

A Study of Assisted Dying under English Law—Based on Moral and Legal Perspectives

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Abstract: *This essay examines from both moral and legal perspectives, the different legal positions between the right to refuse life-sustaining treatment and the right to receive active assistance to die. In English law, an adult with capacity has the absolute right to refuse life-sustaining treatment but cannot legally receive active assistance to die, via either physician assisted-suicide or euthanasia. Case law and scholars have put forward legal and ethical principles to support the existing law, including the difference between acts and omissions, the doctrine of double effect, the principle of autonomy, the sanctity of life and the argument of slippery slope. Exploring those principles, this essay shows that the distinction between a right to refuse life-sustaining treatment and a right to receive active assistance to die lacks a moral force, and there is no satisfying justification for the blanket ban imposed. This essay concludes that the current law is inconsistent. Instead of imposing a blanket ban on addicted dying, cases should be examined on an individual basis.*

Keywords: *Right to Refuse Life-Sustaining Treatment, Assisted Dying, Euthanasia*

1. Introduction

English common law confers absolute protection to a competent adult's right to refuse life-sustaining treatment, and it is implicit in the text of the European Convention of Human Rights (ECHR) that there is a right to refuse medical treatment.^[1] In contrast, in the UK, there is no such right to active assistance to die, in other words, a right to die under others' assistance (i.e., assisted dying). *Pretty v United Kingdom* highlights that Article 2 ECHR, a right to life, does not imply a right to die. Instead, assisting someone to die is equivalent to murder and is illegal under s.2 of the Suicide Act 1961. There is no defence against murder, though people who assist others in dying may be motivated by compassion and sympathy. The law is inconsistent unless the different treatments can be justified for good reasons because withdrawal of life-sustaining treatment and assisted dying both result in someone's death. This essay will examine several justifications forwarded by the case law and scholars. In general, the law governing this area is inconsistent and unsatisfying, and the distinction between treatment withdrawal and assisted dying lacks a 'moral force'.^[2] For the purpose of this essay, when referring to 'patients', only adults who can understand and retain information, reason, and communicate their decision to others will be considered.

2. Act and Omission

The law justifies its position by referring to the act and omission argument. Whereas assisted dying is an unlawful act, treatment withdrawal is lawful because it is an omission.^[3] Unlike an act, an omission usually will not lead to legal liabilities, unless there is an established duty of care. The rationale behind the law being more restrictive to acts is that acts are regarded as morally more culpable than omissions since that, compared to omissions, acts usually contribute directly and have a close legal causal link to the result.^[4] For instance, sending poisonous food to a starving child in a foreign country contributes directly to the child's death. However, the causal relationship between the failure to deliver food to the child and his death is ambiguous.^[5] Therefore, there is a moral difference between acts and omissions.

However, the extent of the difference depends on the case's specific facts, and it cannot be assumed that all acts are morally more culpable than all omissions.^[6] The culpability of a specific act or omission is fact-based. Killing one of the conjoined twins to save the other is not more condemning than doing nothing and letting both of the twins die. Nevertheless, altogether abandoning the difference between acts and omissions is unreasonable, as it would mean carrying the whole world on one's shoulder that one is under a duty to exert its power to do good and frustrate bad.^[7] Such a duty is overburdensome and

disproportionately infringes individual autonomy. Therefore, although generally, acts and omissions are morally different, the context of each case needs to be considered.

In the context of medical practice, The House of Lord in *Bland*^[3] holds that treatment withdrawal is lawful because it involves an omission rather than a positive act. When a patient refuses treatment, their doctor is relieved from their duty to care. However, while failing to provide treatment to the patient at the start is clearly an omission, withdrawing life-sustaining equipment in the middle of treatment is more controversial as the doctor acts positively to withdraw the equipment. Lord Neuberger expresses his concern that switching off one's life-supporting machine is arguably 'a more drastic interference in that person's life and a more extreme moral step' than physician assisted-suicide (PAS), where an authorised third party provides the patient with the means, such as lethal drug, and the patient can choose to administer the drug according to their will. While switching off the machine contributes directly to the person's death, the legal chain in PAS seems to be broken by the patient's 'free, deliberate and informed' act,^[8] so PAS is made less culpable.

Accepting the moral difference between acts and omissions, Jackson argues that the division between them is not binary, and it makes more sense if it is considered in terms of a spectrum. Whereas active voluntary euthanasia, where an authorised third party administers the lethal drug to the person, sits firmly on the 'acts' end of the spectrum, treatment withdrawal lies in the middle, where the boundary between acts and omissions becomes unclear.^[9] Therefore, the law artificially labels treatment withdrawal as an omission, in the absence of a convincing reason why PAS is more culpable than treatment withdrawal. Therefore, the law is incoherent in this aspect.

