from a religious source or indeed any source at all, it being rather a matter of intuition.[539]

The courts have commented many times on the interest which the state has in upholding the sanctity of life principle. Lord Donaldson has said that 'Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible'.[540] Similarly, in *Bland* the House of Lords noted that the sanctity of life was 'a principle long recognised not only in our own society but also in most, if not all, civilised societies throughout the modern world, as is indeed evidenced by its recognition both in Article 2 of the European Convention on Human Rights, and in Article 6 of the International Covenant on Civil and Political Rights'.[541] The judges hearing the *Pretty* case also took note of the principle, as did the court in *Rodriguez* and in the *Washington* and *New York* litigation. Yet, in none of these jurisdictions has the sanctity of life principle been found to be absolute.

It is, rather, 'one of a cluster of ethical principles which we apply to decisions about how we should live'.[542] Were it not, the state could not sanction lawful killing in self-defence (or, in the US, capital punishment), nor could competent adults refuse or request the withdrawal of life-saving medical treatment. Indeed, in the context of the latter, the courts have affirmed that 'the principle of the sanctity of human life must yield to the principle of self determination'.[543] The question to be asked, therefore, is: already acknowledging that there are these exceptions to the idea that human life is inviolable, why should the interest in upholding the sanctity of life principle preclude us recognising a right to assistance in dying? The answer, clearly, is that it should not. As an abstract state interest in preserving an *idea* about human life, it offers an effete rejoinder to the

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[537] This basic conviction is shared by all of the major western religions. See J. Paris and M. Moreland, 'A Catholic Perspective on Physician-Assisted Suicide'; C.Cohen, 'Christian Perspectives on Assisted Suicide and Euthanasia: the Anglican Tradition'; N. Zohar, 'Jewish Deliberations on Suicide: Exceptions, Toleration and Assistance', all of which are to be found in M.P. Battin *et al*, *Physician Assisted Suicide* (London: Routledge, 1998).

[538] R. Dworkin, *Life's Dominion: an Argument about Abortion and Euthanasia* (London: HarperCollins, 1993), ch.3.

[539] See Jonathan Glover's comments in his oral evidence to the House of Lords Select Committee on the Assisted Dying for the Terminally-Ill Bill, HL Paper 86-II, Q65 (London: HMSO, 2005), particularly his reference to George Orwell's account of an execution.

[540] *Re T (An Adult) (Consent to Medical Treatment)* [1992] 2 Fam 458, p. 470.

[541] [1993] 1 AC 789, p.863-64.

[542] *ibid.*, *per* Hoffmann LJ at p.826.

[543] *ibid*, per Lord Goff at p.864. This dicta was cited with approval by Munby J in *R (Burke) v GMC* [2005] EWHC 1879 (Admin), where he stated that 'Important as the sanctity of life principle is, it has to take second place to personal autonomy' [213]. Although Munby J's judgment has since been criticised by the Court of Appeal, who counselled 'strongly against selective use of Munby J's judgment in future cases', the view that 'personal autonomy or the right of self-determination prevails' was not cast in doubt by the higher court: [2005] EWCA Civ 1003 [24], [30].

concrete interest of a competent individual who is expressly stating that he no longer wishes to continue living. The interest in preserving the sanctity of life is thus only a starting point: its function is to allow the state to demonstrate that it respects the interest which the great majority of people have in continuing to live and that it will protect that interest—but it is no more than that. To sanctify the life of one who rationally covets death is not only ineffectual, but it is also invidious.

Sometimes, however, the sanctity of life principle is defended in a slightly different way. The argument here is not so much that it is always wrong to end a human life before its natural span, but rather that the social implications of a significant change in the paradigm that we now have would be thoroughly undesirable—the danger is that life would become cheapened and killing would become easy.[544]

Clearly this is a possibility; but it is *only* a possibility. We have no way to predict how people will react to reform, and whilst we should take every caution to ensure that society does not become indifferent to life, the dangers should not be exaggerated. There is, for instance, no data to show that in a country such as the Netherlands, where assisted dying has been legalised, respect for life is any lower than in other jurisdictions where assisted dying is prohibited: the Dutch murder rate is only one-tenth the rate of that in the US and well below the average for the EU; Dutch suicide rates have increased less than the statistical average increase for EU states and were the fourth lowest out of 12 countries surveyed between 1974 and 1988.[545]

Likewise, I know of no evidence to suggest that people began to think about life with a more callous mindset after the *Bland* case clarified that doctors could lawfully terminate life by withdrawing life-sustaining medical treatment. Quite the opposite in fact. I should imagine that of those familiar with the case, *Bland* instilled in the majority a sense of just how precious life was, and what it was that made it so, namely, some sense of being able to control one's life. The tragedy and great difficulty of Anthony Bland's case was that no-one knew what he himself would have done if he had been faced with his situation while competent; so others were left to decide for him. In any event, there is in Western democracies a whole plethora of things which could to a greater of lesser degree have the effect of undermining our reverence for human life: from violent television programmes and computer games at one end of the scale, to capital punishment at the other. Arguably, the potential for a slide towards barbarism as a result of these sorts of things is at least equal to, if not greater than, any potential for the same which could come about as a result of a change in the law which would permit assistance in dying—which is, after all, about a competent person asking for help to die because he no longer wishes to go on suffering.

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[544] J. Glover, *Causing Death and Saving Lives* (London: Penguin, 1977), p.58-59.

[545] S.W. Smith, 'Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia' (2005) 13 *Med L Rev* 17, p.32.

The interest in preventing suicide

The state has a strong interest in preventing individuals from taking their own lives. The problem of suicide is one that is pandemic and deeply distressing. Although overall suicide rates in the UK are falling, in 2003 there were still some 5,755 adult suicides.[546] Suicide in men is an especial problem, male suicides accounting for three-quarters of all self-inflicted deaths. Yet while the state has a legitimate interest in preventing the majority of suicides, that interest, like the state's interest in maintaining the sanctity of life, is notably less compelling in the case of a terminally ill, competent adult who is asking to die to avoid the needless and pointless suffering of the final stages of his illness. As the Ninth Circuit Court of Appeals noted in the *Washington* case:

> One of the heartaches of suicide is the senseless loss of a life ended prematurely. In the case of a terminally ill adult who ends his life in the final stages of an incurable and painful degenerative disease, in order to avoid debilitating pain and a humiliating death, the decision to commit suicide is not senseless, and death does not come too early. Unlike the depressed twenty-one year old, the romantically devastated twenty-eight year old, the alcoholic forty year old, or many others who may be inclined to commit suicide, a terminally ill competent adult cannot be cured. While some people who contemplate suicide can be restored to a state of physical and mental well-being, terminally ill adults who wish to die can only be maintained in a debilitating and deteriorating state...[547]

The simple point is that suicide is not always a rash or irrational choice. Whilst the old saying is generally true—suicide is an all too permanent solution to what are often temporary problems—it does not hold universally. For some, suicide is the only reasonable choice. But we are then forced to think about the kinds of circumstances when this may be so. Whilst many people would probably agree with the Ninth Circuit Court that there is an obvious difference between the suicide of a terminally ill patient and that of a depressed twenty-one year old, a romantically devastated twenty-eight year old, or an alcoholic forty year old (all of whom have the possibility of finding long-term future happiness), there is less clear water between the position of the terminally ill patient and, say, a life-sentenced prisoner. It is not at all beyond the realms of possibility to imagine that such a prisoner, rather than spend the rest of his days behind bars, would prefer to die. Are we prepared to admit that suicide in these circumstances should also be permitted? Before answering this, I should first clarify that the kind of case I have in mind here is

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[546] UK suicide rates are not based only on those deaths which are officially classified as suicides. As coroners will return a definite verdict of suicide only where it is beyond all reasonable doubt that the deceased deliberately intended to kill himself, many probable suicides are classified as 'open verdicts' (no doubt to avoid the stigma for the deceased's family). To take account of this, UK suicide rates therefore also include deaths of so-called 'undetermined intent', thus hopefully giving a truer picture of the actual numbers who do end their own lives. (Figures are those published on the Office for National Statistics website on 10 March 2005; see also the Samaritans' *Information Resource Pack 2004*, available at www.samaritans.org.)

[547] *Compassion in Dying v State of Washington* (1996) 79 F 3d 790, pp.820-21.

not like the sorts of rash suicides that occur in prisons all too frequently, where the prisoner is either depressed, or racked with guilt, or, upon entering prison and without giving himself time to adjust, simply cannot imagine how he will cope. The kind of case I am thinking of, rather, is one where the prisoner has already been in jail for a good number of years and so has had plenty of time to adapt to life incarcerated, is not suffering from depression or any other mental impairment, and has fully come to terms with his crimes. In other words, his decision to end his life is free from vitiating elements and has been reached after long and careful deliberation, possibly over many years. It is a decision based *solely* on the assessment that he would prefer to be dead rather than serve out the remainder of his days locked away.

So should suicide in these circumstances be permitted? Although some people I think might agree that the prisoner's choice was not necessarily a bad one, i.e. he might be better off dead if the prospect of a life of imprisonment is truly intolerable to him, there are nonetheless two good reasons why the state may legitimately act to prevent such suicides, which reasons do not apply in the case of suffering, terminally ill patients—and I am not here talking about the clear duty on the state to prevent the sorts of rash suicides which I have distinguished from the example of our prisoner's 'considered suicide'. First, the state may act to prevent the prisoner's considered suicide because if he succeeds in killing himself he is escaping his due punishment; the retributionary element of the sentence is thwarted and the public can rightly feel aggrieved that justice has not been done. One need only think about the reactions of many of the relatives of the victims of Dr Harold Shipman, when it was revealed that he had hung himself after serving less than 4 years of his life sentence: they expressed shock and anger that he had 'taken the easy way out'. Secondly, the state has an interest in maintaining the internal order, security and discipline of prisons.[548] Allowing prisoners to kill themselves while in state custody could have all sorts of unpredictable negative effects, stemming from the other prisoners losing faith in the system.

