Family Education Trust

False Autonomy and Hobson's Choice: How 'Assisted Dying' Harms the Family

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Executive Summary

- Two Bills currently being considered in UK legislatures – the 'Leadbeater Bill' in Westminster' the 'McArthur Bill' in Holyrood – respectively propose systems of **assisted suicide** (where a physician provides a qualifying person with lethal drugs to end their own life) based on the purported safeguards of **eligibility criteria** and **procedural gatekeeping**.
- The **eligibility criteria** are meant to limit the application of assisted suicide to 'terminally ill adults', defined ostensibly in a limited manner but which textual analysis and international analogues show **would be far more expansive than has been presented**.
- Evidence from Oregon, the assisted suicide model of which both Bill are following, shows that these eligibility criteria have over time **led to applications for assisted suicide for normally non-terminal conditions such as anorexia, diabetes, hernias, and arthritis**, due to their becoming **'artificially terminal'** by human action or inaction rather than the inevitable progression of the disease.
- The risk of that occurring in the UK is worsened by the **potential for doctor-shopping amongst a minority of doctors** who would be providing an assisted suicide service, who would be by definition those with the fewest qualms and least scruples about doing so.
- For more 'ordinary' cases, **even six-month prognoses are in any case very unreliable**, and the danger exists that hundreds if not thousands of people would have their lives ended prematurely, even by a matter of years, if these Bills were passed into law.
- The procedural gatekeeping meanwhile relies on a system whereby the patient seeking to procure an assisted suicide would make two declarations followed by 'periods of reflection' (altogether 21 days in one Bill and 7 days or less in the other) and two doctors would assess that they are making an autonomous decision free of duress, in the case of the Leadbeater Bill including an 'Assisted Dying Review Panel' to confirm that the procedure has been followed.
- **Nothing however establishes how the doctors would know (certainly in a three week period) how to detect undue pressure or coercion in the patient**, even with psychological training. As such, the inclusion of a Panel would only be an added layer of bureaucracy **without any ability to safeguard patients**.
- The risk of abuses occurring in the UK is obvious from recent medical history (e.g. scandals surrounding Stafford Hospital and the Liverpool Care Pathway), and is worsened by the potential for doctor-shopping amongst a minority of doctors who would be providing assisted suicide – **by definition those with the fewest qualms and least scruples about doing so**.
- Given the permissive nature of a two-doctor system as demonstrated by the Abortion Act 1967, and given that opposition to the reestablishment of the death penalty exists notwithstanding the forensic nature of the investigation and court process justifying a guilty verdict for a serious crime, this raises the question as to why we would affirm the enabling of patient suicides based on procedural gatekeeping which amounts to nothing more than **a box-ticking system which is certainly neither 'thorough' nor 'robust'**.
- **The Oregon Model has shown many problems over time**: amongst others, **the removal of safeguards**, a **failure to protect those with mental illness**, **expansive application of terminal illness**, and a **rise in numbers of those opting for assisted suicide over fear of being a 'burden'**.
- **Suicide prevention has been demonstrably undermined**, and the **development of palliative care has also been evidently retarded** in those jurisdictions which have legalised assisted suicide or euthanasia. The question of **difficult medical resource application in this context also has dehumanising implication**s.
- The rationale for legalising assisted suicide carries within itself **not merely a slippery slope, but a logical cliff** – the precedent to widen the eligibility criteria to all those who would claim a right to 'choice', 'autonomy' and the 'right to die'. Evidence from those jurisdictions (Belgium, Canada and the Netherlands) which have followed this logic into euthanasia shows appalling cases of premature death for those who are **disabled**, **mentally ill**, or have had **hard life experiences**.
- The two Bills, like all proposals of assisted suicide and euthanasia, are dangerous **and would undermine both the integrity of family relationships and the safeguarding of vulnerable patients**.

Introduction

In 2016, a 74-year old Dutch woman with severe dementia due to Alzheimer's was held down by her husband and daughter as she struggled against her doctor's attempts to insert a drip into her arm through which a dose of lethal drugs could be administered[1]. The doctor had beforehand slipped a sleeping drug into the woman's coffee, but she woke and resisted being euthanised. The basis for the administration of the fatal injection to her was that she had previously expressed a desire for 'assisted dying' (even though at that point she clearly could not give immediate consent), and the physician responsible was later cleared of any wrongdoing by the Dutch Supreme Court. This decision effectively widened euthanasia in the Netherlands as it established that doctors could not be prosecuted for carrying it out on dementia patients who have previously, even if not contemporaneously, given written consent[2].

This story illustrates many of the key problems surrounding 'assisted dying' (euthanasia and / or assisted suicide[3]): illustrate many of the key problems surrounding such practices: the corruption of medical culture and the doctor-patient relationship, the abuses engendered by physician involvement in the death of their patients (including *de facto* involuntary euthanasia), and most pertinently for this paper, the poisoning of family relationships. In the above case by the complicity of a family in the death of their wife and mother in collaboration with the doctor who euthanised her, elsewhere in the temptation it gives to pressure those for whom an early death is an 'option'. It is this dimension which this paper aims to explore.

An assumption typically exists when discussing many social practices and phenomena that the actions of the individual only affect that person and no-one else around them, as if their choices are entirely discrete and the effects limited to them alone. This atomistic assumption is a constitutive element of much 'social liberalism', at least as it is often conceived and expressed in social and political debate. An encapsulation of this ideology by the late former Home Secretary Lord Jenkins – the central political architect of the 'permissive society' – was recently cited by the journalist Dan Hitchens[4]:

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[1] Jennifer Rankin, 'Netherlands euthanasia case: doctor 'acted with best intentions'', *Guardian*, (26 August 2019).

[2] 'Euthanasia: Dutch court expands law on dementia cases', *BBC News* (21 April 2020).

[3] Proponents of assisted suicide (when a doctor provides a patient with lethal drugs which they then self-administer to commit suicide) or euthanasia (where the doctor administers the drugs themselves, killing their patient) object to the use of these phrases, notwithstanding their long-standing usage in international political and ethical discourse. (E.g. It is no coincidence that a) both phrases have been used in laws and official reports where those practices have been legalised in Oregon, the Netherlands, Belgium, and Luxembourg, amongst other countries where it is licensed under a legal framework, and b) attempts to legalise 'assisted dying' in the UK have always tried to – as does section 24(3) of Kim Leadbeater's Bill, though with mis-stated legal reference – amend or remove section 2(1) of the Suicide Act 1961, which criminalises intentionally 'encouraging or assisting the suicide or attempted suicide of another person'.)
The preferred term for almost twenty years amongst advocates of euthanasia and assisted suicide in Anglophone countries is 'assisted dying'. Tellingly, one such group, EXIT International, uses that phrase alongside 'voluntary euthanasia' and 'rational suicide'.
Unfortunately, they have succeeded in making this term normative in social and political debate. I consider that this constitutes the bowdlerisation of language and desensitises public debate to the moral and practical gravity of what is being proposed for introduction into law, medicine and society. Irrespective of the reason for someone wishing to end their life, the Oxford English Dictionary definition of 'Suicide' is, 'the intentional taking of one's own life'. All forms of 'assisted dying' that involve a patient taking lethal drugs therefore, tragically involve suicide. For that reason, this paper will use the older standard terminology.

[4] Dan Hitchens, 'Assisted Suicide and the Politics of Fear', *First Things*, 25 November 2024.

> *Let us be on the side of those who want people to be free to live their own lives, to make their own mistakes, and to decide, in an adult way and provided they do not infringe the rights of others, the code by which they wish to live...*

Such a sentiment is at the heart of much advocacy for assisted suicide, and it is perhaps this subject which most powerfully illustrates how simplistic it is and how consequently damaging. When a 'choice' is extended to some, it does not change things merely for those people, but for everyone. This is because the effect of the extension of an option is experienced and felt differently by the weak than by the strong – by those whose mental and physical condition (and the degree to which society accommodates this or fails to do so) compromises their personal 'autonomy' most profoundly. Further, the choice not only affects those people, but all those connected to them, in particular their closest family.

The dying process is an intimate one, and in the best of familial situations the trauma of grief and loss are caused to those closest to the person who has died. In worse cases, it can be a means by which the least caring see a dying person as a cost or even a liability. Where social care requires selling assets such as a house to pay for it, some will see such an action as the loss of money they were counting on. Others may resent the time, effort and other resources that a dying person takes up of their own already busy lives. This will be felt keenly by dying people when they perceive that they are a burden on others (a possibility even when they are shown nothing but love and compassion), and could pressure them towards premature death especially when this perception is reinforced by others. Given the tragic reality of existing elder abuse, it is not difficult to see how allowing others to enable the suicide of a patient, and setting the precedent in law of further involvement even with a law of ostensibly minimal extent, creates palpable potential for the poisoning of familial relationships. Safeguarding concerns in light of this are substantial.

It is these considerations we will bring to the fore in surveying the effects, potential and demonstrable, of assisted suicide in particular and euthanasia in prospect, promoted by the introduction of two Bills which, at time of writing, are being considered by the Westminster and Holywood Parliaments respectively. We will focus on the model that these propose (albeit with some variations from it and from each other): that of the U.S. State of Oregon, and what effects this can reasonably be prognosed to have.

It is to be hoped that this provides a contribution to the debate around 'assisted dying' which will help to 'reframe' it away from the simplistic individualism of much of the rhetoric and argumentation currently surrounding this issue, and towards a consideration of the wider familial and social consequences of introducing physician assisted-suicide into British law and medicine. Throughout its history, the Family Education Trust (FET) has critically evaluated what is often classed as socially 'liberal' or 'progressive' legislation with a particular view to the effects of these developments on the family and the most vulnerable members of society. This paper continues that perennially urgent and important work.

Peter D. Williams

Contemporary British Assisted Suicide Proposals

In the Parliamentary sessions of 2024–2025, the House of Commons has considered the Terminally Ill Adults (End of Life) Bill[5], introduced by Kim Leadbeater MP, sister and Parliamentary successor of the late Jo Cox MP. introduced by Kim Leadbeater MP (hereafter, the ‘Leadbeater Bill’), sister and Parliamentary successor of the late Jo Cox MP. At the same time, the Health, Social Care and Sport Committee of the devolved Scottish Parliament has been considering the Assisted Dying for Terminally Ill Adults (Scotland) Bill[6] of Liam McArthur MSP (hereafter the ‘McArthur Bill’), and published its report on 30 April 2025 ahead of an in-principle vote. Both Bills passed their initial vote, but are being considered further by the respective Parliaments before a final legislative decision to pass them is made.