Additionally, although AVE is closer to the 'act' end on the spectrum than treatment withdrawal under the patient's request, this does not automatically render AVE morally more culpable. In a scenario where the withdrawal of treatment does not lead to an immediate death but a slow and painful suffering, a quick and painless death following AVE does not seem to be more condemning.^[10] Therefore, the context in which AVE and treatment withdrawal are carried out need to be examined, and further explanation is required to support that AVE is morally more culpable.

3. Doctrine of Double Effect

Another legal justification is the doctrine of double effect (DDE), which refers to the moral difference between foresight and intention. Robert gives the example of a General sending his troops to the war, where he could foresee many of them would be killed but he did not intend it, which is less culpable than intentional killing.^[10] DDE states that an act with a bad consequence is permissible when it is not itself bad; the bad consequence is not a means to the good consequence; the bad consequence is foreseen but not intended and can be justified by a sufficiently serious reason. Doctors constantly use DDE to justify giving out pain-killing drugs, which have a life-shortening effect, to their patients to relieve the patients' pain. While doctors are under the Hippocratic Oath to 'do no harm' to their patients, the life-shortening effect is an unintended side effect of pain-relieving so can be justified. Withdrawal of life-sustaining treatment can be justified by DDE as well. When withdrawing treatment, doctors do not intend to kill their patients but to stop the prolonged pains and suffering brought by the treatment.^[6] In contrast, assisted dying always involves an intention to kill, and it uses the bad consequence (i.e., death) to achieve the good end of pain-relieving. Hence, assisted dying cannot be justified by DDE, and so illegal.

However, DDE can be problematic due to the conflation of the legal definitions of foresight and intention.^[11] According to Woollin, foresight with virtual certainty can amount to an oblique intention, given that it has the same moral culpability as a direct intention. In *re A (Children)*, it was found that the surgeons committed murder because they foresaw with virtual certainty that one of the conjoined twins would die due to the separation. Because usually doctors can foresee with virtual certainty that withdrawing life-sustaining treatment will lead to their patient's death, they fail the requirement of DDE under the Woollin definition of intention. Despite this, the judgment of *Nicklinson* continues to endorse DDE without resolving the definition difficulties. Therefore, owing to the conflation of foresight and intention, the law governing mens rea is inconsistent. Hence, DDE cannot be regarded as a satisfying legal justification.

4. Individual Autonomy

The principle of individual autonomy underlies modern medical practices, whereas a blanket ban on assisted dying is 'an extraordinary exception' to this 'patient-centred development of medical law', because patients' autonomy to choose how and when to die is significantly constrained.^[12] Autonomy makes a person the sovereign authority over her life, enabling her to be self-determinate, but it is not unlimited.^[13] Some may argue that there is no autonomy to choose how and when to die since autonomy is valid 'only when it recognises moral values, especially the respect due to human life as such, whether someone else's or one's own'.^[14] Keown states that autonomy is only valued when exercised 'for the well-being and flourishing of human beings who possess it'.^[15] Therefore, because active assistance to die does not further the well-being of human beings but destroys it, a right to receive assisted dying conflicts with the principle of individual autonomy. However, if this is the case, treatment withdrawal is also a moral wrong since it fails to flourish human life as well.

In contrast to Keown, Mill does not regard individual autonomy as a means to further the well-being of human beings. Instead, he develops the harm principle that individual autonomy is only limited when an individual's sovereign decision threatens to harm others. Because decisions of both treatment withdrawal and active assistance to die only harm the person who makes the decision but not anyone else, individuals should enjoy the autonomy to do both. However, individual autonomy can be subject to other principles, such as the principle of paternalism, where individuals do not know what their best interests are, so the state decides for them. In *R v Brown*, it is held that one cannot give valid consent to harm to oneself. Nonetheless, in the area of medical practice, there is a shift of attitude from strong paternalism, where doctors decide what is in the patients' best interest, to the principle of patient autonomy, where 'doctors must respect the patient's autonomy and will in refusing treatment', even if it is not in patients' best interests. *Re B (refusal of medical treatment)* shows such a shift of attitude, where it is held that the patient has a right to refuse even life-sustaining treatment.