Yet, in spite of these arguments there is authority to suggest that in limited circumstances the state need not act to prevent prisoners killing themselves. In the case of *Secretary of State for the Home Department v Robb*,[549] a declaration was granted at the request of the Home Secretary that it would be lawful for the prison authorities not to force feed a prisoner who was on hunger strike. How can we reconcile this decision with what has just been said? Kennedy and Grubb have remarked of the case that it is important to notice what the judge actually decided.[550] He held that there was no *duty* to force feed the prisoner but left open the question of whether the

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[548] See *Secretary of State for the Home Department v Robb* [1995] 1 All ER 677; *Thor v Superior Court* (1993) 5 Cal 4th 725; *Department of Public Welfare v Kallinger* (1990) 580 A 2d 887; *Re Caulk* (1984) 125 NH 226.

[549] [1995] 1 All ER 677.

[550] I. Kennedy and A. Grubb, *Medical Law* (London: Butterworths, 2000), p.924.

authorities *could* do so if there were sufficient state interests compelling this.[551] On the facts, Thorpe J found that there were not sufficient state interests, although it is to be noted that the judge failed to consider the interest the state may have in seeing to it that prisoners fully serve out their sentences. However, on the question of the interest in preventing suicide, Thorpe J did note that although this interest was recognisable to English law, it was of no application because the refusal of nutrition and hydration in the exercise of the right of self-determination does not constitute an act of suicide.[552] Clearly, the underlying assumption in *Robb* was that, all things being equal, the interest in self-determination cannot be outweighed by the state interest in preventing suicide. And if the latter cannot be used to frustrate a hunger-striking prisoner's wish to die, it surely should be no bar to recognising a right to assistance in dying for terminally ill patients suffering in their final months.

The interest in protecting dependants

One of the reasons that the state may have an interest in preventing suicide is that the person wishing to die might have responsibilities towards dependants. In some jurisdictions this has in the past been used to justify the overriding of refusals of life-saving treatment. For example, in the US case of *Application of the President and Directors of Georgetown College*, a mother of a seven-month old infant was given a blood transfusion against her wishes, because she owed a responsibility to the community to care for her child.[553] Similar decisions are to be found in *Matter of Powell v Columbian Presbyterian Medical Center*[554] (mother of six forcibly transfused), and *Matter of Winthrop University Hospital v Hess*[555] (advance directive against blood products overruled to prevent a mother abandoning her child). However, subsequent decisions have made it plain that the interest in protecting dependants cannot prevail over the right to self-determination, even where the exercise of this right will inevitably lead to death. In *Norwood Hospital v Munoz*,[556] the Massachussets Supreme Judicial Court found that a Jehovah's Witnesses's refusal of blood products could not be overridden on the ground that her son would be abandoned, because the child could be cared for by other family members. The same decision was reached by the Florida District Court of Appeals in *Wons v Public Health Trust of Dade*

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[551] In the subsequent case of *R v Collins, ex parte Brady* (2001) 58 BMLR 173 , where a declaration was sought to break the hunger strike of the 'Moors Murderer', Ian Brady, although the declaration was granted because Brady was found to be incompetent and therefore his refusal could be invalidated, the court noted that even had he been found competent, the force feeding could have gone ahead because Brady's hunger strike was motivated by a desire to force the prison authorities to change his conditions of detention.

[552] This proposition was established in *Bland* when the House of Lords proclaimed that, where life-sustaining treatment is withdrawn from a patient, 'there is no question of the patient having committed suicide...' [1993] AC 789, p.864. For judicial authority supporting the opposite view, i.e. that a prisoner who refuses food is committing suicide, see *Laurie v Senecal* (1995) 666 A 2d 806, p.809.

[553] (1964) 331 F 2d 1000. This case should be regarded with caution because there was a suggestion that the patient was in fact incompetent to make the decision required of her.

[554] (1965) 267 NYS 2d 450.

[555] (1985) 490 NYS 2d 996.

[556] (1991) 564 NE 2d 1017

County.[557] More significantly, in *Fosmire v Nicoleau* the New York Court of Appeals affirmed that, even where dependant children could not be taken on by other family members, the individual right to self-determination was still paramount. The court noted:

> Although the state will not permit a parent to abandon a child, the state has never gone so far as to intervene in every personal decision a parent makes which jeopardizes the family unit or parental relationship. The laws of adoption and divorce show that the state recognizes competing interests and, in some instances, accords them priority. Indeed the state's need to punish those who violate its laws has never been held to be subordinate to the needs of the prisoner's family...The state does not prohibit parents from engaging in dangerous activities because there is a risk that their children will be left orphans...We know of no law in this state prohibiting individuals from participating in inherently dangerous activities or requiring them to take special safety precautions simply because they have minor children.[558]

This would unquestionably be the position of the UK courts. Given cases such as *Re MB*[559] and *St George's Healthcare NHS Trust v S,*[560] both of which found that pregnant women had an unassailable right to refuse consent to a Caesarean section even when that refusal could mean the death of both the woman and the unborn child, it is unimaginable that English law would countenance any limitation being placed on the right of self-determination for the sake of preventing the abandonment of a dependant child. In any event, in the context of the assistance in dying debate, arguments about the interest in protecting dependants are utterly unavailing for the obvious reason that the terminally ill individual will shortly die anyway.

The interest in preserving the integrity of the medical profession

It is sometimes argued that the law ought not to be changed to allow assistance in dying because of the negative effects that such a change could have on the integrity of the medical profession. Essentially this is an argument about bright lines, and it is usually put in one of the following two ways. On the one hand, it is stated that for doctors to assist in a patient's dying is fundamentally at odds with the physician's role of healer. On the other, it is said that assisted dying would undermine the trust that is essential to a productive doctor-patient relationship—some patients would be unsure whether their doctor is there to kill or to cure. The courts have approached the interest in protecting the integrity of the medical profession in contrasting ways. In the *Washington* case, the Ninth Circuit Court of Appeals dismissed the interest, noting 'we do not

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[557] (1987) 500 So 2d 679.

[558] (1990) 551 NE 2d 77.

[559] [1997] 2 FLR 426.

[560] [1998] 3 All ER 673.

believe that the integrity of the medical profession would be threatened in any way by the vindication of the liberty interest at issue here'.[561] But when the case was before the Supreme Court, Chief Justice Rehnquist took the opposite view.[562] Likewise, there have been divergent opinions expressed by judges in this country. While Thorpe J noted in *Robb* that the interest is 'one that I find hard to recognise as a distinct consideration',[563] in *R v Collins, ex parte Brady* the trial judge uttered that: 'it would seem to me to be a matter of deep regret if the law has developed to a point in this area where the rights of a patient count for everything and other ethical values and institutional integrity count for nothing'.[564]

A good discussion of this state interest is to be found in the report of the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill. Here, on the issue of whether a change in the law would be likely to erode patients' trust in their doctors, it was noted by the Committee that 'opinion polls do not suggest any significant anxiety on this score'.[565] The report refers to a 2004 YouGov poll which showed that if the law were to be changed to allow assistance in dying for the terminally ill, 70% of respondents' trust in their doctors would not be affected, while 9% would trust their doctors more, and a further 9% would trust their doctors less.[566] Another survey showed that out of 11 European nations including the UK, it is the Dutch (who of course have legalised assistance in dying) who have the highest regard for and trust in their doctors.[567]

As to whether assistance in dying is at odds with the doctor's role as healer, the evidence before the Committee was more mixed. While the Royal Colleges of Physicians and General Practitioners adopted a neutral stance,[568] and the General Medical Council stated that its guidance would always be consistent with the law as it stands,[569] the GMC did make a written submission in which it stated that 'a change in the law to allow physician-assisted dying would have profound implications for the role and responsibilities of doctors and their relationships with patients. Acting with the primary intention to hasten a patient's death would be difficult to reconcile with the medical ethical principles of beneficence and non-maleficence'.[570] Predictably, of the individual doctors who gave evidence to the Committee, some were of the view that assistance in dying should be part of a whole therapeutic package; others had profound reservations about altering the status quo. Less predictably, perhaps, some wondered whether or

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[561] *Compassion in Dying v State of Washington* (1996) 79 F 3d 790, pp.827.

[562] *Washington v Glucksberg* (1997) 521 US 702, p.731.

[563] [1995] Fam 127, p.132.

[564] (2001) 58 BMLR 173.

[565] HL Paper 86-I, p.40.

[566] *ibid.*, appendix 7, p.131. It should be noted that the poll was commissioned by the Voluntary Euthanasia Society.

[567] *ibid.* p.40; also, HL Paper 86-I, p.6.

[568] Subsequently, the Royal College changed its stance to one of opposition after it balloted its members and found that the majority of respondents did not wish to see a change in the law.

[569] HL 86-I, pp.41.

[570] *ibid*, p.42. HL 86-II, p.112.

not, to avoid the problems relating to the integrity of the profession, assisted dying could be carried out outside of the mainstream medical profession. A representative for the British Geriatrics Society noted: 'People can be given the wherewithal to end someone's life...but I'm not entirely sure why doctors need to be involved, because effectively it is a social decision, not a medical decision'.[571] The Committee made reference to this point in its conclusions, thus indicating that it was something that it wished to see Parliament consider carefully in any future debate on the Bill.[572]

There are a number of points which may be made on this issue of the compatibility of assisted dying with the doctor's traditional role—all of which were rehearsed by the Ninth Circuit Court in the *Washington* case.[573] First of all, doctors have been discreetly helping patients to hasten their deaths for a very long time; the prevalence of this covert assistance may be disputed, but that it happens is not.[574] Second, doctors may openly take actions which intentionally cause their patients' deaths insofar as they are legally able to withdraw life-sustaining medical treatment or nutrition and hydration; cease respiratory assistance; and may even, under the doctrine of 'double effect', administer lethal quantities of drugs provided only that the drugs also have some analgesic benefit. Thirdly the Hippocratic Oath is not, and never has been, rigidly determinative of the scope of a doctor's duties. As the Ninth Circuit Court noted, 'Twenty years ago the American Medical Association contended that performing abortions violated the Oath; today, it claims that assisting terminally ill patients to hasten their death does likewise. Clearly, the Hippocratic Oath can have no greater import in deciding the constitutionality of physician-assisted suicide than it did in determining whether women had a constitutional right to have an abortion'.[575] Given all this, would recognising a right to assistance in dying represent that radical a redefinition of the doctor's role?