Both Bills aim to introduce a system of assisted suicide into their respective jurisdictions of England and Wales (Leadbeater) and Scotland (McArthur), and what they propose is ostensibly quite limited. Wishing to satisfy concerns that legalisation of any practice that involves one person involving themselves in causing the death of another is inherently dangerous due to the potential it opens up for vulnerable people to be coerced, or even just subtly pressured into an early death, the authors of these Bills have proposed a series of purported ‘safeguards’. These may be summarised under two headings:

- **Eligibility Criteria**
- **Procedural Gatekeeping**

Eligibility Criteria

By ‘eligibility criteria’, we mean restrictions as to who can access the provision of medical involvement in the death of patients, a restriction also affected by the means by which that takes place. Both Bills thereby limit access to what they legalise to:

- **Terminally ill adults**, that is those who (other than being ordinarily resident in their respective jurisdictions and registered patients)[7]:
  - Are over 18;
  - Have mental capacity;
  - Suffer from:
    - ‘*an inevitably progressive illness, disease or medical condition which cannot be reversed by treatment*’ (Leadbeater Bill);

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[5] Terminally Ill Adults (End of Life) Bill (‘Leadbeater Bill’; October 2024–).

[6] Terminally Ill Adults (Scotland) Bill (‘McArthur Bill’; 2024–).

[7] *Op. cit*., Leadbeater Bill, clauses 1–2; *ibid*., McArthur Bill, clauses 1–3.

            - (The Leadbeater Bill further requires that the patient does not 'only' have 'one or both of' a mental illness or a disability[8].)
        - '*an inevitably progressive illness, disease or medical condition which cannot be reversed by treatment*' (Leadbeater Bill);
    - Of which condition:
        - '*in consequence of that illness, disease or medical condition can reasonably be expected within 6 months*' (Leadbeater Bill);
        - '*can reasonably be expected to cause their premature death*' (McArthur Bill)
- **Assisted suicide, and not euthanasia**, (definitionally restricting 'assisted dying' to those capable of ending their own lives and not those who are sufficiently disabled from doing so – e.g. those who suffer from conditions that leave them unable to manually consume tablets or digitally manipulate a device such as a syringe):
    - The Leadbeater Bill states that '*the decision to self-administer the approved substance and the final act of doing so must be taken by the person to whom the substance has been provided*'[9], though the 'coordinating doctor' may not merely prepare the lethal dose or a machine that will enable the patient to take it, but also '*assist that person to ingest or otherwise self-administer the substance*'[10];
    - The McArthur Bill simply authorises a registered medical practitioner to '*provide a terminally ill adult with an approved substance with which the adult may end their own life*'[11].

These ostensibly limiting criteria, whilst contrary to the argument from 'autonomy' and 'choice' (raising the question as to why these principles apply to the terminally ill, but not other suffering patients such as those unable to personally commit the act that ends their life and thereby their suffering), are meant to assuage concerns about vulnerable cohorts of patients being affected by assisted suicide provision. Nonetheless, they are potentially wider in scope than they might seem.

It should be immediately noticed that the Leadbeater Bill's extent is limited in a way that the McArthur Bill is not, partly because of the absence of a six month prognosis condition within the latter, but also because of the stipulation in the former that a person is not to be considered as terminally ill if they 'only' have 'one or both of' a mental illness or a disability. The McArthur Bill's definition of 'terminal illness' as an '*advanced and progressive disease, illness or condition from which* [the patient] *is unable to recover* [and which] *can reasonably be expected to cause their premature death*' therefore covers a range of common incurable chronic illnesses and physical impairments, which could be alleviated by

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[8] *Ibid.*, Leadbeater Bill, clause 2(3).

[9] *Ibid.*, Leadbeater Bill, clause 23(8).

[10] *Ibid.*, clause 23(7)(c).

[11] *Op. cit.*, McArthur Bill, clause 15(1).

treatment and enable years of further happy life for those patients suffering from it but which they could conceivably be expected to prematurely die at some point. This could include:

- Diabetes;
- 'Long' COVID-19;
- Down's syndrome;
- Parkinson's and Alzheimer's syndromes
- Dementia;
- Inflammatory Bowel Disease (Ulcerative Colitis, Crohn's disease);
- Hypertension (high blood pressure);
- Ischaemic Heart Disease (which can cause heart attacks, heart failure, and arrhythmias);
- Chronic Obstructive Respiratory Disease (CORD);
- Cerebrovascular disease (strokes);
- Multiple Sclerosis (MS);
- Osteogenesis imperfecta ('Brittle Bone Disease');
- HIV;
- Renal failure.

Even the Leadbeater Bill's six-month prognosis condition however, allows for a more expansive law than initially appears, as we can see from a key international analogue. Under the Oregon system on which the two Bills are based[12], 'terminal illness' is similarly defined as an '*incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months*'[13]. The application of this has been interpreted to include anorexia[14], and has even encompassed conditions such as diabetes[15], hernias and arthritis[16], because certain physicians were willing to class their condition as 'terminal' even with a six-month life-expectancy[17]. Whilst something like anorexia *could* and arguably *should* be ruled out in the Bill's case by the rejection of an application which 'only' constitutes a mental illness or disability, this shows that that there could be

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[12] It is also similar to the law in the Australian State of Victoria, although that is more expansive (in that it legalised euthanasia and not just assisted suicide) and has only been running for just over five years (much of which was under COVID, and of which there are currently only *four* years of data). Almost every other Australian jurisdiction has introduced EAS, but these have been running for even less time than Victoria and as they have also diverged from Victorian law, the Victorian data itself is not a reliable guide to what is happening within them. Many of the safeguards enacted in the Victorian law have been abandoned by the other Australian States, with it being noted that increased access has been given priority over safety – cf. *Wrong Side of the World: The Misplaced Reliance on Australia in the UK Debate on 'Assisted Dying'*, Professor David Albert Jones, Anscombe Bioethics Centre (2025).

[13] Death with Dignity Act 1997, 127.800 §1.01.(12).

[14] Roff & Cook-Cottone, 'Assisted death in eating disorders: a systematic review of cases and clinical rationales', *Front. Psychiatry*, 31 July 2024 *Sec. Public Mental Health* Volume 15, 2024 | https://doi.org/10.3389/fpsyt.2024.1431771.

[15] Bradford Richardson, 'Diabetics eligible for physician-assisted suicide in Oregon, state officials say', *Washington Times*, 11 January 2018.

[16] Death with Dignity Act 2021 Data Summary, p. 14. Reference 3 explains the heading of 'Other illnesses' given on p. 12 as the physical basis of why someone has received an assisted suicide. It mentions that this '*[i]ncludes deaths due to anorexia, arthritis, arteritis, blood disease, complications from a fall, hernia, kidney failure, medical care complications, musculoskeletal system disorders, sclerosis, and stenosis*'. Subsequent reports have not chosen to provide this explanation.

[17] See Carrie Arnold, 'Some anorexia patients want the right to die. A few doctors are willing to listen', *Guardian*, 13 July 2023.

circumstances in which someone with significant vulnerability might try to make themselves sufficiently physically unwell that they would be able to procure an assisted suicide if they can find a doctor who would be willing to consider their condition potentially fatal within six months. It is noteworthy that on the 14 November 2024, leading specialists in eating disorders wrote to the British Medical Journal to oppose the Leadbeater Bill citing these concerns[18].

The shifting application of the six-month prognosis in Oregon demonstrates this in the inclusion of cases which are *'artificially' terminal* – that is, where the underlying disease becomes a prognosable cause of death due to human action or even *inaction*, rather than the *inevitable* progression of the illness. In 2018, the Oregon Health Authority confirmed[19] to a Swedish researcher, Fabian Stahle, that someone with diabetes could decide not to continue life-sustaining treatment for their condition, as a result of which what is normally a chronic and manageable condition would become 'terminal' under the law, qualifying them for assisted suicide. 'Terminal illness' then, in Oregon, is now defined to include people who will become terminally ill *merely if they refuse effective medical treatment or care*. As Stahle encapsulated the situation[20]:

> '*[A]ssisted death laws* à la Oregon *give the impression of being responsible and restrictively designed; but it is a deception. Since "incurable' is not defined but given an open interpretation, these laws apply to a wider population of patients. Those who would survive with treatment can convert themselves to a terminal state by refraining from treatment for any reason whatsoever. Alternatively, they may be forced into a terminal state by being denied treatment through lack of access to state-of- the-art treatment, or denial of insurance coverage. By these pathways, patients could end up with two doctors deciding that they have a maximum of six months left to live thus declaring them legally eligible for assisted death. The original vision that the law should only apply to "untreatable' illness with six months to live is lost.*'

Such cases are certainly not unthinkable in England and Wales, as we shall account later in considering claims that we can 'trust doctors' with the procedural gatekeeping that is supposed to form added 'safeguards' in either Bill.

Even in what might be thought as more 'normal' cases however, where a prognosis is not 'artificially' generated, the 'six-month' prognosis element is still problematic. Whilst such a criterion might assume that doctors can accurately predict the death of their patients, the nature of prognoses is that they are uncertain – they constitute predictions based on statistical averages, which in themselves are very unreliable in determining what will happen to any given individual patient. It is notoriously difficult to prognose a patient's death from a particular condition or the complications relating to it, and a necessary and objectively demonstrable clinical judgement cannot reasonably be expected within

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[18] 'Rapid Response: Re: Assisted dying laws around the world: Proposed UK Assisted Dying Bill Fails the Public Safety Test', *BMJ* 2024;387:q2385.

[19] Fabian Stahle, Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model (January 2018).

[20] *Ibid*.

anything more than a relatively short timescale[21]. Medical prognoses of death outside of such a period are commonly mistaken, and many people who have been told they will die within months or even weeks go on to live much longer and happier lives. To illustrate this point, albeit with a graver ending: the assisted suicide campaigner Noel Conway, who suffered from Motor Neurone Disease (MND), was prognosed with twelve months to live in January 2017; in fact, he died four-and-a-half years later, in June 2021, having made the decision to remove his ventilator[22].

This unreliability of clinical prognoses over time has long been recognised. In their evidence to the Lords Select Committee examining a voluntary euthanasia bill in 2004, the Royal College of General Practitioners stated: '*It is possible to give reasonably accurate prognoses of death within minutes, hours or a few days. When this stretches to months then the scope for error can extend into years*'. The Royal College of Physicians, giving similar evidence, said that, '*prognosticating may be better when somebody is within the last two or three weeks of their life… when they are six or eight months away from it, it is actually pretty desperately hopeless as an accurate factor*'[23].

Consequently, proportions of prognostic error include 20% of predictions in motor neurone disease[24], 50% of predictions in heart failure[25], and 5% of terminal diagnoses overall[26]. Further research has consistently shown that clinicians' predictions are frequently inaccurate:

- A 2016 systematic review of predictions of patient survival in palliative care, including 4,600 medical notes where doctors predicted survival, concluding that '*the evidence suggests that clinicians' predictions are frequently inaccurate*', having showed a wide variation in errors ranging from an underestimate of eighty-six days to an overestimate of ninety-three days[27].
- In 2017, a study[28] conducted by researchers at the Marie Curie Palliative Care Research Department at University College London looked at 26 previously published studies comprising 25,718 predictions made by clinicians using the 'Surprise Question' ('*Would you be surprised if this patient died within the next 12 months?*') over a ten-year period, as a means of recognising those patients who might benefit from palliative care. It found that the accuracy of predictions varied considerably, with clinicians tending to over-predict the number of people whom

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[21] Glare P *et al*. 'A systematic review of physician's survival predictions in terminally ill patients'. *BMJ*, 2003; 327: 195-8.