However, patients' autonomy may be restricted by the need to protect the vulnerable. Lord Neuberger expresses his concern that legalising assisted dying would disadvantage the vulnerable. Firstly, there might be a higher chance of the vulnerable who want to live requesting assisted dying because they either 'feel that they have some sort of duty to die, or are made to feel (whether intentionally or not) that they have such a duty by family members or others, because their lives are valueless and represent an unjustifiable burden on others. Secondly, legalising assisted dying might send a wrong message to the vulnerable and expose them to a higher risk of committing suicide while lacking the requisite desire to do so. Therefore, the restriction imposed by s.2 Suicide Act 1961 on individual autonomy to receive active assistance to die may be justified as it plays a crucial role in protecting the vulnerable's interests.

Nevertheless, a blanket ban on assisted dying is an excessive and disproportionate infringement on individual autonomy. In *Nicklinson*, Lady Hale and Lord Neuberger reach the similar conclusion that the blanket ban significantly infringes Article 8 ECHR and cannot be necessarily justified. The right of a competent individual to choose how and when to die is one of the aspects of the right to respect for private and family life, and it should not depend on one's physical capability to carry out their choice without assistance. While Article 8 does not require the state to help individuals to die, it does not follow that the state can obstruct individuals from receiving assistance from others to die. Lady Hale regards the blanket ban as 'a form of cruelty' to people who suffer insurmountable pain but lack of means or physical abilities to end their lives. Less restrictive methods, such as external review to safeguard the interests of the vulnerable, are more appropriate. Therefore, the law fails to strike the balance of interests between the vulnerable and people who want to die and so overly restricts individual autonomy to receive active assistance to die.

Opposition to legalising assisted dying would argue that the law does not disproportionately infringe individual autonomy since the Director of Public Prosecution (DPP) does not always prosecute people for breaching s.2 Suicide Act 1961, regarding the specific facts of the case. However, DPP's discretion is not enough. Firstly, the risk of facing criminal prosecution makes active assistance suicide hardly accessible. Secondly, it is understandable that individual wants to ensure that their loved ones who help them to die will not be prosecuted afterward. Hence, DPP's discretion does not justify the excessive blanket ban.

In contrast, a right to refuse life-sustaining treatment is almost unlimited, provided that the individual has the required mental capacity, even if the vulnerable are under the same risk of being pressurised by

their family or others to feel they have a duty to die. Therefore, it is legally and morally incoherent that, given the same importance of protecting the interests of the vulnerable, a right to treatment withdrawal is guaranteed by the law to emphasise the importance of individual autonomy, whereas a right to choose how and when to die is infringed disproportionately by the law.

5. Sanctity of Life

Vitalists regard human life as an absolute moral value. All human lives are intrinsically valuable because they establish the basis of human flourishing.^[16] Therefore, given that death is the antithesis of life, any means that produce death is morally wrong and cannot be justified.^[17] Therefore, both withdrawal of life-sustaining treatment and assisted dying are moral wrongs under vitalism. A less extreme opinion would be that the value of life depends on the quality of life, as it is instrumental in 'providing a vehicle for a life of sufficient worth and quality'.^[12] *Laskey, Jaggard and Brown v UK* holds that in respecting human dignity and human freedom, which links closely to the quality of life, the principle of sanctity of life is not negated. Diminishing human dignity and human freedom inevitably leads to a significant decrease in the quality of life. It is possible that at some point, the pain and suffering deprive human dignity and freedom to such an extent that life is of quality so low that there is little value left. In this situation, an act or an omission to end such a life is morally permissible, as it does not negate the sanctity of human life.

Nevertheless, people who support treatment withdrawal but not assisted dying argue that assisted dying contradicts the modern moral tenet that all lives are of equal value. If there are situations when death is preferable to life, it can be inferred that some lives are essentially more valuable, whereas some do not worth living. In contrast, a decision to withdraw treatment is not based on human life's worthiness but on whether the treatment is in the patient's best interests.^[6] However, Doyal questions the validity of this argument since it is hard to see how a life-sustaining treatment can be so futile that it is not of the patient's interests at all. Hence, what undermines the doctors' decisions is the value of a patient's life. Doyal argues that it is not morally problematic to conclude that some lives are more valuable than others.^[9] Doctors constantly make judgments on the value of lives, owing to the limited financial and medical resources, and we do not condemn doctors for making these judgments. Therefore, under the doctrine of quality of life, a patient's requests for both treatment withdrawal and assisted dying should be permitted when their life is of such low quality. Hence, the law is morally incoherent in only permitting the former.