It is convenient at this juncture also to say something about the matter of conscientious objection, because as well as being concerned to maintain the integrity of the medical profession as a whole, we should also want to ensure the integrity of individual healthcare practitioners.[576] That laws which permit assistance in dying should in principle allow healthcare workers to opt out of assisting in patients' deaths if that is what their conscience dictates is not, I think, a matter

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[571] HL 86-II, p.386. Hazel Biggs makes the point that, 'Death and dying are presently regarded as the domain of medical science and easing the passing from dying into death is an accepted part of a doctor's duty, so it would seem apt [that doctors should be involved in assistance in dying]. Further, there is some evidence to suggest that assisted death is regarded as more dignified if attended by a qualified medical professional.' H. Biggs, *Euthanasia, Death with Dignity and the Law* (Oxford: Hart, 2001), p.6.

[572] HL 86-I, p.83.

[573] (1996) 79 F 3d 790, pp.827-830.

[574] HL 86-1, pp.31-32, 81-82. See also, Introduction, Candidness of Doctors.

[575] (1996) 79 F 3d 790, pp.829.

[576] This is a point made by Biggs throughout her book, although she talks about the 'dignity' of health care practitioners as opposed to their integrity: H. Biggs, *Euthanasia, Death with Dignity and the Law* (Oxford: Hart, 2001), e.g. at pp. 113, 158.

which would cause much disagreement.[577] There are, however, a couple of practical issues that call for consideration.

First, there is the danger that a right to conscientious objection could effectively render any right to assistance in dying nugatory. The House of Lords Select Committee was presented with evidence from the Association of Palliative Medicine which suggested that 72% of the association's members would not be prepared to participate in a process of patient assessment which formed part of an application for assisted suicide or voluntary euthanasia.[578] The Committee was also warned by the Royal College of Nursing that any change in the law would be 'unacceptable to many nurses on moral, ethical or religious grounds'.[579] A representative for the RCN pointed to the large number of nurses within the NHS who are from overseas, the implication being that cultural differences could cause many staff to view assistance in dying with abhorrence.

Clearly, a right to assistance in dying cannot work unless healthcare professionals are actually prepared to provide the necessary assistance. But there is little reason to think that they would not be. In spite of views such as those expressed by the RCN, and data such as that provided by the APM, the overwhelming evidence before the Select Committee indicated that conscientious objection would not fatally undermine a right to assistance in dying. Since 1987, the vast majority of opinion polls conducted have consistently shown that at least 30 per cent of doctors support the principle of assistance in dying, many of whom would be prepared to practise it if the law were liberalised.[580] In 2003, a survey carried out by the Nursing Times found that of 2,700 respondents, two-thirds were in favour of legalisation of assistance in dying, and 31 per cent believed that nurses should be allowed to provide such assistance.[581] A 1998 postal survey of pharmacists by the Universities of Bristol and Manchester found that 70 per cent of respondents believed that a patient should have the right to choose to die, and 49 per cent said they would willingly dispense a prescription to be used in a case of assisted dying.[582] Furthermore, as the Committee noted, there is no evidence of significant opt-out problems in countries where assistance in dying is already legal.[583]

A second concern relating to conscientious objection supposedly stems from the multidisciplinary nature of terminal care. A worry is that, if the doctor with primary responsibility for the patient decided that a patient's request for assistance in dying should be acceded to, others in the care team might feel that they were being implicated in that decision, even though they would

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[577] Examples of conscientious objection provisions can be found in the Assisted Dying for the Terminally Ill Bill (draft clause 7) and the Oregon Death with Dignity Act (127.885).

[578] HL 86-I, p.44.

[579] *ibid* p.43; HL 86-II, p.97.

[580] HL 86-I, appendix 7, pp.134-144.

[581] *ibid.*, p.145.

[582] *ibid.*

[583] HL 86-I, pp.43-44.

not want to be.[584] For my part, I have to confess I do not understand this argument. It seems to me to be valid only on the assumption that the principal doctor alone will have a right of conscientious objection, and that everyone else—other doctors, nurses, pharmacists, and auxiliary staff—could potentially find themselves conscripted into an enterprise they morally do not agree with. But of course, this need not be the case. If each individual healthcare worker has a right to conscientiously object to taking part in assistance in dying, then this particular problem dissipates.[585] There may be the residual problem of whether a conscientious objector should be required to refer the patient to someone without such objections, but this is surely not an insurmountable one.[586]

The interest in not demeaning the disabled

The state has a legitimate interest in protecting the infirm and disabled from prejudice and societal indifference. It is sometimes argued that to repeal the ban on assistance in dying would send out the dangerous message that the lives of those who are ill or disabled are not as valuable as those of people who are healthy and non-disabled. This argument seems to me to rehearse the same idea that we saw used to defend the sanctity of life principle, i.e. that permitting assistance in dying will in some way cheapen life, in this case, specifically the lives of the ill and the disabled.

As I said earlier, we simply have no way of knowing how people will react to reform; all we can do is to extrapolate from past experience. I said that I knew of no evidence to suggest that, after *Bland* clarified that doctors could lawfully terminate life by withdrawing life-sustaining medical treatment, people thought about the lives of individuals with any a more callous mindset. Doubtless, there will be some disability groups that will consider this uninformed naivety on my part. For example, when the Disability Rights Commission gave its evidence to the House of Lords Select Committee, it felt that one of the key reasons why it could not support reform of the law was that disabled people were already subjected to discrimination in current end-of-life treatment practices; to legalise assistance in dying would only exacerbate this problem. One of the Commissioners, Ms Jane Campbell, recounted her personal experience of this kind of discrimination. She described how, on being admitted to hospital with pneumonia in both lungs, the assumption of the doctors treating her was that, should she go into respiratory failure, she would not want to be ventilated because the quality of her life was so poor—at least in the doctors' eyes. Commissioner Campbell noted 'Fortunately, my husband and I succeeded in

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[584] *ibid.*, pp.89-90.

[585] The Committee noted in its conclusions that the conscientious objection clause in the Assisted Dying for the Terminally Ill Bill should be drawn to 'protect the interest of all members of the clinical team. In particular it should seek to address such situations as that in which, for example, a nurse with conscientious objections is asked by a patient to raise with a doctor on his or her behalf a request for assisted suicide or voluntary euthanasia': *ibid.* p.89.

[586] The Select Committee took the view that there ought not to be a duty to refer, because of the risk of violating Art 9 of the European Convention: *ibid.*

countering the assumptions of the consultants treating me. If I had been too ill to communicate effectively, the consultants' assumptions may have prevailed. That would have been much more likely, I feel, if assisted dying were on the statute books, for it would have somehow legitimised their prejudice'.[587]

This incident does not appear to be an isolated one. Alison Davis, the national coordinator of No Less Human (a group dedicated to protecting and promoting the equal right to life of all disabled people), highlighted the case of Sue Maynard-Campbell. Mrs Maynard-Campbell, who uses a wheelchair and is a vice-chair of an NHS Trust, went into hospital in 1998 with a chest infection and found that a 'Do Not Resuscitate Order' had been placed on her medical notes. The doctor had apparently decided that she had nothing to live for after speaking 'no more than six words' with her.[588] The DRC also pointed to evidence showing that, when making treatment decisions, 32 per cent of doctors judge a patient's 'usefulness to society'.[589] There is also the recent case of Leslie Burke,[590] in which the DRC intervened. Mr Burke was so concerned that food and fluid might be withdrawn from him once he ceased to be able to express his objections to such a move that he challenged the General Medical Council's guidance on the subject in the courts. All of this clearly very worrying. But is it particularly germane to the issue in hand?

The whole purpose of a right to assistance in dying is to allow each individual the right to decide *for himself* if and when his life is no longer worth living; in other words, precisely the opposite of what happened in all of the above cases, where that decision was usurped by the medical profession. This was a point made to the Committee by Dr Tom Shakespeare, a sociologist who has written widely in both bioethics and disability studies. He stated: 'The disability rights movement has not always drawn clear distinctions between different issues at the end of life...It is necessary to distinguish situations where the autonomy of disabled people is undermined (abuse of Do Not Attempt Resuscitation, non-voluntary euthanasia) from situations where disabled people themselves are exercising their autonomy by requiring assistance in death, or withdrawal of treatment (advance directives, assisted suicide)'.[591] The DRC seems to be muddying the waters. The right to assistance in dying is not primarily about people with disability; it is about people with terminal illness.

Underlying the DRC's opposition to the right to assistance in dying is the fear of compounding or legitimising what it takes to be the already too prevalent attitude in society that it is better to be dead than disabled, i.e. the kind of attitude typified by the assumptions of the consultants in Ms Campbell's case. However, if a right to assistance in dying is saying anything, it is not that it is better to be dead than disabled, but rather, *in some circumstances*, it is better to be dead than suffering terminal illness. Again, the point was put well by Dr Shakespeare:

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[587] HL 86-II, p.235.
[588] HL-86 III, pp.26-27
[589] HL 86-II, p.225.
[590] *R (Burke) v GMC* [2005] EWHC 1879 (Admin); [2005] EWCA Civ 1003.
[591] HL 86-II, p.245.