[22] Harriet Sherwood, 'Noel Conway, assisted dying campaigner, dies at home aged 71', *Guardian* (11 June 2021).

[23] Both cited in chapter 4 of the Select Committee on Assisted Dying for the Terminally Ill Bill, First Report, House of Lords (04 April 2005).

[24] Agosta F *et al*, 'Survival prediction models in motor neurone disease'. *European Journal of Neurology*, 2019; 26(9): 1143-52.

[25] Warriach HJ *et al*. 'Accuracy of physician prognosis in heart failure and lung cancer: comparison between physician estimates and model predicted survival'. *Palliative Medicine*, 2016; 30(7): 684-9.

[26] House of Lords Report 86-II (Session 2004-05).

[27] White N., Reid F., Harris A., Harries P., Stone P. 'A systematic review of predictions of survival in palliative care: how accurate are clinicians and who are the experts?' *PLoS One*. 2016;11(8) doi: 10.1371/journal.pone.0161407

[28] White, N., Kupeli, N., Vickerstaff, V. *et al*. 'How accurate is the 'Surprise Question' at identifying patients at the end of life? A systematic review and meta-analysis'. *BMC Med* 15, 139 (2017).

they thought would die. Over half (54%) of those predicted to die within a specified time period lived longer than expected, and clinicians made inaccurate predictions in a quarter (25%) of all cases including a third of the patients who did die, both a significant proportion of patients.
- A 2019 study found that clinicians' temporal predictions of patient mortality are frequently inaccurate and unreliable, this time finding a systematic tendency to overestimate how long a patient has to live[29], rather than the over-predictions of previous studies.

The reality that we see in Oregon reflects this[30]. The latest annual report from the Oregon Health Authority on the operation of their 'Death with Dignity Act'[31] shows that patients lived far longer than six months – some for over *four-and-a-half years* (1,633 days). Comparison with previous reports finds that in only one year of the operation of Oregon's assisted suicide regime (the very first – 1998), did no patients die outside a six-month prognosis. Health officials are clearly sensitive to this as the report now notes how many patients have '*outlived [their] 6-month prognosis*' – 122 people out of the 2,847 people who have died by assisted suicide since 1998. As will be noted later, reporting is not mandatory in Oregon; no penalties for failure to report figures are imposed on doctors, meaning that only the most conscientious doctors in Oregon report at all. As such, the data concerning Oregon is limited at best, and so any figures will underestimate the true reality. Nevertheless, even this artificial figure obscures a fundamental point: the six-month prognosis concerns the time left to patients before their underlying illnesses cause death, and we cannot know how many of the 367 people who died by assisted suicide in Oregon during 2023 would have lived perhaps longer than six months had their suicides not been enabled by their doctor.

Demonstrably then, statutory reliance on terminal prognoses as prescribed within the Leadbeater Bill opens up the premature death of many more patients, and cohorts of patients, than is typically proposed and intended. A number of patients would lose years of life, and their families would lose that precious time with them.

Procedural Gatekeeping

Added to the eligibility criteria, the two Bills propose a similar system of procedural gatekeeping. The patient applying for an assisted suicide must make two declarations with a period or periods of reflection: both the Leadbeater and McArthur Bills require 7 days after the first declaration[32]; the Leadbeater Bill requires a further 14 days after the second[33]. Further, two registered medical

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[29] Chu C., White N., Patrick S. 'Prognostication in palliative care' *Clinical Medicine* Jul 2019, 19 (4) 306-310; doi: 10.7861/clinmedicine.19-4-306

[30] For case studies of the inaccuracy of prognosis in the context of the American experience of assisted suicide, see Nina Shapiro, 'Terminal Uncertainty', Seattle Weekly (13 January 2009).

[31] Death with Dignity Act: 2023 Data Summary, Oregon Health Authority (20 March 2024), p. 13.

[32] *Op. cit*., Leadbeater Bill, clauses 10(2) and (3); McArthur Bill, clause 9(3)(a).

[33] *Ibid*., Leadbeater Bill, clauses 17(1) and (2).

practitioners (doctors) must make assessments that the eligibility criteria has been met and that the person seeking to procure an assisted suicide has made two declarations to that effect voluntarily[34].

(I should note here that assisted suicide declarations would be capable of being signed *by a proxy*, which the patients could give their consent to '*by reason of physical impairment, being unable to read or for any other reason*' (emphasis added); the *exact same language* exists in both Bills[35]. Whilst people close to the patient, including their carers, beneficiaries of their will, and family members are excluded from acting as such, it still seems open to potential abuse by malicious organisation – e.g. those pressuring the patient getting a remote person to act as proxy by promise of material gain.)

The McArthur Bill requires no further layer of confirmation beyond the two-doctor system just outlined. By contrast, a further layer has been proposed within the Leadbeater Bill, and this has taken two forms at different stages. In the previous draft which was laid before the House of Commons at Second Reading on 29 November 2024, the Leadbeater Bill then required that an application be made to the High Court which would have checked that this procedure has been followed (including that the eligibility criteria had been met)[36]. Following the practical objection which was made that such a system would swamp the already overloaded High Court (Family) Division with thousands of cases each year[37], the most recent version of the Bill has removed this requirement and added in the operation of a three-person 'Assisted Dying Review Panel' for determination of the eligibility of the person applying for an assisted suicide[38] made up of a 'legal member' (a Judge or King's Counsel), a 'psychiatrist member' (a practising psychiatrist who is registered both as a medical practitioner and as having a psychiatric specialism) and a 'social worker member' (a registered social worker).

Putting aside this latter detail, the system prescribed in the two Bills relies on the two doctors (the 'coordinating' doctor and the 'independent' doctor) having the ability to discern correctly whether the person presenting for assisted suicide or euthanasia is making a choice that is truly 'voluntary' and 'without coercion or pressure'. Nothing sets out *how* either of the two doctors might go about

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[34] *Ibid*., Leadbeater Bill, clauses 9–13; *op. cit*., McArthur Bill, clause 6.

[35] *Ibid*., Leadbeater Bill, clause 19(1)(a) *et seq*; McArthur Bill, clause 12(1)(a) *et seq*.

[36] Leadbeater Bill as introduced, clause 12.

[37] According to the latest Oregon statistical report (*op. cit*., 2023), assisted suicides accounted for 0.8% of deaths in Oregon. If this were reflected as a proportion of deaths in England and Wales that same year – see *Death registration summary statistics, England and Wales: 2023*, Office for National Statistics (16 May 2024) – 4,650 people would procure an assisted suicide. The Government's Impact Assessment of the Terminally Ill Adults (End of Life) Bill (Department of Health and Social Care and Ministry of Justice, 02 May 2025) found that the number of assisted suicides in England and Wales would reach close to this figure in Year 10 of implementation, assuming that there would be (as tends to be the case) a slow initial uptake of EAS, as culture shifts and more readily accepts physician-assisted suicide or administered euthanasia.
The 18 Judges of the High Court Family Division would have had to hear roughly 5 of these cases a week, on top of their existing work (including cases involving child protection, forced marriage, female genital mutilation and applications for financial relief where a divorce has taken place outside England and Wales). This would have been patently unsustainable, unless the Government had expanded the number of High Court Judges for the Family Division, at significant public expense. For many other practical objections from the point of view of the Judiciary excellently enumerated, see Sir James Munby in 'Assisted Dying: What Role For The Judge?', Parts 1 (30 October 2024) and 2 (14 November 2024), for the Transparency Project.
Some MPs are reportedly dismayed that such a 'safeguard' was removed by the Bill, but it seems clear that this was an unworkable proposal.

[38] *Op. cit*., Leadbeater Bill, clause 14(2), cf. Schedule 2.

evaluating the patient to discern that they are not acting under any form of inordinate pressure in relation to his or her wish to request assisted suicide or euthanasia. In fact, the Bill simply allows the doctor to 'ascertain' by whatever means they wish that the request made by the patient for assisted suicide is 'clear, settled and informed'[39]. Indeed, there is no requirement that they have the psychological training that might begin to allow them to properly do so.

In all, the process of application for assisted suicide is envisaged to take potentially 21 days for the Leadbeater Bill (encompassing both 'periods of reflection' altogether during which the application would take place)[40], or else 7 days or even less for the McArthur Bill[41]. Additionally for the Leadbeater Bill, two new criminal offences of 'coercion into assisted suicide' are envisaged wherein a person who '*by dishonesty, coercion or pressure, induces*' a patient to either falsely '*make a first or second declaration, or not to cancel such a declaration*' or '*to self-administer an approved substance*' could be imprisoned for up to 14 years under the former offence or given a life sentence under the latter one[42].

In response to concerns expressed by journalist Victoria Derbyshire about the insufficiency of the Leadbeater Bill's 'safeguards', particularly as regards the impossibility of the two doctors to detect pressure or coercion, Kim Leadbeater MP[43] firstly mentioned that doctors would receive training, and when pushed on how even with training they would be able to detect pressure or coercion on a person presenting for assisted suicide, responded primarily that, '*We have to trust medical professionals*'. When presented with the same challenge by the same interviewer on another occasion, Christine Jarvis MP[44] responded after having been asked the question by Derbyshire four times, with the same promise of training and argued that '*... medical practitioners sign an oath. 'First do no harm'; they will take this very, very seriously*'.

We will address the two MPs' trust in doctors later, but even if doctors did have psychiatric training or were given training in how to recognise 'coercive control', the 'safeguard' also relies on both physicians knowing the patient well enough, their families, and their overall situation, to be able to put such training into effect by evaluating the patient's intentions, mental capacity, and freedom from duress. This would include pressure (however subtle) felt by an individual from unscrupulous relatives wanting to remove the burden of care the patient constitutes for them or to access their estate upon inheritance, still less that of medical staff at the very least wanting to free up a bed given their tightened

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[39] *Ibid*., clause 1(2)(a), cf. clauses 9(2)(g), 10(2)(d), 15(2)(h), 17(5)(c) and 23(5)(b). In the introduced draft of the Bill, the phraseology was 'clear, settled, informed *and voluntary*' (italics added); 'voluntary' has since been removed.

[40] *Ibid*., clauses 10(3) and 17(2).