6. Slippery Slope

The slippery slope argument may justify the non-existence of a legal right to assisted dying. It is trite that people are concerned that entitling competent individual with a right to receive active assistance to die would be followed by legalising the more morally problematic non-voluntary euthanasia, where individual cannot give consent, and even involuntary euthanasia, where euthanasia is carried out against individual's will. Opponents to assisted dying worry about a reoccurrence of the Nazi regime, where mass murder was committed via involuntary euthanasia.^[18] However, Jackson suggests that the slippery slope argument should be tackled with care. While a slippery slope is often mentioned because no system is perfect and free of the moral 'grey area', it is seldom proved or reputed.

There must be at least some probability of moving from legalising voluntary assisted suicide to non-voluntary and involuntary euthanasia to prove a real risk of slippery slope. However, there is insufficient evidence indicating a right to voluntary assisted dying can lead to legalising of non-voluntary euthanasia or involuntary euthanasia.^[19] Firstly, the Dutch rate of involuntary and non-voluntary euthanasia is not higher than in other countries where PAS and AVE are illegal. Secondly, a possibility of moving from voluntary assisted dying to non-voluntary or involuntary euthanasia can be inferred from a shift of attitudes towards voluntary assisted dying. If people become more open to non-voluntary and involuntary euthanasia after legalising voluntary assisted dying, then the chance of a slippery slope can be inferred. However, there is no evidence as such. While the disparity in the Social and Cultural Planning Bureau's data indicated a higher degree of acceptance of PAS and AVE in the Netherlands than in the US, the high disparity had existed before the Netherlands legalising PAS and AVE.^[20] Thus, it can be deduced that legalising voluntary assisted dying has little impact on people's attitudes towards voluntary, involuntary, and non-voluntary euthanasia. Thirdly, it is argued that a slippery slope may result from lower respect

for life due to legalising PAS and AVE, but the relatively low suicide and murder rate in the Netherlands disqualifies this argument. Therefore, the current evidence is insufficient to support that there will be a slippery slope to non-voluntary and involuntary euthanasia.

However, it is worrying that, in the Netherlands, children over 12 years old are eligible for euthanasia. Also, in the cases of Chabot and Sutorious, AVE was provided to people who were not terminally ill. These together indicate the possibility of an enlarged scope of AVE and PAS, exposing more people to risk if abuse occurs. Nevertheless, the scope is relevant to what safeguards should be employed but irrelevant to a slippery slope to non-voluntary and involuntary euthanasia. Therefore, since there is insufficient evidence to support that a slippery slope will occur, a blanket ban on a right is morally incoherent.

7. Other Arguments

Opponents to assisted dying also argue that legalising assisted dying would undermine the doctor-patient relationship. Knowing their doctors can put their lives to end, patients may be less likely to trust their doctors for fear of their doctors harming them. Consequently, patients may be less willing to go to hospitals, threatening public health. In addition, legalising assisted dying may discourage people from seeking cures for irrecoverable diseases. However, these arguments lack evidence to support them. In addition, the same problems exist with treatment withdrawal. It can be argued that patients are unwilling to trust their doctors, knowing that they can withdraw life-sustaining treatment and put them to death;^[21] people will be disincentivised by a right to treatment withdrawal to look for cures. Hence, the different legal positions of treatment withdrawal and assisted dying are morally incoherent.

8. Conclusion

The law is incoherent in permitting an absolute right to refuse life-sustaining treatment but putting a blanket ban on a right to receive active assistance to die. Compared to PAS, withdrawal of treatment contributes directly to a patient's death, and so the legal labels of acts and omissions are artificial and cannot reflect the degree of culpability. Specific facts need to be considered when assessing the culpability of assisted suicide and treatment withdrawal. In addition, owing to the conflation of the legal definition of foresight and intention, the law governing mens rea is inconsistent. Hence, DDP is no longer a good legal justification for permitting withdrawing life-sustaining treatment while foreseeing with virtual certainty that patients' death will follow. Furthermore, it is morally incoherent that the principle of individual autonomy underlies a right to refuse medical treatment, but individual autonomy to choose how and when to die is subjected disproportionately to the interests of the vulnerable. In terms of the sanctity of life, under the doctrine of quality of life, it is morally justified to end a life by an act or omission when the quality of life decreases to the extent that there is little value left. Therefore, because both treatment withdrawal and assisted dying do not negate the principle of the sanctity of life, it is morally incoherent that there is only a right to treatment withdrawal but no right to assisted dying. The slippery slope argument against a right to active assistance to die lacks sufficient evidence to support it and cannot provide convincing moral justification for the different legal positions of treatment withdrawal and assisted dying. In terms of the arguments associated with the trust between doctors and patients and incentives to seek a cure for irrecoverable diseases, they can be used against treatment withdrawal as well, and so the legal difference between treatment withdrawal and assisted dying is morally incoherent.

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