> I do not think this Bill [the ADTI Bill] is a threat to disabled people. I think that the Bill is—as I have read and understood it—carefully limited to people at the end stage of terminal illness which is by no means the equivalent to being a disabled person. There are 10 million disabled people in Britain, a very small proportion of them are in that state. Terminal illness people could be seen to be disabled but disabled people are not necessarily terminally ill. I think Jane's evidence [Commissioner Campbell] and the evidence for the DRC generally is very moving and it is absolutely true that disabled people face discrimination in many areas of life and we should combat that in any way possible. However, I do not think that evidence or that testimony is relevant to this Bill. As I say, this Bill is about terminal states.[592]

Commissioner Campbell had argued otherwise. When examined orally by the Committee, she had begun by stating 'I want to stress that there is absolutely no distinction between those of us described as "terminally ill" and those of us described as "disabled". The two are so inextricably linked that the terms are interchangeable in the eyes of the public'.[593] This, perhaps, is somewhat surprising coming from a DRC Commissioner, because it is part of the disability movement's philosophy that disability is as much a matter of self-definition as it is classification by others—to sweepingly categorise all disabled people as terminally ill and all terminally ill people as disabled seems, therefore, a little high-handed.

But then, this is not the only surprising aspect of the DRC's position. As Dr Shakespeare also noted: 'In general, the disability rights movement have supported the autonomy of disabled people throughout life: the basis of independent living philosophy is support for the rights and choices of disabled people to have control over their own lives. It seems to be inconsistent to support the principle of autonomy for disabled people in all matters except at the end of life'.[594] He also highlighted the discrepancy between the DRC's opposition to legislative reform and the attitudes of the disabled community at large. In a survey conducted by the DRC itself, 60 per cent of respondents supported a change in the law to allow assistance in dying. More recently, a YouGov poll found that: 80 per cent of disabled persons were supportive of change; disabled people believe more strongly than others that the law currently discriminates against terminally ill disabled people who wish to commit suicide but need assistance to do so; and that disabled people are slightly more likely than others to believe that reform of the law would improve society's views of disabled people.[595] It is hard not to agree with Dr Shakespeare's conclusion

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[592] *ibid.* p.248.
[593] *ibid.*, p.235.
[594] *ibid.* p.248
[595] *ibid*, and HL 86-I, appendix 7, p.130.

that the opposition of organisations of disabled people to reform can be put down either to them being 'wiser or are less representative than their constituencies'.[596]

So the interest in protecting the disabled from prejudice and negative attitudes is not a knock-down argument against recognising and respecting the right to assistance in dying altogether. At best, it is an argument for limiting the exercise of such a right to those individuals who are suffering in the final stages of terminal illness.[597]

The interest in protecting the lives of those who do not want to die

The first point to note about this state interest is that it is not the same as the interest in maintaining the sanctity of life principle, although the two are often confused. The sanctity of life principle is about upholding an *idea* that all life is inviolable, or at least that all life has a certain value which society should be careful not to degrade. In contrast, the interest we are examining now is concerned with protecting actual lives: the lives of people who, though they might not want to die, nonetheless may be at risk of death if assistance in dying were to be legalised. The second point about this interest is that it is undoubtedly the strongest of all the state interests and the one that is most likely, if any, to preclude recognition of the right to be assisted in dying. In *Pretty*, *Rodriguez*, and the US cases, it was this interest which the courts relied on to justify upholding the state ban on assisted dying. A final point by way of introduction: this state interest is perhaps more complicated than others, because it encompasses a number of different concerns. The threat from recognising the right to assistance in dying to the lives of those who do not want to die can stem from different sources, but these are often dealt with by the courts in a confused and confusing manner. With this in mind, I have divided this section into four parts, each part articulating a different concern, examining how real it is, and what might be done to deal with it. I begin by examining the problem of vulnerable people being coerced into assisted dying by others.

(a) Pressures from without

The concern here is that certain vulnerable individuals, particularly those who are elderly or infirm, might come under pressure to request assistance in dying from unscrupulous relatives, carers, or other self-interested persons standing to benefit from the individual's death. The courts

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[596] HL 86-II, p.248.

[597] I have until now resisted the urge to define what I mean by phrases such as 'terminal illness' or 'terminally ill'. The problem, as the Select Committee noted, is that there is a difference between the popular view of terminal illness and the clinical reality of predicting death, which is notoriously inexact. The issue is not one which ultimately needs to be resolved by a thesis that looks at assisted dying from a rights perspective, it being a problem rather of legislative detail. However, if pushed, I think that the definition used in the Assisted Dying for the Terminally Ill Bill is probably as good as any other. Terminal illness is defined in the Bill as 'an illness which in the opinion of the consulting physician is inevitably progressive, the effects of which cannot be reversed by treatment (although treatment may be successful in relieving the symptoms temporarily) and which will be likely to result in the patient's death within a few months at most.' Any attempt to be more precise than this will, I think, be doomed to failure.

take this threat very seriously indeed. In the *Washington* case, the US Supreme Court recognised that there was a 'real risk of subtle coercion and undue influence in end-of-life situations';[598] in *Pretty*, the European Court of Human Rights noted, 'clear risks of abuse do exist';[599] and in *Rodriguez* the Canadian Supreme Court cited with approval a working paper of the Canadian Law Reform Commission, which stated that 'the probable reason why legislation has not made an exception for the terminally ill lies in the fear of...the abuses to which liberalisation of the existing law could lead'.[600] Fears of coercion were also voiced to the House of Lords Select Committee. The British Geriatrics Society stated in its memorandum: 'Older people are often unduly influenced by their families and carers. It is important to remember that not all these people will necessarily have the older person's well being at heart. Even if they do, it is noteworthy that almost all requests to end life—made either directly or indirectly to us as Geriatricians—come from the patients' families and not the older person themselves'.[601]

The potential for coercion and undue influence of the vulnerable is clearly very real. However, it is important to accept that this potential already exists as the law stands: relatives or carers can convince elderly patients on artificial ventilation or feeding to ask for it to be withdrawn; in jurisdictions where the courts accept substituted judgment for incompetent patients, relatives can themselves take the decision to withdraw life-sustaining treatment; under the pretence of concern for the patient's pain, family members may ask doctors to increase to dangerous levels the analgesic drugs which a patient is receiving—indeed, Baroness Finlay, one the Select Committee members and Professor of Palliative Medicine at University of Wales College of Medicine, provided an example of this latter from her own practice, which involved a 59 year old woman. The woman's relatives appeared to be concerned that the patient was in pain and constantly badgered the medical team to increase her levels of diamorphine. The doctors were unconvinced, however, and the patient herself declined the higher doses. The woman turned 60 with minimal celebration, after which her relatives stopped visiting her. The woman consequently became depressed and explained that the problem was that, on her 60th birthday, her fixed-term life insurance policy had expired: the family would not now inherit what they would have done had she died before her birthday—this was the real reason why the relatives had asked for increased drugs.

The point being made is a straightforward one. Given the possibilities for undue influence which already exist, recognition of the right to assistance in dying would not seem to be putting people in any more danger than they already are. In fact, it could be argued that the involvement of an impartial and professional third party such as a doctor in the decision-making process would more likely act as a safeguard against the risk of coercion. There is, further, evidence to suggest that in

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[598] *Washington v Glucksberg* (1997) 521 US 702, p.732.
[599] *Pretty v United Kingdom* [2002] ECHR 427 (App. No. 2346/02) [74].
[600] *Rodriguez v British Columbia (AG)* [1993] 3 SCR 519, 614.
[601] HL 86-II p.375.

those places where assistance in dying is legal, it is only those people who are extremely forceful and dynamic who have the resilience and stamina to go through the various legal procedures and overcome the numerous hurdles set out in assisted dying legislation; weaker, more vulnerable people are screened out because they do not have the drive or energy to take the process through to the end.[602] Moreover, if the right to assistance in dying is restricted to the terminally ill, the temptation to exert undue influence will be tempered by the knowledge that the person will die shortly in any event.[603]

(b) Pressures from within

A related, but more subtle problem is the risk of individuals feeling pressure to hasten their deaths, not because of coercion or undue influence, but because they believe themselves to be a burden on their loved ones. The risk is that, out of concern for either the emotional or economic welfare of their families, some people might choose an early death because that is what they believe to be the right and decent thing for them to do, even though it is not what they really want to do.

Again, this concern is genuine enough. In *Pretty*, it is at the heart of the decision that the interference with the right to respect for private life could be justified under Article 8(2).[604] But the same can clearly be said about the risk of people opting for assistance in dying because they perceive themselves to be a burden as was said vis-à-vis coercion and undue influence. The risks already exist: people on life-sustaining treatment can ask for it to be withdrawn; those who are being given analgesic drugs may exaggerate their pain and ask for their doses to be increased to life-endangering levels. Yet this response seems somehow too shallow here, for it fails to answer the charge that is actually being put.

The real worry of those who highlight the pressures that some individuals feel to choose death is that society simply is not doing enough to make sure that those pressures do not arise in the first place. As the British Geriatrics Society noted to the Select Committee, 'many older people, probably because of the care that we in the United Kingdom offer them, often feel burdened and often feel a burden to their families, and consequently we are anxious that the choices they make may not truly reflect their wishes but may reflect the way they have been led to feel by the way they are treated within the health and social care system'.[605] The Disability Rights Commission also reflected:

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[602] HL 86-II, p.534 (Professor Tallis) and p.273 (Ms Glidewell). See also the evidence relating to the higher numbers of educated people availing themselves of the right than non-educated people: *ibid.* p.258.

[603] A point that was made by the Ninth Circuit Court in the *Washington* case: (1996) 79 F 3d 790, p.826.

[604] *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61 [29]; *Pretty v United Kingdom* [2002] ECHR 427 (App. No. 2346/02) [74].

[605] HL 86-II p.379.