[41] *Op. cit.*, McArthur Bill, clause 9; cf. 9(1)(3)(b) which allows for a '*shorter period (being not less than 48 hours) beginning with the day on which the first declaration was made', in situations 'where both the coordinating registered medical practitioner and the independent registered medical practitioner reasonably believe that the adult's death is likely to occur before the end of [the standard seven day] period*'.

[42] *Ibid*., clause 31.

[43] *"Even with training, how could you possibly assess whether someone had been pressed [into assisted dying] or not?" @vicderbyshire asks Kim Leadbeater MP how medical professionals will counteract possible coercion if assisted dying is made legal in the UK*. @BBCNewsnight Post on X, 12:21AM, 16 October 2024.

[44] 'MP is asked 4 times how a doctor would know if someone had been pressured into assisted dying', *BBC Newsnight* (YouTube), (15 November 2024).

finite resources, or the series of other situations that would potentially push a patient towards premature ('assisted') death. Anything approaching such a close relationship, if it exists at all, would be restricted to that between patients and their General Practitioners (GPs), and even this for a substantial number of people is much less familiar than it used to be, so this is strikingly unrealistic. As barrister Thomas Chacko points out[45]:

> *'Pressure and coercion aren't obvious. The person asking for assisted suicide won't tell the doctors, as (due to the pressure) they will have chosen to die, and doctors aren't investigators. Medical records don't reveal the family life or finances of the patient. To identify this, you would investigate the patient's home life and finances (and those of anyone who might inherit). This would be intrusive and slow, and it would require powers to demand information and question friends and relatives. Without this, coercion and pressure will simply be invisible to the decision makers.'*

In light of all this, the added alleged 'safeguard' that the process be confirmed by an Assisted Dying Review Panel such that the criteria within the Bill for an assisted suicide to proceed has been met is a useless added layer of bureaucracy. Since the process is inherently flawed inasmuch as it cannot detect pressure, the so-called 'safeguards' would be effectively toothless, and lack the detail and power to protect vulnerable people. To ask a Panel to merely confirm that a weak process has been followed, would in no way provide extra strength and safety to the proceedings. As a matter of both legal right and sufficient time, the three members would not be able to use their skills in such a way that would be useful: to detect undue influence or pressure on the patient. The 'legal member' would not be able to critically investigate the surrounding circumstances of a person's requested assisted suicide, and neither the 'psychiatrist member' nor the 'social worker member' would have a relationship that would allow for psychiatric or pastoral evaluation.

Additionally, it is not obvious how the new offence of 'coercion into assisted suicide' would be detectable and prosecutable, and this is therefore (contrary to claims that the proposed law would improve upon a supposed lack of protection in the current law) a weaker set of safeguards than the current criminalisation of assisted suicide, which provides a deterrent against malicious action by involving a post facto forensic investigation into suicides. (Including a coroner investigation, which duty to perform the Leadbeater Bill would remove for deaths undertaken under its auspices[46], thus further weakening existing protections.)

Two Social Analogies: Abortion and the Death Penalty

Two other social issues provide useful analogies to consider the two Bills' proposed structure of 'safeguards'. The first of these is another social issue which involves a system which uses a legally-prescribed 'two-doctor' certification system – abortion. According to the Abortion Act 1967, two doctors have to certify 'in good faith' that a woman meets one of the grounds under section 1 in order to have

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[45] Tom Chacko, 'Kim Leadbeater's "safeguards" won't keep people safe', *The Critic* (20 November 2024).

[46] *Op. cit.*, Leadbeater Bill, clause 29(1).

an abortion[47]. Data from the Department of Health and Social Care consistently shows that the vast majority (~99.9%) of abortions are carried out under 'Ground C' alone (where abortion is performed because of a risk to the woman's mental health)[48]. No clinical evidence is required for two doctors to make a 'good faith' judgement that abortion is necessary to safeguard maternal mental health, and no training or mental health qualification (beyond very basic general medical education) is required for doctors who are asked to make such an adjudication.

This is why when 'ground C' abortions are recorded they are classified as '*F99 (mental disorder, not otherwise specified) under the International Classification of Disease version 10 (ICD-10)*'[49]. No further breakdown is possible within the official figures, because no further detail or evidence base is asked for in recording such abortions. This is despite the fact that on page 4 of the HSA4 forms on which abortion grounds must be given[50], if an abortion takes place due to a physical condition, the specific physical pathology must be described under '*State main medical condition*'. For mental health grounds only, the question '*Was there a risk to the woman's mental health?*' is asked, followed by two boxes: '*Yes*', or '*No*'. Unlike every other 'medical' ground for abortion, further detail is not required. Consequently, it is widely accepted that this statute is commonly abused so as to 'cover' for abortion on request, and as a result, whereas in 1969 there were 49,827 abortions[51] performed, by 2023, there were 251,377[52], totally outstripping population growth as an explanatory factor.

The Abortion Act 1967 was not designed to be very permissive – its sponsor, David Steel, famously made his Bill more restrictive during its Parliamentary passage by removing a 'social clause' so as to attract support from the medical profession – but its operation is very permissive. Doctors who wish to grant a woman an abortion can do so as the Act puts the onus on them to interpret how to certify according to its provisions. Given this, how can a two-doctor certification really be described as a 'safeguard' in the Leadbeater Bill when it has singularly failed as an effective restriction in other social legislation governing medical procedures?

Taking this with the other considerations above, it is clear that the alleged safeguards within the Leadbeater Bill are not safeguards at all, and certainly neither 'thorough' nor 'robust'. Rather, they altogether constitute a set of bureaucratic hoops through which, going by the Oregonian experience, abuses would still be possible. Bearing this in mind, we may consider the other social analogy.

It should be noted that when the Murder (Abolition of Death Penalty) Bill was being debated in 1965, Dr Shirley Summerskill MP stated her concern that, '*I do not believe that sufficient has been said*

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[47] Abortion Act 1967, section 1.

[48] Cf. Abortion Statistical Reports for England and Wales 2014-2022, Abortion Research and Statistics, Department of Health and Social Care.

[49] See under '*Statutory grounds for abortion*' in Abortion statistics, England and Wales: 2022, Office for Health Improvement & Disparities, Department of Health and Social Care (23 May 2024).

[50] Form HSA4: abortion notification – summary of the information collected, Department of Health and Social Care (1 May 2024).

[51] Figures taken from Department of Health and Social Care figures, gained on request.

[52] Abortion statistics, England and Wales: 2022, Department of Health and Social Care.

in this debate about the fact that there is always one case in 100 or more where the innocent man is hanged. That is probably the greatest argument against hanging.'[53] This statement was made in the context of convictions for murder being arrived at after a forensic police investigation and subsequent court process in which hard evidence would have been weighed and tested. For those who oppose capital punishment then, one of the best arguments, if not the 'greatest argument against' it is that even after the rigours of the police and judicial process there would still not be sufficient confidence that a person found guilty might not be wrongly convicted such that the death penalty could be safely applied. (A good justification for this belief could be said to be the Birmingham Six case fifty years ago[54], in which six men were imprisoned for 16½ years in one of the biggest miscarriages of justice, and episodes of corruption, in British legal history.)

If such a concern can be valid even after a process *that is normally rigorous*, then it surely follows that the same concern should exclude legalising involvement in the death of a patient when the only confidence we may have in their 'clear, settled, informed and voluntary' wish to end their own lives, without any coercion or undue pressure, is a bureaucratic box-ticking exercise which has failed to provide restrictive safeguards elsewhere?

Ought We To 'Trust Doctors'?

As mentioned, both Leadbeater and her ally Jarvis expressed a sentiment that we should 'trust doctors' in the context of their detecting coercion and pressure. In the context of assisted suicide, this is a concerning attitude.

The Bill allows those seeking an assisted suicide to 'doctor-shop' (apply to multiple doctors), if they do not get from any one doctor the assent to the process of assisted suicide they wish. Bearing that in mind, it is worth considering further that one study looking at Oregon's system between 2001–2007 showed a majority (61%, 165 out of 271) of the lethal prescriptions were written by a minority (18%, 20 out of 109) of the participating physicians. More striking still, just 3 physicians were responsible for 23% of lethal prescriptions (62 out of 271)[55]. This means that of the approximately 10,000 licensed physicians in Oregon at the time, a large proportion of lethal prescriptions were written by a small number of physicians.

Similarly, in Canada, according to the Fifth Annual Report on Medical Assistance in Dying (MAiD) in Canada as it operated in 2023 (the most recent report), of the 97,384[56] physicians then operating in

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[53] Murder (Abolition of Death Penalty) Bill, Second Reading, HC Deb 21 December 1964 vol 704, column 954.

[54] Ed Barlow, 'Why Britain's biggest unsolved mass murder is being revisited 50 years on', *BBC News InDepth* (4 November 2024).

[55] K. Hedberg, D. Hopkins, R. Leman, and M. Kohn, 'The 10-Year Experience of Oregon's Death with Dignity Act: 1998-2007', *The Journal of Clinical Ethics* 20, no. 2 (Summer 2009): 124-32. (Kenneth R. Stevens, Jr. MD, *Concentration of Oregon's Assisted Suicide Prescriptions & Deaths from a Small Number of Prescribing Physicians*, Physicians for Compassionate Care Education Foundation. Revised 18th March 2015.)

[56] Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2023 — Data Tables. Ottawa, ON: CIHI; 2024. See Table A: Summary.

Canada, 2,079[57] engaged in euthanasia of their patients. That is 2.14% of Canadian doctors, of whom the *Fifth Annual Report* states that '*89 practitioners [were] responsible for 35.1% of all Track 1 and 28.6% of all Track 2 cases respectively, suggesting that MAID is becoming an area of focused expertise for some*'. Of the 8,302[58] Canadian Nurse Practitioners (NPs), 121[59] were engaged in euthanasia procedures – 1.46% of nurses in Canada. This may be for good personal reasons: in Canada, a majority of those doctors who have refused to participate in assisted suicide did so not based on religious or moral grounds, but because of fear of the repercussions on their mental health[60].

Indeed, consistent minorities of doctors involve themselves in assisted suicide or euthanasia in those jurisdictions where these are introduced into medical practice. In Belgium, where euthanasia and assisted suicide have been legal for almost two decades, only 13% of psychiatrists were prepared to participate in the assisted suicide process[61]. One study found that of 52 GPs interviewed only 9 (17%) had performed euthanasia[62]. Correspondingly, in a most recent (2020) British Medical Association poll of practising UK doctors, only 26% said they were willing in prospect to prescribe lethal drugs[63], and it is possible even fewer would do so were assisted suicide actually to be legalised in England and Wales.

Such minorities of doctors will be those with the least qualms and fewest scruples about involving themselves in the death of their patients. If a similar situation to Oregon, Canada, or Belgium were allowed to develop in England and Wales, it would be these who would be responsible for ensuring that the patient applying for assisted suicide fulfilled the eligibility criteria set out in the Bill and who might be minded to interpret it according to the widest practical scope.

Given the aforementioned experience of Oregon and Canada of smaller numbers of medical professionals being willing to take part in provision of assisted suicide, and the potential within the Leadbeater Bill for doctor-shopping, this suggests that *the sorts of doctors who would most be willing to take part in the process for assisted suicide would be the ones responsible for confirming that the patient is making a 'voluntary' decision*. It is worth noting the power they would have:

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[57] Fifth Annual Report on Medical Assistance in Dying (MAiD) in Canada, Health Canada (December 2024), p. 53.

[58] Canadian Institute for Health Information. *Nursing in Canada, 2023 — Data Tables*. Ottawa, ON: CIHI; 2024. See *Table 5: Workforce*.

[59] *Op. cit.*, *Fifth Annual Report on Medical Assistance in Dying (MAiD) in Canada* (December 2024), p. 53.

[60] Bouthillier ME, Opatrny L. 'A qualitative study of physicians' conscientious objections to medical aid in dying'. *Palliat Med*. 2019 Oct;33(9):1212-1220. doi: 10.1177/0269216319861921.

[61] Verhofstadt M *et al*. 'Belgian psychiatrists' attitudes towards, and readiness to engage in, euthanasia assessment procedures with adults with psychiatric conditions: a survey'. *BMC Psychiatry* 2020; https://doi.org/10.1186/s12888-020-02775-x

[62] Sercu M, Pype P, Christiaens T, Grypdonck M, Derese A, Deveugele M. 'Are general practitioners prepared to end life on request in a country where euthanasia is legalised?'. *J Med Ethics*. 2012 May;38(5):274-80. doi: 10.1136/medethics-2011-100048.

[63] BMA: Physician-Assisted Dying Survey (February 2020).

- Whilst only those with 'capacity'[64] are allowed by the Bill to procure assisted suicide, this is defined by the Mental Capacity Act 2005[65], which states that a person '*must be assumed to have capacity unless it is established that he lacks capacity*'. The 'coordinating' and 'independent' doctors could therefore conceivably certify someone as having capacity who really did not, simply because this is the legal presumption and because they did not, by commission or omission, establish otherwise. They would only have the discretion rather than the duty to refer for psychiatric assessment if they doubted the patient's mental capacity[66].
- The doctor would be able to unilaterally discuss assisted suicide with the patient[67], effectively initiating the process with patients who may thereby feel pressured to go down that path.
- The 'coordinating' doctor would be the one to secure the 'independent' doctor (which raises the question as to how 'independent' this second physician might be from the first), and were the latter to decline to approve the assisted suicide it would be possible to re-refer to someone else[68].

Given all this, claims that we should blithely 'trust doctors' are extraordinary, not to say grossly naïve and complacent. As the journalist Ian Birrell has argued[69]:

> '*Legalised euthanasia frees a genie from the bottle, while fundamentally altering the nature of doctoring with its oath of first do no harm. It sends a message that killing is an acceptable form of treatment… Yet we know doctors… are fallible humans who can make mistakes, be swayed by pressure or fail to detect coercion amid daily clinical stresses… Bear in mind we live in a nation where several of the worst negligence scandals involved mass killing of elderly patients and the care system has been allowed to rot. A land that still locks up autistic people and citizens with learning disabilities in psychiatric hellholes with the connivance of doctors.*'

Tragic institutional scandals such as those in Gosport War Memorial Hospital, Alder Hey, Stafford Hospital and Stepping Hill prove his point even more so, as indeed do the equally if not more infamous cases of doctors such as Marcel Petiot, Harold Shipman, Michael Swango, Christopher Duntsch and

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[64] *Op. cit*., Leadbeater Bill, clause 3.

[65] Mental Capacity Act 2005, section 1.

[66] *Op. cit*., Leadbeater Bill, clause 9(3)(b).

[67] *Ibid*., clause 4(2).

[68] *Ibid*., clause 10(1).

[69] Ian Birrell, 'I have investigated assisted dying in Europe and North America – it frees a genie from the bottle', *iNews* (25 November 2024).

Paolo Macchiarini amongst many others[70]. Added to this is an appallingly extensive international list of nurses and other hospital or care home staff who have chosen to murder and abuse vulnerable patients, sometimes justifying their actions on the basis of mercy killing[71].

Another such case even more pertinent to end-of-life care is that of the Liverpool Care Pathway (LCP), a model care pathway developed from hospice experience, which formed a procedure by which palliative care could be given to patients towards the very end of their life. Very unfortunately, a series of complaints were raised over several years about the extent to which it had withdrawal of basic care (food and fluids, which can become burdensome in the last hours of a person's dying process) to cause premature deaths due to dehydration and malnutrition. The findings of an independent review led by Baroness Neuberger[72] led to it being ostensibly discontinued, but it was claimed that the pathway was simply 'rebranded' and used further[73], which led to more abuses.

In 2023, the Lords and Commons Family and Child Protection Group report, *When End of Life Care Goes Wrong*[74], accounted the continued '*misapplication, misuse – and even abuse – persist*' in the LCP-replacement 'care package' recommended by the National Institute of Clinical Excellence (NICE). It did so by providing the '*medically analysed and validated accounts*' of 16 families of the deaths of 17 loved ones out of 800 complaints of ill-treatment they had collated. They had subjected these to a full medical assessment by Emeritus Professor Sam Ahmedzai FRCP, a cancer and palliative medicine specialist, who acted as Clinical Adviser to the 2019 NICE NG142 guideline on service delivery for people in the last year of life, as well as to legal assessment by barrister and medical law specialist James Bogle. The report described cases in which the '*[e]xcessive and inappropriate use of Midazolam and Morphine, rendering a patient comatose, coupled with the withdrawal of food and hydration, have combined to impose a death sentence*'.

If even under the present medical culture, such mistakes and abuses can happen in end-of-life care with the current law, then it is reasonable to ask how abuses might not be worsened by a system in which doctors now feel legally enabled to involve themselves in causing the death of their patients. The Alder Hey, Stafford Hospital and Stepping Hill scandals happened less than 20 years ago and the LCP abuses within the last 15 years *are allegedly ongoing*. These are not ancient history. What they illustrate is the potential for doctors to engage in abuse, even with the most well-intentioned and deliberately

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[70] Added to this list could be the late Dr David Moor, a British doctor acquitted in 1999 of murdering a terminally ill patient who had nonetheless admitted in a press interview to having killed (euthanised, and so murdered) 300 patients over 30 years by diamorphine overdose, or the also late Dr Howard Martin who in 2010 admitted shortening the life of some of his patients, often without their express permission, and to euthanising his terminally ill son in 1988.

[71] Cf. the many cases of 'medical professionals and pseudo-medical professionals' who engaged in serial murders and other abuse collated by Wikipedia. Those who ostensibly cited compassion for the terminally ill and other suffering patients as justification for their actions include Americans Charles Cullen and Donald Harvey (who self-described as the 'Angel of Death'), Austrian Frederick Mors, Brazilian Edson Izidoro Guimarães, Dutchman Frans Hooijmaijers, Frenchwomen Christine Malèvre and Ludivine Chambet, and German Stephan Latter.

[72] More Care, Less Pathway: A Review of the Liverpool Care Pathway (July 2023).

[73] Laura Donnelly, 'Liverpool Care Pathway being 'rebranded' not axed', *Telegraph* (01 December 2013).

[74] Robert S. Harris (Ed.), When 'End of Life Care' Goes Wrong: A Report from the Lords and Commons Family and Child Protection Group (March 2023).

benign structures such as the Liverpool Care Pathway. *Abusus non tollit usum* ('abuse does not cancel [proper] use'), but when practices can all too easily lead to lethal and thus permanent and irrevocable consequences, we think it is right to erect laws preventing them.

Leadbeater's Provenance: the Oregon Model

As noted, the basic system proposed by the Terminally Ill Adults (End of Life) Bill is based on the model of the U.S. State of Oregon[75], which has the longest-running formal system of assisted suicide in the world and has mainly been copied in other U.S. jurisdictions[76]. Proponents of this system typically claim that it has seen no widening of the initial, limited scope, and no cases of abuse of the law. Both claims are highly misleading.

Oregon's Legislative Assembly expanded the State law in 2019[77] by removing one of its purported 'safeguards', allowing those who procure assisted suicide to forego a 15-day waiting period before accessing lethal drugs. By 2023, Oregon's eligibility criteria was relaxed both *de iure* and *de facto*: the legislature repealed the residency requirement[78] that year, and as noted above, whilst Oregonian assisted suicide is ostensibly only for terminal illness (commonly understood to mean illnesses such as advanced cancer), in 2021 two patients with anorexia underwent assisted suicide after their physician deemed their condition to be 'terminal' alongside people suffering with hernias and arthritis[79].

Two other U.S. States followed suit in 2023: Washington State (the first State to adopt its neighbour Oregon's system in 2008) also removed its 48-hour waiting period[80], and Vermont removed its residency requirement[81]. Indeed, they and others went further: Vermont[82] allowing 'telemedicine' requests for lethal drugs with a required physical examination to be conducted by a doctor other than the one prescribing them in 2023, and Hawaii[83] and Washington State[84] allowing nurses to prescribe lethal drugs that same year. Both States also reduced the time between two oral requests for assisted

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[75] Death with Dignity Act (1997).

[76] Those being Washington State (2008), Vermont (2013), California (2015), Colorado (2016), Washington D.C. (2016), New Jersey (2018), Maine (2019), Hawaii (2019) and New Mexico (2021). Montana has decriminalised assisted suicide by Court judgement, but does not have a formal regulated system as in Oregon and the other places that have followed it.

[77] SB 579 (2019).

[78] HB 2279 (2023).

[79] See notes 11–15.

[80] SB 5179 (2023).

[81] H.190 (2023–2024).

[82] S. 74 (2022).

[83] HB 650 (2023).

[84] S. 5179 (2023–2024).

suicide, in Washington State[85] from 15 days to 7 days, and in Hawaii[86] from 20 to 5 days, California[87] having reduced its own from 15 days to 2 days in 2022. The claim that the Oregonian system of assisted suicide has remained static is demonstrably untrue.

Beyond this, the lack of transparency in Oregon's system makes it highly difficult to evaluate. The Oregon Health Authority publishes Annual Reports concerning the operation of its Death with Dignity Act (DWDA) every year, but these are based on minimal data collection, requiring doctors to report any lethal drug prescriptions they make but without any enforcing penalties for those who fail to do so, or monitoring of non-compliance or under-reporting. Since the information is voluntarily reported by doctors, it is only the most conscientious that do so, and the underlying data records are destroyed each year.

Also, worryingly, even this minimal data collection has declined, including in important areas. A 25-year analysis of the Reports made by palliative care specialists Dr Ilora Finlay and Dr Claud Regnard between 2010 and 2022[88] found that there were medical complications in 11% of those assisted suicides that were reported, but in 2022 the cases on which data complications-related data existed *per se* was only 26%.