> Many disabled people do not have access to good healthcare and adequate and properly resourced social support and this can lead to indignity and lack of independence. Many carers do not receive the help they need to support the person they care for and to have a good quality of life themselves...The DRC believes that disabled people and their families are subject to indirect coercion that could lead to a request for assisted death. There is evidence that many disabled people are living intolerable lives, not because of their impairment, but due to lack of choice, control and autonomy brought about by the lack of basic amenities and support services including inaccessible and inadequate housing, insufficient personal care, and lack of essential equipment...The DRC believes the [ADTI] Bill would reduce the autonomy of disabled people. It would represent the failure to portray alternatives to death as viable options and would add weight, through acceptance of the legalisation of assisted dying, to the belief that early death is the only choice for people with terminal illnesses in the interests of themselves and their loved ones.[606]

What is one to say to this? The accusation that our society has its priorities all wrong, and that we should be doing more to improve health and social care before we consider permitting assistance in dying, is especially stinging because of its self-evident truth.

I do not want to appear to be ducking this argument; but I do think it is important at this point to remember the perspective from which this thesis is looking at the issue of assistance in dying—this is a rights analysis. As such, it is crucial to stand aside from arguments about what social policy we ought to pursue in an ideal world, and to concentrate on what balance of justice we can achieve in the imperfect real world.[607] Of course it would be better if our health and social care systems were such that no one ever felt themselves to be a burden on others—but that, sadly, is a utopian hope. On the other hand, it is not a utopian hope that we might prevent the needless pain, suffering, and anguish of those individuals who would prefer to hasten death than to endure the final stages of terminal decline. This is not to say that we should not, at the same time, strive by all means to improve health and social care. For the right to assistance in dying and improved care are not mutually exclusive goals: for instance, in both Oregon and the Netherlands hospice and palliative care has substantially expanded since legalisation of assisted dying.[608]

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[606] *ibid.*, p.223.

[607] In her evidence to the Select Committee, Baroness Greengross noted: 'I feel the burden question is a societal problem and a problem of resources in this country, in the way in which we allocate resources, and it has to be treated differently from this subject [of assistance in dying]. There are lots of things that get muddled up together, like the disability organisations feeling they are undervalued. They are. People with disabilities are undervalued...We have to do something about that...If we start about the burden that individuals feel they are on society, that is about reallocation of resources, training care-staff better and changing our culture, and not about this Bill': *ibid.* p.548.

[608] The evidence is summarised at HL 86-I, pp.57-58, 65-67.

It is also important to remember the ethical principles underlying the right to assistance in dying. If the right is founded at all on respect for autonomy, then it is possible to argue that a request for assistance in dying should not be invalidated automatically by an individual's feelings of being a burden. As Glanville Williams long ago pointed out: 'If a patient, suffering pain in a terminal illness, wishes for euthanasia partly because of his pain and partly because he sees his loved ones breaking under the strain of caring for him, I do not see how this decision on his part, agonising though it may be, is necessarily a matter of discredit either to the patient himself or to his relatives'.[609] The argument is that, an individual may be motivated to action by feelings of being a burden but yet—out of a sense of ultimate altruism—truly wish to die. This scenario needs to distinguished from those other cases where the individual believes he is a burden and asks for assistance in dying, not because he wishes to die, but because he thinks he is doing right by his loved ones. The state interest in protecting those who do not want to die only applies in the latter type of case.

(c) The 'logical slippery slope'

Another anxiety encompassed by the interest in protecting the lives of those who do not want to die is that, if once the principle of a right to assistance in dying is conceded in the case of a competent terminally ill patient, sooner or later the law will be compelled by force of logic to permit assisted dying in other cases, for example where the patient is not competent, or is not terminally ill—the so-called 'logical slippery slope'.

The problem of the 'logical slippery slope' has been most clearly expressed perhaps by Dr John Keown, in his book *Euthanasia, Ethics and Public Policy*.[610] Here, Keown presents us with a dilemma whereby we must accept either: (1) that the justification for assisted dying is autonomy, in which case he says we must logically accept that the right to an assisted death has to be extended to those who are not terminally ill, and indeed to those who are not ill at all but who nevertheless ask for assistance in dying; or (2) we accept that it is the doctor's judgment that the patient is suffering terribly that is crucial, in which case we are logically committed to accommodating non-voluntary euthanasia, because of course such a judgment can be made in the case of an incompetent patient just as easily as in the case of a competent patient.[611]

There are several things that might be said about Keown's work; but the first point to make is that, for obvious reasons, any logical progression of the sort envisaged under (1) above does not actually invoke the interest presently under consideration. The interest in protecting the lives of those who do not want to die clearly can have no application where a person is *asking* for assistance in dying, and that is so whether the patient is terminally ill, ill, or perfectly healthy. I

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[609] G. Williams, 'Mercy Killing Legislation—a Rejoinder' (1958) 43 *Minn L Rev* 1, p.5.

[610] J. Keown, *Euthanasia, Ethics and Public Policy: an Argument against Legalisation* (Cambridge: CUP, 2002).

[611] *ibid.* pp.77-79.

deal with this issue here only because it is expedient to consider the various extensions of assistance in dying all at once.

The more important point, however, is that it can fairly be said that Keown's logical slippery slope argument has recently been quite refuted. For, as the works of Hallvard Lillehammer[612] and Dr Stephen W. Smith[613] show, Keown's dilemma rests on a fundamental fallacy.

Both of these writers have demonstrated that Keown confuses the concept of a 'necessary condition' with that of a 'sufficient condition'. A necessary condition is one that is required for a state of affairs to obtain, viz. the state of affairs could not occur without the condition. By contrast, a condition is sufficient if it is *all* that is necessary for a state of affairs to obtain. So, a condition may be a necessary condition for a certain state of affairs but not be a sufficient condition, because additional conditions must also occur before the state of affairs can obtain. The simple, but elegant point is that neither the autonomy justification nor the judgment that the patient is suffering terribly can hold up the right to assistance in dying on their own. In other words, both are necessary conditions but neither are sufficient conditions. As Smith puts it:

> Both the doctor's judgment and the autonomy interest of the patient are necessary to provide a sufficient justification. The autonomy interest by itself can justify the individual making the request, but cannot justify the actions of the doctor. The judgment of the doctor provides the necessary justification for the doctor to act, but only at the request of the patient. It does not provide a sufficient justification for the doctor to act without that request.[614]

Once this is understood, it can be seen that the logical slippery slope is not so logical after all. Because autonomy *and* the humanitarian concern to prevent suffering must both bear the justificatory burden of the right to assistance in dying—a point I have insisted on from the outset—there is nothing to compel us to make the choice that Keown insists we have to. It is perfectly logical for us to draw a line and to say that the right to an assisted death should be restricted exclusively to those patients who are both competent and suffering terribly. However, this only takes us so far. For although Lillehammer and Smith have comprehensively demonstrated why the right does not logically have to be extended beyond those who are both competent and suffering terribly, what they have not done is shown a reason why we ought to restrict the right to assistance in dying to those who are both competent and suffering *terminally*; because clearly, a patient may be competent and suffering terribly but yet he may not be dying. In

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[612] H. Lillehammer, 'Voluntary Euthanasia and the Logical Slippery Slope Argument (2002) 61 *CLJ* 545.

[613] S.W. Smith, 'Fallacies of the Logical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia' (2005) 13 *Med L Rev* 224.

[614] *ibid.*, p.232.

this case, logic surely indicates that the patient has as much right to assistance in dying as anyone—both the autonomy condition and the humanitarian condition are after all satisfied.

True enough. But then, it is still possible to suggest that the right to assistance in dying should not be granted to such a non-terminal patient, on the basis that there are other considerations which militate against the logical argument. One obvious such consideration has already been discussed: the risk that in granting the right to assistance in dying to those who are in non-terminal states we might inadvertently send out a signal that could be interpreted as saying certain types of lives are not as valuable as others. Although the disability lobby's argument that the right to assistance in dying would reinforce negative attitudes and legitimise the view that it is better to be dead than disabled does not provide a reason for ruling out the right *in toto*, it does, as I said, provide us with a cogent reason for limiting the right to those who are close to death; that way there can be no confusion as to the right's proper message, that in some circumstances a person may decide it is better to be dead than suffering terminal illness. Based on this, then, we can see that concerns that there will be a slide towards non-voluntary assisted dying, and that the right will be extended to those who are not terminally ill, do not appear to be well founded. I would conclude as Smith has: the weight given to the logical slippery slope argument should be kept to a minimum.[615]

(d) The 'practical slippery slope'

The logical slippery slope argument, however, is only one type of the slippery slope argument. The other, perhaps more prominent, slippery slope argument in the assistance in dying debate is the 'practical slippery slope'. The practical slippery slope suggests that, even if there is reason to believe that we can draw a logical line between assisted dying for competent, terminally ill patients on the one hand, and all other types of assisted dying on the other, we will not be able to hold this line in practice and non-voluntary assisted dying and assisted dying for those who are not terminally ill will follow nonetheless. In support of this contention, opponents of the right to assistance in dying usually point to empirical data from the Netherlands which purport to show widespread abuse of the law, leading to the deaths of many individuals who are not necessarily wanting to die.

There have been three studies carried out which are of importance. The results of the first study were published in 1991 and relate to data collected in 1990.[616] The second study was published in 1996 and relates to data collected in 1995.[617] The third study was published in 2003 and

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[615] *ibid.*, p.243.

[616] For a translated summary, see P.J. van der Maas *et al*, 'Euthanasia and other Medical Decisions Concerning the End of Life' (1991) 338 *Lancet* 669.

[617] G. van der Wal *et al*, 'Euthanasia, Physician-Assisted Suicide, and other Medical Practices Involving the End of Life in the Netherlands' (1996) 335 *NEJM* 1699.

relates to data collected in 2001.[618] The main findings of the three studies are as follows. First, euthanasia accounted for 1.7 per cent of all Dutch deaths in 1990, 2.4 per cent of all deaths in 1995 and 2.6 per cent of all deaths in 2001. Secondly, physician-assisted suicide accounted for 0.2 per cent of all Dutch deaths in 1990, 1995 and 2001. Thirdly, terminations of life without the explicit request of the patient accounted for 0.8 per cent of all deaths in 1990, 0.7 per cent of all deaths in 1995, and 0.7 per cent of all deaths in 2000. It is these last figures that are usually pounced upon as evidence for the practical slippery slope.

Again, it is John Keown who has been one of the most voluble commentators. The Dutch figures, he argues, provide all the evidence we could possibly need for maintaining the ban on assisted dying: the data for terminations of life without explicit request show the clear danger that what starts as voluntary, wished-for death soon descends into non-voluntary, possibly even unwanted killing.[619]

It is worth noting that Keown does not take the findings of the Dutch research at face value. Although he does not question the methodologies of the studies, he argues that they do not show the true rates of euthanasia in the Netherlands because they do not classify as such all life-ending practices where the doctor intends the patient's death. Keown believes that the true euthanasia rate can only be arrived at by including, for example, all withdrawals of life-sustaining treatment and administrations of palliative drugs where the doctor at least holds a partial intention that the patient die. It is not I think unfair to say that Keown's interpretation of the data is somewhat idiosyncratic. He is, indeed, regarded by many commentators, including the authors of the Dutch studies themselves, as having unreasonably misinterpreted and inflated the findings of the research.[620] Perhaps, however, this is beside the point. For even if the Dutch findings are taken as read, they still make for worrying reading. In real terms, the percentage figures for terminations of life without patients' requests translate into 1000 and 900 non-voluntary deaths respectively. Obviously, were these the bare facts this would be highly controversial.

But the facts need filling out. In the 1991 study, for example, the authors note that in more than half of the cases where there was apparently no explicit request, the decision had in fact been discussed with the patient, and the patient had in a previous phase of his illness expressed a wish for euthanasia should suffering become unbearable; in the other cases, possibly with a few exceptions, the patients were near to death and clearly suffering grievously, yet verbal contact had become impossible. The decision to hasten death was then nearly always taken after

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[618] B.D. Onwuteaka-Philipson *et al*, 'Euthanasia and other End-of-Life Decisions in the Netherlands in 1990, 1995 and 2001' (2003) 362 *Lancet* 395.

[619] J. Keown, *Euthanasia, Ethics and Public Policy: an Argument against Legalisation* (Cambridge: CUP, 2002), chs. 9-13.

[620] P.J. van der Mass *et al*, 'Dances with Data' (1993) 7 *Bioethics* 323; J. van Delden, 'Slippery Slopes in Flat Countries—a Response' (1999) 25 *JME* 22; C.J. Ryan, 'Pulling up the Runaway: the Effect of New Evidence on Euthanasia's Slippery Slope' (1998) 24 *JME* 341; S.W. Smith 'Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia' (2005) 13 *Med L Rev* 17, pp.34-35.

consultation with the family, nurses, or one or more colleagues. This evidence was recently reiterated by the Dutch researchers before the Select Committee:

> Roughly speaking, in about half of all those cases there has been some kind of discussion before the patient became incompetent; because most of the patients are incompetent—that is to say, no longer capable of making a request. We do not know whether they would have done it, but they are not capable of it. Before they became incapable or incompetent, there has been some kind of discussion about ending life—but not an explicit request for euthanasia. As I said, almost all patients are—and, in our last study, 100 per cent of all patients were—incompetent at the moment of that decision.[621]

It is also important to note that the research clearly shows that the numbers of non-voluntary deaths have not increased between 1990 and 2001—this is in spite of the fact that the overall proportion of deaths by euthanasia has risen from 1.7 per cent to 2.6 per cent in the same period (as Smith points out, we might have expected the rate of terminations of life without request to increase at a similar rate[622]).

Not only are the Dutch rates of non-voluntary deaths stable, but they also compare favourably with the figures of terminations of life without request from countries where assistance in dying is prohibited. For instance, in a 1997 survey which adopted similar methodology to the Dutch research, Kuhse *et al* showed that, in Australia, the rate of unrequested medically assisted deaths was 3.5%.[623] A similar rate was also observed in Belgium prior to that country's moves to legalise assisted dying in 2002. Here, it was found that lethal quantities of drugs were given to patients without their explicit request in 3.2 per cent of all cases.[624] Taken together, these findings seem to belie the claim that legal acceptance of assisted dying endangers the lives of those who might not wish to die. Quite clearly, greater numbers of people are dying non-voluntarily in jurisdictions where assisted dying is outlawed than in the Netherlands, where it is not.

Yet, it is easy to overstate the argument, as Smith notes. He points out that the Australian research has been criticised by some because, unlike the Dutch research, it did not include a physician-interview element in the survey. It has been argued that had this element been included in the study, the rate of non-voluntary deaths would have been much lower. Another allegation made was that the Australian study mistranslated one of the Dutch researchers' questions, again

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[621] HL 86-II, p.477.

[622] S.W. Smith 'Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia' (2005) 13 *Med L Rev* 17, pp.36.

[623] H. Kuhse *et al*, 'End-of-Life Decisions in Australian Medical Practice' (1997) 166 *Medical J of Australia* 191. On the same, see Roger Magnusson's excellent study *Angels of Death: Exploring the Euthanasia Underground* (London: Yale University Press, 2002).

[624] L. Deliens *et al*, 'End-of-Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey' (2000) 365 *Lancet* 1806.

leading to skewed results. The Belgian study was criticised because of its low response rate.[625] Such criticisms may or may not be valid (Smith notes, for example, that the allegation of mistranslation does not specify which particular question was mistranslated; he also remarks that because assistance in dying was illegal in Australia and Belgium at the time of the research, if anything, the figures are likely to be underestimated, because fewer doctors are likely to admit to such practices when they know they are liable to prosecution[626]).

At any rate, the same kinds of criticisms are more difficult to make in relation to a more recent study, the very purpose of which was to compare end-of-life decision making between six different countries. This study looked at data from Belgium (before the passing of the new law), Denmark, Italy, the Netherlands, Sweden and the German-speaking part of Switzerland.[627] Again, Smith has summarised the results in his article, and once more they seem to lend little support to the idea of the practical slippery slope. What was found was that although the Netherlands unsurprisingly had the highest rates of physician-assisted suicide and euthanasia, it had a lower rate of non-voluntary ending of life than two of the other countries surveyed—Belgium and Denmark. Furthermore, the Netherlands was the only country whose rates of physician-assisted suicide or euthanasia were *higher* than the rates of ending of life without explicit request. Apart from Switzerland, all of the other countries were found to have rates of ending life without request that were higher than requested euthanasia and physician-assisted suicide combined. Only three of the countries (Sweden, Switzerland and Italy) had a rate of non-voluntary deaths which was lower than the Netherlands.

The conclusion seems ineluctable. The available evidence, in the form of overall rates of non-voluntary deaths, does *not* support the idea that acceptance of assistance in dying necessarily endangers the lives of those who do not want to die. However, as Smith warns, this does not foreclose the argument. 'While there may be no indication of slippage in the general rates of non-voluntary and involuntary euthanasia, some evidence of slippage may exist in particular practices that may be steps leading to a greater acceptance of non-voluntary and involuntary euthanasia. In other words, it may be too soon to see the bottom of the slope but there may be evidence to indicate that things are on their way down the slope'.[628] Smith is here referring to the evidence from the Netherlands that shows that guidelines concerning the proper practice of euthanasia are not being followed as they should be.

To give some background, a Dutch physician will only be exempt from prosecution for his involvement in a patient's death if he fulfils a number of specified 'due care' criteria and notifies

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[625] S.W. Smith 'Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia' (2005) 13 *Med L Rev* 17, p.37.

[626] *ibid.*, note 88.

[627] A.van der Heide *et al*, 'End-of-Life Decision Making in Six European Countries: Descriptive Study (2003) 361 *Lancet* 345.

[628] (2005) 13 *Med L Rev* 17, p.38.

the local coroner. There are six such criteria.[629] The patient must have made a voluntary and well-considered request to die; his suffering must be lasting and unbearable; he must have been informed about his medical condition and prognosis; both the doctor and the patient must be satisfied that there is no other reasonable solution to the situation; the doctor must consult at least one other (and independent) physician, who must visit the patient and give his written opinion of whether the requirements of due care have been met; and, finally, the doctor must terminate the patient's life with due medical care. Once the patient has died, it is the doctor's responsibility to report the death to the coroner and to complete a report. The coroner visits the place of death, performs an external examination on the patient, and notifies the public prosecutor and the civil registrar. The coroner then compiles his own report, noting the cause of death and forwards this, together with the second-opinion doctor's report and, if necessary, the patient's medical notes, to one of five regional assessment committees, whose role it is to investigate each reported case of assisted dying and to determine whether the due care criteria have been met with. If the criteria have been met with, that is the end of the matter; there are no further investigations and no prosecution. If, on the other hand, the criteria have not been fulfilled then the committee must notify the public prosecution service and the health inspectorate, and prosecution becomes a possibility.

Keown has asserted that every one of these guidelines has been breached at one point or another.[630] It is true that the reporting requirement is not strictly adhered to: the latest figures show that only 54 per cent of euthanasia cases are notified to the authorities in the Netherlands.[631] Smith notes other problems: doctors do not always consult with colleagues, discussion is often inadequate, and 'intolerable suffering' is still very difficult to define.[632] This, Smith suggests, may be taken as evidence in favour of the slippery slope.

However, there is no reason that it *must* be taken to be so. For instance, in relation to the reporting requirement, there are several explanations that can be put forward for the non-compliance.[633] Doctors may fail to notify the authorities simply because they do not want the administrative bother involved. Others might not report because they believe that what they are doing is best kept within the confines of the doctor-patient relationship. Yet others will, no doubt, be unsure as to whether their actions will satisfy the due care requirements. But clearly, it is only this last explanation that can have any bearing on the slippery slope argument whatsoever. Though we might find the other two explanations for non-reporting objectionable, they cannot be taken as evidence of a move towards non-voluntary killing. And the same applies to failings in

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[629] These are discussed at HL 86-I, p.62.

[630] J. Keown, *Euthanasia, Ethics and Public Policy: an Argument against Legalisation* (Cambridge: CUP, 2002), p.136.