Meanwhile, no information is collected from patients or their relatives, there is no official means by which the public can complain about abuses of assisted suicide, and there is no strong oversight of the process associated with it exercised by the State Government. Little wonder that an editorial in *The Oregonian* in 2008 described assisted suicide in the State as '*a system that seems rigged to avoid finding*' abuses[89].

Despite this, what we do know about the Oregon system, whether from the DWDA Reports or other studies and information across the 25 years of its operation, is extremely troubling. An overview of that State's practice in 2008[90], including some case studies as well as statistical evidence, showed problems with doctor shopping, suspect coercion and lack of sufficient psychiatric evaluation. That same year, 2008 British Medical Journal study examined 58 Oregonians who sought information on assisted suicide. Of them, 26% met the criteria for depressive disorder, and 22% for anxiety disorder. Three of the depressed individuals received and ingested the lethal drugs, dying within two months of being interviewed. The study's authors concluded that Oregon's law '*may not adequately protect all*

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[85] *Ibid*.

[86] HB 650 (2023).

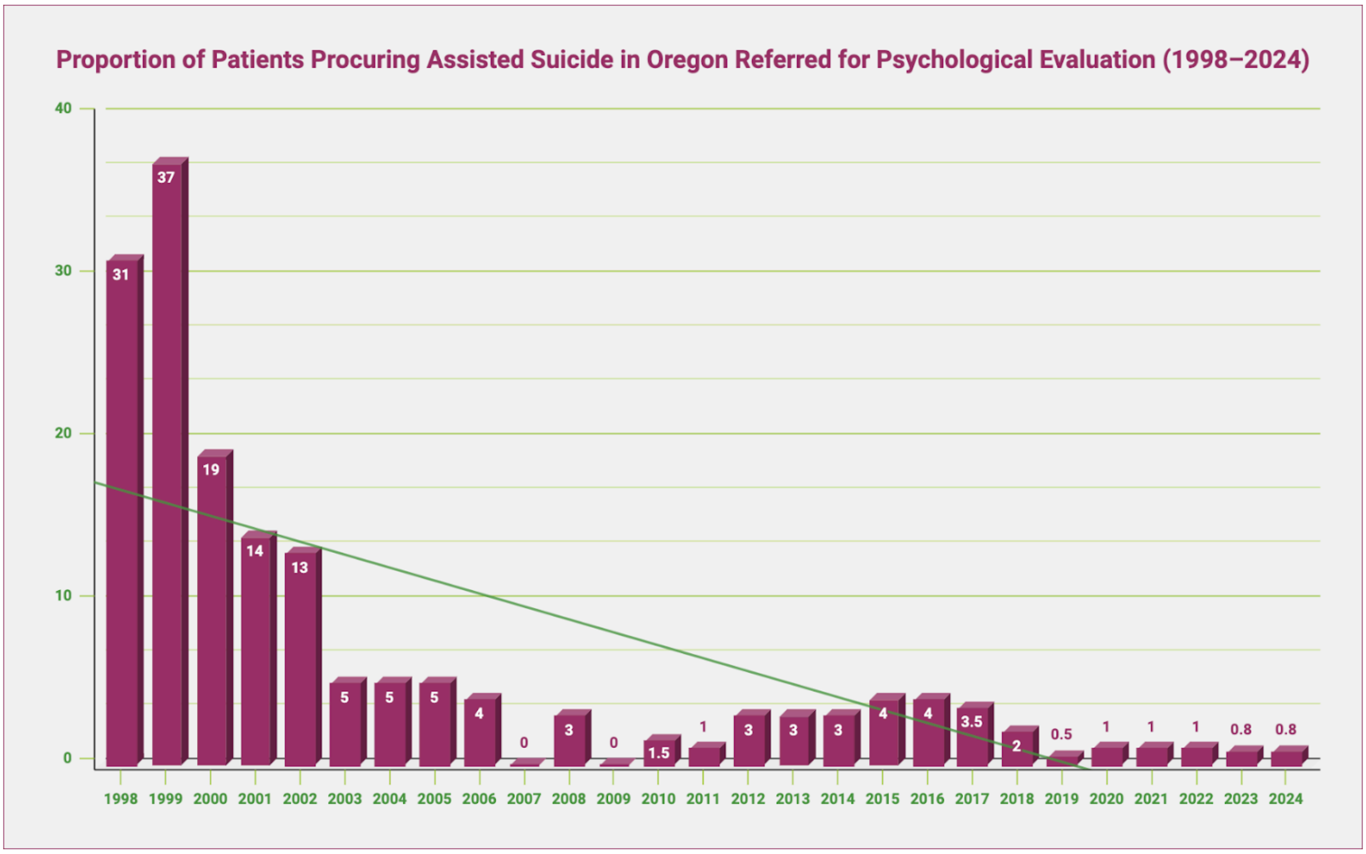
[87] SB-380 End of life. (2021-2022).

[88] Regnard, Claud, Worthington, Ana and Finlay, Ilora 2023. 'Oregon Death with Dignity Act access: 25 year analysis'. *BMJ Supportive & Palliative Care* 10.1136/spcare-2023004292.

[89] 'Living With the Dying Experiment', *The Oregonian* (08 March 2005).

[90] Herbert Hendin & Kathleen Foley, 'Physician-Assisted Suicide in Oregon: A Medical Perspective', 106 *MICH. L. REV*. 1613 (2008). Available at: https://repository.law.umich.edu/mlr/vol106/iss8/7

mentally ill patients'[91]. More recently, Finlay and Regnard found a reduction in the length of the average physician-patient relationship from 18 weeks in 2010 to 5 weeks in 2022, a low proportion of patients referred for psychiatric assessment (1%)[92], and an increasing trend of those citing fear of being a burden and financial concerns for opting to undergo assisted suicide.


Proportion of Patients Procuring Assisted Suicide in Oregon Referred for Psychological Evaluation (1998–2024)

It is in this context that abuses may easily occur. In 2008[93], a man suffering from Motor Neurone Disease, Thomas Middleton, moved into the house of a friend, Tami Sawyer, before procuring an assisted suicide. Two days later, Sawyer placed his home on the market and transferred $200,000 to her own account. That is an example of how Oregon's assisted suicide system was abused to the permanent detriment of the victim, but which was eventually caught – Sawyer and her husband were later indicted for first-degree criminal mistreatment and first-degree aggravated theft – it raises the question however, of how many more such crimes have been enabled and gone undetected.

Such a system would worsen the already very real threat of abuse of vulnerable cohorts of people. As Jess Asato MP in a letter to her constituents opposing the Leadbeater Bill notes[94]:

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[91] Ganzini, Goy, and Dobscha, 'Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey', *BMJ* 2008;337:a1682.

[92] For a fully up-to-date chart of this particular figure, see below, derived from the Oregon Health Authority's Death with Dignity Act Annual Reports.

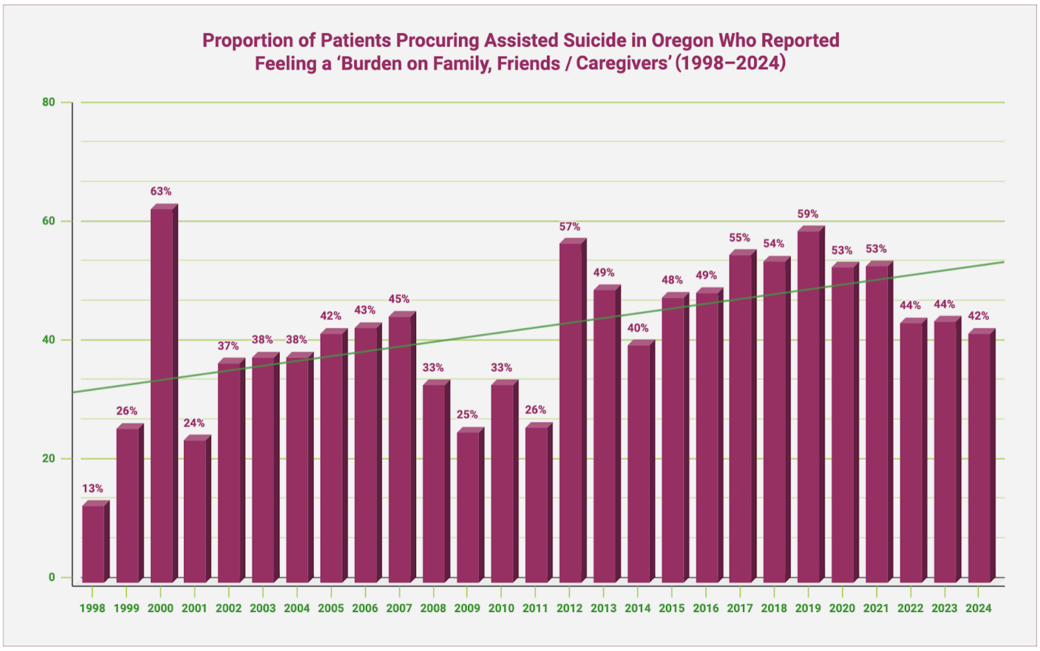
[93] 'Ex-broker Tami Sawyer arrested on theft charges', *The Oregonian* (11 July 2011).

[94] Jess Asato MP, Letter to Constituents on why I Oppose the Terminally Ill Adults (End of Life) Bill (25 November 2024).

> ‘*We don’t want to think about it, but abuse surrounds us. It's a very real and present threat. And it’s a complex thing – it can be difficult for professionals to identify without training, victims often don’t realise until they have got free, and it remains incredibly hard to prove in a court of law. We also tend not to think of older people as victims of abuse, but the reality is that one in six of those over 60 experience it in some form. Almost half of older victims have disabilities and 44% are abused by a family member (compared with 6% of younger victims). We know that older victims tend to be less likely to leave their abusers and are more likely to experience abuse from current intimate partners.*’

Added to this, consider the ‘*epidemic of elder abuse across the UK*’ revealed by a poll[95] which found that almost 10% of older people said that they are being abused, and that closer to 20% have been abused previously. In this context, introducing the Oregon model of assisted suicide into England and Wales would be deeply concerning. Just as nothing in the two-doctor model enables proper diagnosis of depression, so the same constraints of doctor training or time with the patient prevent realistic detection of explicit or even more subtle pressures on an individual to end their own life by uncompassionate family and supposed friends, or manipulation by the unscrupulous into premature death.

Finally concerning is the extent to which assisted suicide in Oregon has seemingly normalised vulnerable patients opting for assisted suicide because they believe they are a ‘burden on their family, friends or caregivers’. Numbers of those procuring assisted suicide for that reason have risen steadily if not consistently. In 1998 when the Oregon system came into effect, the numbers giving that motivation were 13%; by 2019 it was 59%. Last year it was 43%, with numbers being consistently above 40% since 2012[96]. The numbers doing so in Washington State have been consistently above 50% since 2011[97].