[631] HL 86-II, p.469.

[632] (2005) 13 *Med L Rev* 17, p.40.

[633] See the evidence given to the Select Committee by Dr Onwuteaka-Philipson, HL86-II, p.471.

respect of any of the other guidelines. The reasons for the failings are not necessarily indicative of a slide down the slippery slope.

Additionally, as Smith notes, these problems may only be problems for the Dutch system.[634] The evidence available from the US state of Oregon seems to show that the regulations there are not being flouted in the same way.

The history of assisted dying in Oregon is very different from that in the Netherlands.[635] The Oregon Death with Dignity Act was passed in November 1997 and, unlike the Dutch law, permits only assisted suicide: doctors are permitted to write a prescription for a lethal quantity of drugs, but they are not allowed to administer them to the patient. In the seven years that the Act has been in force, the number of Oregonions availing themselves of the right to assistance in dying has remained very small. In 2003, only 42 patients died from physician assisted suicide; this compared with 38 in 2002, 21 in 2001, 27 in 2000, 27 in 1999, and 16 in 1998. The 42 patients who took advantage of the law in 2003 represent an estimated 14 out of 10,000 total deaths; this compares with 12.2 in 2002, 7.0 in 2001, 9.1 in 2000, 9.2 in 1999, and 5.5 in 1998. These data are collected by a neutral state agency, the Oregon Department of Human Services (ODHS).[636] It is this body which is also responsible for collecting information regarding non-compliance with the Act.

In its evidence before the House of Lords Select Committee, the ODHS explained that the number of cases involving non-compliance in Oregon was very small.[637] It explained that where it did discover a case of non-compliance, it referred the matter to the medical regulatory body, the Oregon Board of Medical Examiners (OBME),[638] whose role it then is to take the decision both on whether to discipline the doctor and also, in more serious cases, whether to inform the public prosecutor. The OBME gave its own evidence to the Select Committee; this confirmed that non-compliance was rare. Since the Act has been in operation, the OBME has investigated only four complaints, none of which was serious enough to result in a doctor being disciplined. In two of the cases, the OBME made a finding that there had not been a violation of the guidelines; in the other two cases, the doctors were sent letters of concern but no further action was taken. All four cases involved relatively minor administrative errors, such as incorrect form completion or failing to get adequate witness signatures (though in fact the correct number of witnesses were present).[639] This evidence makes clear that although the Dutch system may have its problems in relation to compliance, these are not unavoidable. The Oregon model shows us that, given the right

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[634] (2005) 13 *Med L Rev* 17, p.40.
[635] HL 86-I, ch.5
[636] HL 86-II, p.255.
[637] *ibid.*, pp.265-66
[638] The OBME is roughly the equivalent of our own General Medical Council.
[639] *ibid.*, p.322-24. On the other hand, the Select Committee did hear limited testimony that suggested that the criteria of the Oregon Act were not being so well observed. It is notable, however, that much of this involved anecdotal evidence, and one has to ask—as indeed the Select Committee did ask—why this evidence had not been reported to the OBME for investigation?

framework, doctors can and will participate in assisted dying only when their actions accord with the criteria set down by law.

Thus we can conclude that, as with the evidence relating to the overall rates of non-voluntary death, the current evidence on reporting and compliance does not appear to support the practical slippery slope argument either. The Dutch problems with compliance are not necessarily related to a slide towards non-voluntary euthanasia, there being other possible explanations for the failure to abide by the criteria. In any event, these problems appear to be problems that are specific to the Dutch set up. We ought, then, to be sceptical of those who insist that the practical slippery slope does provide conclusive evidence that the right to assistance in dying will endanger the lives of those who do not want to die. As Smith remarks, the most significant conclusion we can draw at this point is that additional research is required in this area.[640]

Recapitulation

We have identified a number of state interests which may be appealed to to limit or prevent recognition of the right to assistance in dying. On analysis, the majority of these state interests do not seem to provide compelling argument against the right. As noted, the interest in upholding the sanctity of life principle is only one of a number of ethical ideals that must be weighed in the balance when considering end-of-life issues. It is already accepted that, in cases where a patient wishes to withdraw life-sustaining treatment, the sanctity of life principle must yield to the patient's right to autonomy. If the sanctity of life principle were absolute, the state could not sanction, for example, lawful killing in self-defence or capital punishment. If the argument instead is that acceptance of assistance in dying will lead to widespread indifference to human life, then this does not seem to be borne out in the evidence: the murder rate in the Netherlands is well below the average for most European countries, and is only one-tenth of that in the United States.

The state interest in preventing suicide seems similarly weak. This interest can hardly be persuasive in the case of a competent, terminally ill adult who is asking to die as a merciful release, because there is no feeling of a senseless loss of a life ended prematurely. The patient has made a perfectly rational and well-considered choice; it is difficult to see why the state should interfere with this—particularly when one considers that the interest in preventing suicide has been held by the courts not to be a sufficient justification for frustrating a hunger-striking prisoner's wish to die.

What of the state interest in protecting dependants? This, too, ought to be given short shrift, I would suggest. Not only because the terminally-ill patient will die shortly anyway, thus making any state intervention for the sake of protecting dependants utterly futile, but also because of the judicial authority establishing the unassailable right of women to refuse medical treatment such as

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[640] (2005) 13 *Med L Rev* 17, p.44.

Caesarean sections. Given cases such as *Re MB*[641] and *St George's Healthcare NHS Trust v S*,[642] it is hard to see how it can be maintained that a right to assisted dying ought to be denied on the basis that persons availing themselves of that right might be abandoning their dependants. Such considerations are not allowed to impinge on the right to autonomy in pregnancy situations; they should not be allowed to impinge on the right to autonomy in end-of-life cases.

The interest in protecting the integrity of the medical profession, it will be recalled, comes down to two issues: whether a right to assistance in dying will undermine patients' trust in the medical profession, and whether participation in patients' deaths is fundamentally at odds with the physician's role of healer. As to the first issue, the available evidence does not seem to indicate that there needs to be anxiety on this score. Not only do the Dutch have one of the highest levels of trust in their doctors, but also opinion polls in this country show that, if the law were changed to permit assistance in dying, over two-thirds of respondents' trust in their doctors would not be affected by this. On the issue of the incompatibility of assistance in dying with the doctor's traditional role as healer, it must be remembered that, as the law stands, doctors frequently have to take life-ending courses of action—from withdrawing life-sustaining medical treatment or nutrition and hydration, to administering lethal quantities of analgesic drugs with the primary intention of relieving patients' pain. The integrity of individual practitioners who are opposed to the right to assistance in dying can easily be secured by recognising a right of all healthcare professionals to conscientiously object to participating in a patient's death.

The state interest in protecting the ill and disabled from prejudice and societal indifference does carry some force, but not enough to preclude the right to assistance in dying *in toto*. The concerns of the disability rights movement—of subtly sending out a message that it is better to be dead than disabled—are real, but they are only sufficient to warrant a restriction of the right to assistance in dying to those who are terminally ill. As long as the right remains exercisable only when one is very to near death, the risk of fostering harmful ideas about the value of disabled people's lives will be quite remote. Being disabled is not the same as being terminally ill; it is only when these two states are deliberately confused that it is possible to argue that the interest in protecting the disabled from prejudice provides strong grounds for resisting the right to assistance in dying.

The interest in protecting the lives of those who do not want to die comprises several concerns, which are not always clearly separated out. First, there is the risk of coercion of vulnerable people by unscrupulous relatives and carers. The argument which is made here is that a right to assistance in dying would encourage a situation where the elderly and infirm might find themselves pressurised into making choices that they do not really want to make. The potential for such coercion, it was acknowledged, was real. However, it was suggested that this potential

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[641] [1997] 2 FLR 426.
[642] [1998] 3 All ER 673.

already currently exists, insofar as vulnerable people who are on life-sustaining treatment may be coerced into unwanted deaths by being pressured into asking for such treatment to be withdrawn. I suggested that, given that such possibilities for undue influence already exist, recognising the right to assistance in dying would not seem to be putting people in any more danger than they already are. This suggestion was then bolstered by evidence from Oregon, which shows that it is only people who are quite the opposite to vulnerable, who are forceful and dynamic, who are able to take advantage of the right to assistance in dying. The weak are necessarily prevented from taking up the right by the very formalities involved in lawful assisted dying.

Then there is the concern about internal pressures—that people might choose assisted dying, not because that is what they truly desire, but because they feel themselves to be a burden and believe that they will be doing the decent thing by making their exit from this world. Again, it was accepted that this was a risk; but once more I noted that, as with external coercion, the risk of someone choosing death because of feelings of being a burden already exists. It was also explained that it was important to remember the ethical principles underlying the right to assistance in dying. If the right is at all about autonomy, we have to be prepared to distinguish between those burden cases where someone chooses assistance in dying out of genuine altruistic concern for their loved ones, and those where the individual would rather not die but chooses to anyway because he feels he ought to. Whilst the interest in protecting those who do not wish to die applies in the latter case, it does not apply in the former, because in this situation the person does actually want to die.

Finally, there are concerns about a slide down a slippery slope towards non-voluntary assisted dying and assisted dying for those who are not terminally ill. The slippery slope argument, we saw, can be expressed in one of two ways: either as an argument from logic, or as an empirical argument. However, it was shown that neither of these arguments is particularly successful. The logical slippery slope argument fails because it depends on the fallacy that the autonomy interest and the interest in preventing pain and suffering are both sufficient conditions for a right to assistance in dying, when in fact they are only necessary conditions. The practical slippery slope argument is not supported in the currently available empirical data.

So the concerns encompassed by the interest in protecting the lives of those who do not want to die are not as grave as some would suggest. There are risks, but they do not seem to be new or greater than those risks that we are already willing to live with. The interest in protecting the lives of those who do not want to die is not an incontestable argument against the right to assistance in dying.