Proportion of Patients Procuring Assisted Suicide in Oregon Who Reported Feeling a ‘Burden on Family, Friends / Caregivers’ (1998–2024)

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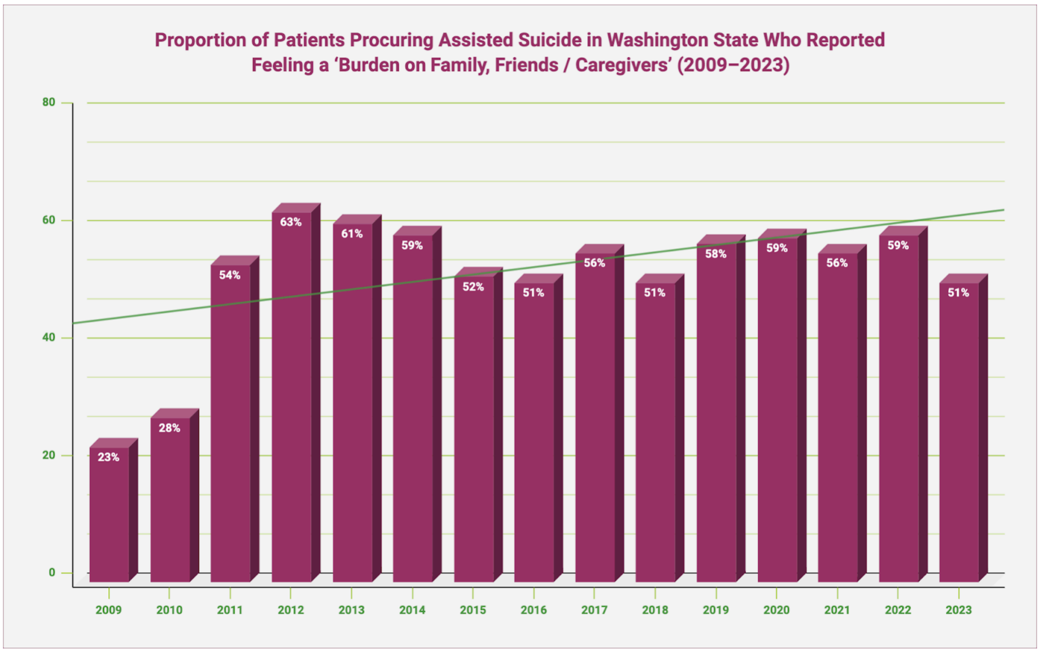
[95] Jamie Doward, ‘One in five older people in the UK have been abused, poll finds’, *Guardian* (29 November 2020).

[96] Data derived from the Oregon Health Authority’s Death with Dignity Act Annual Reports.

[97] Data derived from the Washington State Department of Health’s Death with Dignity Data sets.



Proportion of Patients Procuring Assisted Suicide in Washington State Who Reported Feeling a 'Burden on Family, Friends / Caregivers' (2009–2023)

Some advocates of assisted suicide have justified this motivation as a kind one, and charitable to the family of the person wishing to procure assisted suicide. The journalist Julia Hartley Brewer has argued that[98]:

> '*You say people don't want to be a burden to their families – that's a legitimate moral concern, and a loving concern that a lot of people do have. They don't want to for instance leave the burden of the cost of their funeral to their family members. But also people who [have] been diagnosed with early on-set dementia – a point when… I know the distress that my family members are going to go through, actually, I would rather terminate my life before… I'm no longer a father or a mother to my child or a husband or a wife to my partner. Those I think are reasonable decisions that a reasonable human being could make*'.

Another journalist, Matthew Parris, even welcomed it as '*old age and infirmity*' are '*wildly expensive, cornering resources to fund our health and social care sectors*', predicting '*"Your time is up" will never be an order, but — yes, the objectors are right — may one day be the kind of unspoken hint that everybody understands. And that's a good thing*.'[99] This mirrored the sentiments of the late moral philosopher Baroness Warnock, who in an interview on assisted suicide in 2008, said: '*If you're demented, you're wasting people's lives – your family's lives – and you're wasting the resources of the National Health Service*'. She went on to say that she thought such people had indeed a 'duty to die', and on 'Advanced Directives' (where a patient assigns another person to make life and death decisions

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[98] Peter D. Williams & Julia Hartley-Brewer Debate over Euthanasia & Assisted Suicide (Talk TV), Family Education Trust YouTube (12 November 2024), time-frame 5:27.

[99] Matthew Parris, 'We can't afford a taboo on assisted dying', *The Times* (29 March 2024).

in case he or she is incapacitated), said: '*I think that's the way the future will go, putting it rather brutally. You'd be licensing people to put others down*'[100].

The self-confessedly 'brutal' attitudes of Warnock and Parris are appallingly callous and reductionistic, showing the coarseness of a society that begins to deny the inherent value of the life of each human person. Hartley-Brewer's view, whilst more understandable in its concern for those being left behind when someone is dying, is still dangerously flawed in the way that it pits the material interests of one generation against another rather than asking the younger and stronger to unselfishly care for their dying relatives.

To allow a culture to affirm people who feel a burden on others to end their lives however, is to affirm suicidal ideation in vulnerable people who might live longer (certainly in cases of mis-prognoses) and die more peacefully but for the 'option' they are provided which suits the self-interest of those surviving (and often fully healthy) family members. It is to pit the weak against the strong and to let the sick be pressured by the lack of care or indifference of the healthy (or healthier). Such a culture would not reflect a compassionate society, nor would it be one which takes its duty towards suicide prevention seriously.

Key Family Concerns: The Impact of Assisted Suicide on Suicide Prevention and Palliative Care

One thing that cuts to the heart of family life is the suicide of a family member. Sadly, those advocating for assisted suicide are not always sensitive not to encourage people in thinking of suicide as a proper option. In November 2024, 'Dignity in Dying' (formerly the Voluntary Euthanasia Society) paid for an advert campaign in certain Tube stations advocating assisted suicide[101]. Happily, by the end of the day, their adverts had been covered in suicide prevention posters[102].

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[100] Baroness Warnock, quoted in Macadam J., 'A duty to die?', *Life and Work* 2008:23–5.

[101] Dominic Pena, 'Assisted dying advertised on Tube – while junk food ads are banned', *Telegraph* (25 November 2024).

[102] @FleurMeston, '*Well that didn't take long… On my way home and the assisted suicide propaganda has been covered up with suicide prevention posters. Love it!* 💚' (7:30 PM, 25 November 2024).

In the context of terminal illness, a wish to die is often transient[103] due to depression caused by illness. In the general population, suicidal thoughts and urges are common symptoms of depression[104], and serious suicidal thoughts rarely arise apart from depression. Correspondingly, reports of individual assisted suicide cases show that patients are receiving assisted suicide in Oregon who suffer from depression and dementia. As we have noted from Finlay and Regnard, only 1% of patients dying by assisted suicide since 1998 have been referred for psychiatric evaluation.

There is an extent to which we would expect such a low referral rate. In 2006, having compiled the available evidence, the UK's Royal College of Psychiatrists advised that '*many doctors do not recognise depression or know how to assess for its presence in terminally ill patients*'[105]. Also related to points made already, in the Oregon two-doctor certification system proposed in the Leadbeater Bill, nothing establishes how the coordinating or independent physicians would be able to overcome this, and even requiring one or both to possess mental health training, or the involvement of a mental health professional, would fail to address the insufficient time that would be had in only two meetings over three weeks with the patient to properly diagnose mental illness where it exists. Directly, assisted suicide therefore undermines suicide prevention.

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[103] Monteforte-Royo C, *et al*. 'What lies behind the wish to hasten death? A systematic review and meta-ethnography from the perspective of patients'. *PLoSOne*, 2017; 7(5): e37117 6.

[104] See, e.g., Non-fatal suicidal behaviour among adults aged 16 to 74 in Great Britain, Office of National Statistics (2002), especially pp. 44-59.

[105] Statement from the Royal College of Psychiatrists on Physician-Assisted Suicide (2006), para. 2.4.

Indirectly, there is also evidence it does so more broadly. In 2015, a study[106] examined the association between the license of assisted suicide in individual American States, and the 'conventional' ('non-assisted') suicide rates of those States, between 1990 and 2013. Introduction of assisted suicide was associated with a 6.3% increase in total suicides (including assisted suicides), with a 14.5% effect in those over 65. The study concluded that States which had introduced PAS saw an increased rate of total suicides relative to other States that had not done so, and that the same saw no decrease in non-assisted suicides. The implication of this was that licensing assisted suicide not only does not inhibit suicide more generally, but is associated with an increased inclination to suicide in some individuals. Such a reality would directly entail that PAS directly undermines society's attempts at suicide prevention.

Further studies looking at European analogues have confirmed this, showing that after assisted suicide or euthanasia is introduced rates of 'conventional' suicide increase, in some cases significantly, and also that rates of assisted suicide / euthanasia increase significantly such that a total rate of 'self-initiated deaths' (assisted suicide / euthanasia plus 'conventional' suicide) increase significantly, with a disproportionate effect on women[107]. (Perhaps relatedly, a report[108] by The Other Half, a feminist think-tank, reviewing more than 100 UK cases of 'mercy killings' found that these were overwhelmingly violent domestic homicides of women, by men. Jess Asato MP has also noted that, '*The Monckton Report… found that a third of female suicides could be linked to domestic abuse and the Killed Women campaign group argues that there could be as many as 130 'hidden homicides' every year in the UK where women who are murdered by a partner or relative instead have their deaths recorded as suicide or an accident*'.[109]) By contrast, there has been no study finding a reduction in 'conventional' suicide relative to those jurisdictions which have not introduced assisted suicide or euthanasia.