B. The legislative means: proportionality

The question I have been seeking to answer in this chapter is: when is it legitimate for the state to interfere with the right to assistance in dying? Thus far we have examined the strengths of the countervailing concerns, the various interests which might prompt the state to interfere with the right. However, the question of interference must always be assessed, not just by reference to the end for which the interference occurs, but also by looking at the means chosen by the state to achieve that end—the idea of proportionality. The notion of proportionality is key to all systems of rights protection. Whether one is considering 'what is necessary in a democratic society' under European Convention jurisprudence,[643] the 'strict scrutiny' test in US constitutional law,[644] or the second branch of the *R v Oakes* test in Canadian Charter law,[645] the idea that the state's interference with a fundamental right must be a proportionate way of achieving its legislative aim is central.

There are, for the state, only two means by which it may protect any of the interests that have been discussed in this chapter: either total prohibition of assistance in dying, or regulation permitting it in some limited circumstances. The first of these means—total prohibition—cannot accord with the idea of proportionality, because the interference is simply not specific enough, given both the nature of the state interests in issue and the fact that none of them can be said to be of overwhelming force.

This point was argued well in the *Pretty* case. Here, the state asserted the interest in protecting the vulnerable from unwanted death as its main reason for denying the right to assistance in dying. Against this, however, Mrs Pretty suggested that, whatever the need to protect the vulnerable, there was no justification for a blanket refusal to countenance assistance in dying in the case of someone who, like her, was not vulnerable at all.

The House of Lords, though it found Mrs Pretty's submission 'beguiling', ultimately rejected her argument. Lord Bingham noted that it could be countered by two responses of enduring validity given by Dr Johnson: 'First, "Laws are not made for particular cases but for men in general." Second, "To permit a law to be modified at discretion is to leave the community without law. It is to withdraw the direction of that public wisdom by which the deficiencies of private understanding are to be supplied."'[646]

Laws are indeed 'for men in general'. Yet, as case law clearly shows, they still need to be sensitive to individual cases, at least insofar as they concern fundamental human rights. In *Andersson v Sweden*,[647] for example, a case involving the right to respect for family life and restrictions placed on the contact which a mother could have with her son, the European Court of Human Rights said of the Swedish Government's justifications for the restrictions:

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[643] *Handyside v UK* (1976) Eur Court HR, Series A No. 24; *Olsson v Sweden* (1988) Eur Court HR, Series A No. 130.
[644] Wygant v Jackson Board of Education (1986) 476 US 267.
[645] [1986] 1 SCR 103.
[646] *R (Pretty) v DPP and Secretary of State for the Home Department* [2001] UKHL 61 [29].
[647] (1992) Eur Court HR, Series A No. 226-A.

> The reason adduced by the Government are of a general nature and do not specifically address the necessity of prohibiting contact by correspondence and telephone. The Court does not doubt that these reasons were relevant. However, they do not sufficiently show that it was necessary to deprive the applicants of almost every means of maintaining contact with each other for a period of approximately one and a half years...Having regard to all the circumstances of the case, the Court considers that the aggregate of the restrictions imposed by the social welfare authorities...was disproportionate to the legitimate aims pursued and, therefore, not 'necessary in a democratic society'.[648]

A similar decision was reached by the ECtHR in the case of *Campbell v UK*,[649] where it had been argued by the state that it was entitled to open and read mail between a prisoner and his lawyer, in order to protect against the risk of disorder or crime. Rejecting this argument, the Court stated that, although there was a need for some measure of control over prisoners' correspondence, this could not justify an overall right to peruse, scrutinise and censor prisoners' letters. The threat posed by letters containing illicit enclosures could be obviated merely by opening the letter, and this could be done in front of the prisoner.[650]

The clear principle that emerges from these cases is that, if a state interest can be secured by less general means than blanket proscription, then this is the route that ought to be taken. In *Pretty*, before the ECtHR, the UK Government made much of the fact that, although the UK's prohibition on assisting suicide was exceptionless, there was nonetheless some flexibility provided for, both by the fact that consent is needed from the DPP to bring a prosecution under s.2 of the Suicide Act, and by the fact that courts often reflect the circumstances of each case in the sentences which they pass.[651]

This may well be. However, on its own, non-enforcement of a law does not bring that law within the range of legitimate interference. That this is so can be seen from the ECtHR's decision in the case of *Dudgeon*.[652] Here, despite the fact that the Northern Ireland authorities had recently been refraining from enforcing a complete ban on homosexual activity, the ECtHR nonetheless found that the provisions in question still, *by their very existence*, amounted to a measure which was disproportionate. Turning the non-enforcement argument on its head, the ECtHR commented that, because no evidence had been adduced to show that the non-enforcement policy had been injurious in any way, or that there had been any public demand for stricter enforcement of the law, it could not be maintained in these circumstances that it was necessary to maintain such an absolute prohibition.[653]

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[648] *ibid.* [96], [97]
[649] (1993) Eur Court HR, Series A No. 233.
[650] *ibid.* [48]
[651] *Pretty v United Kingdom* [2002] ECHR 427 (App. No. 2346/02) [76].
[652] (1981) Eur Court HR, Series A No. 45.
[653] *ibid.* [60], [61].

We see the same tensions between principle and outcome in *Rodriguez*. In its prior decision of *R v Chaulk*,[654] the Canadian Supreme Court had declared that 'Parliament may not have chosen the absolutely *least* intrusive means of meeting its objective, but it [must have] chosen from a range of means which impair [the individual's rights] as little as is reasonably possible'. For the Chief Justice Lamer, this case was a guiding precedent. Though he acknowledged that respecting the wishes of people in Ms Rodriguez's position ran the risk that their consent to be assisted in dying may not be true and valid, he nonetheless thought that 'the proper role of the legal system in these circumstances is to provide safeguards to ensure that the consent in question is as independent and informed as is reasonably possible'. Fears of abuse, the Chief Justice thought, could not 'justify the over-inclusive reach of the Criminal Code to encompass not only people who may be vulnerable but also persons with no evidence of vulnerability, and, in the position of the appellant, persons where there is positive evidence of freely determined consent'. In his opinion, a total ban on assistance in dying was not within the range of means which impaired the individual's rights as little as possible; total prohibition was not a proportionate response to the problem.[655]

The Chief Justice was not alone in this opinion. McLachlin J also thought that an absolute ban was excessively broad.[656] However, the majority of the Court took the opposite view. Sopinka J, who delivered the majority opinion, noted that 'a prohibition without exception on the giving of assistance to commit suicide is the best approach. Attempts to fine tune this approach by creating exceptions have been unsatisfactory and have tended to support the theory of the "slippery slope". The formulation of safeguards to prevent excesses has been unsatisfactory and has failed to allay fears that a relaxation of the clear standard set by the law will undermine the protection of life and will lead to abuses of the exception'.[657] In the *Washington* case, the US Supreme Court was able to avoid the question of proportionality, because it determined that the asserted right was not a fundamental liberty protected by the Due Process Clause; this being the case, the Court only required that 'Washington's assisted suicide ban be rationally related to legitimate government interests', which, the Court thought, was unquestionably the case.[658]

The conclusions that have been reached by the Courts on the question of proportionality, even if challengeable, are understandable. Both the ECtHR and the Canadian Supreme Court thought that bans on assisted suicide could be justified by the interest in protecting the lives of those who do not want to die, particularly the elderly and vulnerable; both Courts thought that clear risks of abuse existed and were swayed by the argument of the 'slippery slope'. On the Dutch evidence

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[654] [1990] 3 SCR 1303, p.1343.
[655] [1993] 3 SCR 519, p.567.
[656] *ibid.*, pp.625-628.
[657] *ibid.*, p.613.
[658] (1997) 521 US 702, p.728.

that was then available, and particularly the interpretation given to that evidence by Keown,[659] there probably were good grounds for believing that regulation might not be enough to avert the risks of possible abuses. As such, total prohibition would fall within the range of proportionate and legitimate state responses. However, as we saw from our own consideration of the practical slippery slope, this evidence now seems to be increasingly open to question. The emerging data appears to show that the risks of acknowledging the right to assistance in dying are no greater than those that already exist in jurisdictions where such assistance is prohibited, and that, if there are failings with the Dutch system of regulation, first, the reasons for those failings are not necessarily indicative of a slide down the slippery slope; secondly, such failings are not unavoidable if a different regulatory framework is established, as shown by the data from Oregon.

All of this seems to point to the conclusion that unqualified prohibitions on assistance in dying are a disproportionate means of securing those state interests which may be ranged against the right to assistance in dying. This might seem a rather bold statement, but then the concept and ideology of human rights requires such boldness.[660] It must also be remembered that a finding of disproportionality still leaves the legislature with a range of options—a 'margin of appreciation', as it is known under European human rights law—from which to choose how to protect the various state interests. Regulation of assistance in dying may be as restrictive as the state feels necessary, providing only that the right to assistance is exercisable at least to some degree. Certainly, different legislatures will reach different arrangements. No less certainly, some will work better than others. The detail of these arrangements is not for this thesis. It is enough to note that each state must—as indeed the UK is currently doing with the Assisted Dying for the Terminally Ill Bill—engage in a process of wide consultation and extensive debate, to ensure that it achieves the best possible protection for its citizens, while at the same time ensuring liberty and dignity right to the very end of life.

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[659] Keown's work was cited not only in *Pretty* (see Lord Steyn's opinion, [54],[55]), but also in the *Washington* case (Justice Souter at p.786).

[660] As Judge Loucaides of the ECtHR has written, 'An active and progressive role in the field of human rights on the part of the national judge presupposes a good knowledge of the international legal developments and jurisprudence. But this is not enough. It is also essential for the judge to have the right personality. A personality which will enable him, if necessary, to stand up against the wishes of the Government or even those of the public opinion; he must also have the courage to give a judgment in favour of the right of an individual even if such judgment may be inconsistent with deeply rooted concepts of the society where he is operating': L.G. Loucaides, *Essays on the Developing Law of Human Rights* (Dortrecht: Martinus Nijhoff, 1995), p.172.

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