Intuitively, the cultural effect of enabling suicide seems to undermine the suicide prevention 'signal' sent by suicide prevention strategies. In the recent words of Professor Louis Appleby, Chair of the National Suicide Prevention Strategy Advisory Group, and a Government Advisor on suicide prevention and mental health[110]:

> '*[O]nce the principle behind suicide prevention has been set aside, once any part of the ground has been ceded – not only to allow suicide but to assist it – we have lost something we may not get back… There are countless causes of irremediable hardship, many reasons people may want to make despairing choices. Could they become exceptions to suicide prevention too?*'

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[106] Jones, D. A., & Paton, D. (2015). 'How does legalization of physician assisted suicide affect rates of suicide?'. *Southern Medical Journal*, 180(10), doi:10.14423/SMJ.0000000000000349

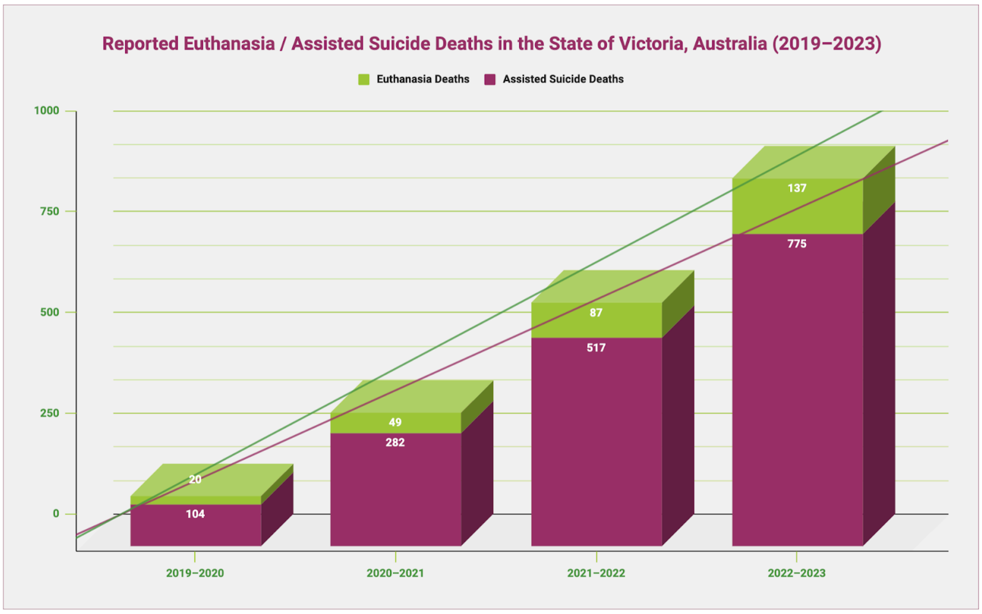
[107] Cf. Professor David Albert Jones, Suicide Prevention: Does Legalising Assisted Suicide Make Things Better Or Worse?, Anscombe Bioethics Centre (November 2022).

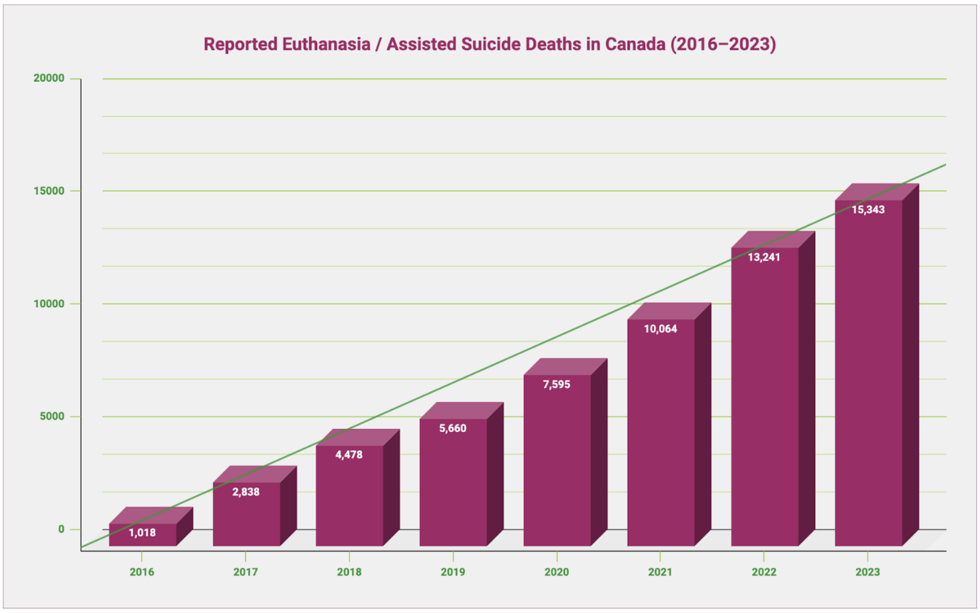
[108] Safeguarding women in assisted dying, The Other Half (22 November 2024).

[109] *Op. cit.*, Jess Asato MP, Letter to Constituents on why I Oppose the Terminally Ill Adults (End of Life) Bill (25 November 2024).

[110] Professor Louis Appleby, '#SuicidePrevention v #AssistedDying' X Thread (25 November 2024).

This evidence suggests that assisted suicide coarsens attitudes to suicide, normalising it in societies that have introduced it, and as studies have indicated, the willingness of people to end their own lives through assisted suicide has been affected: the rates of patients ending their own lives this way have increased exponentially wherever they have been introduced. The statistics gathered by the Oregon Health Authority show that the numbers of assisted suicides rose from 16 in 1998, to 367 in 2023. The same reality has been seen in other jurisdictions, including those which have followed the Oregon system, or which have adopted euthanasia as well[111]:





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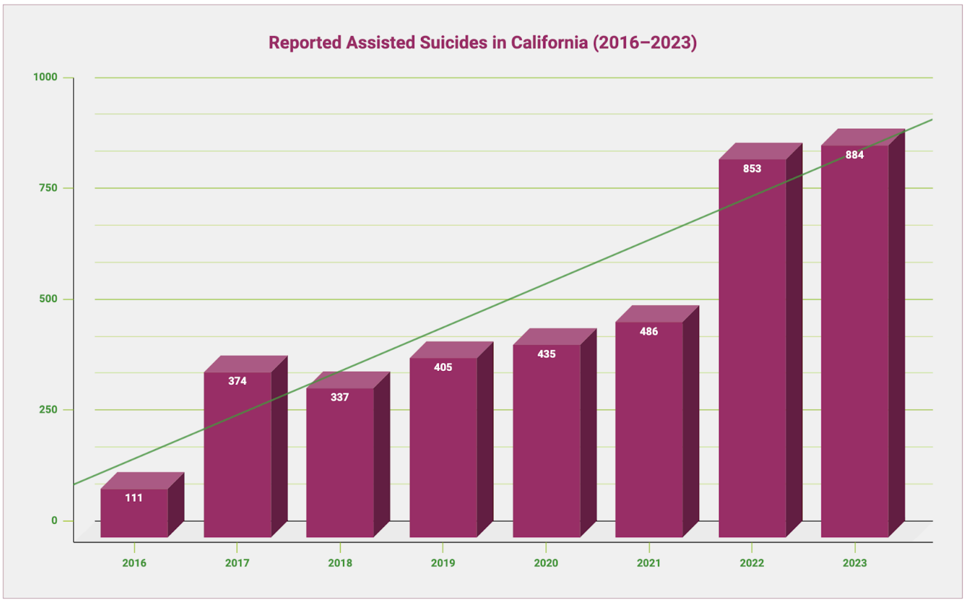
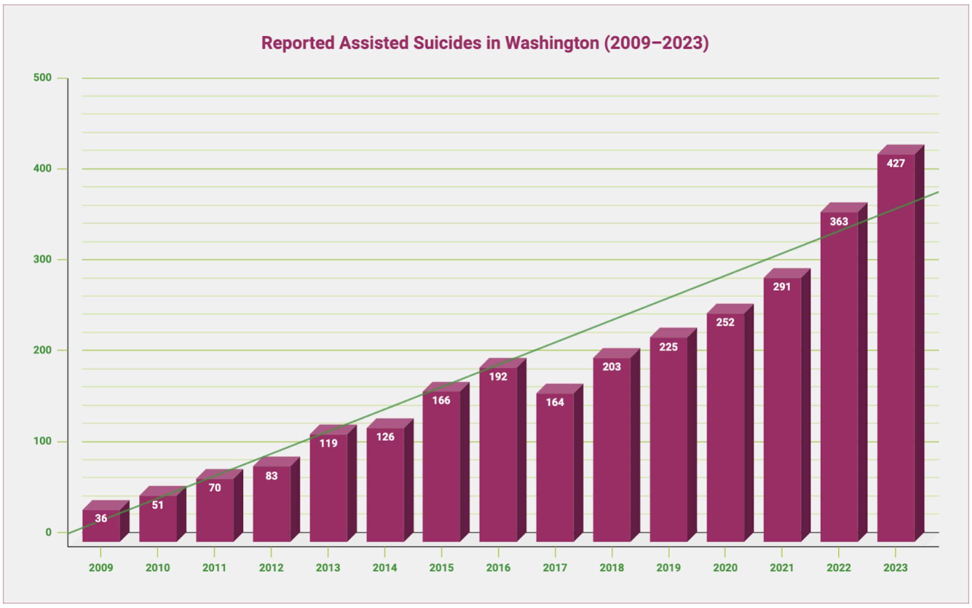
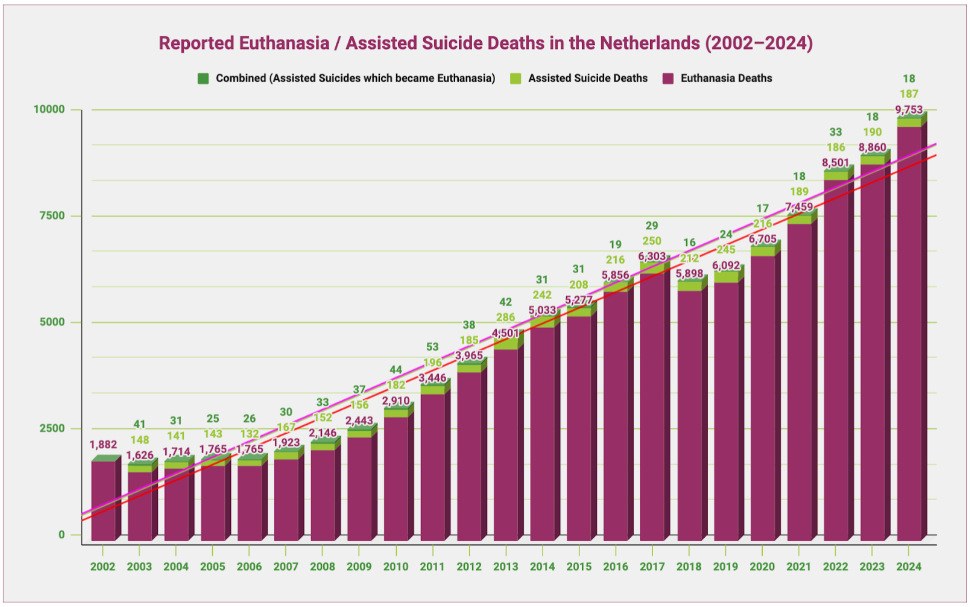
[111] Data derived from *op. cit*. Oregon and Washington State Annual Reports, and the annual reports of Belgium, California, Canada, the Netherlands, and Switzerland, these jurisdictions having both major populations and longitudinal (more than five years of) experience of euthanasia and / or assisted suicide. I have also added (notwithstanding its short term operation) data from the annual reports of the Voluntary Assisted Dying Review Board in the Australian State of Victoria, as this system has also been of interest to UK Parliamentarians. These graphs are listed from shortest (Victoria) to longest (Oregon / Switzerland) records.



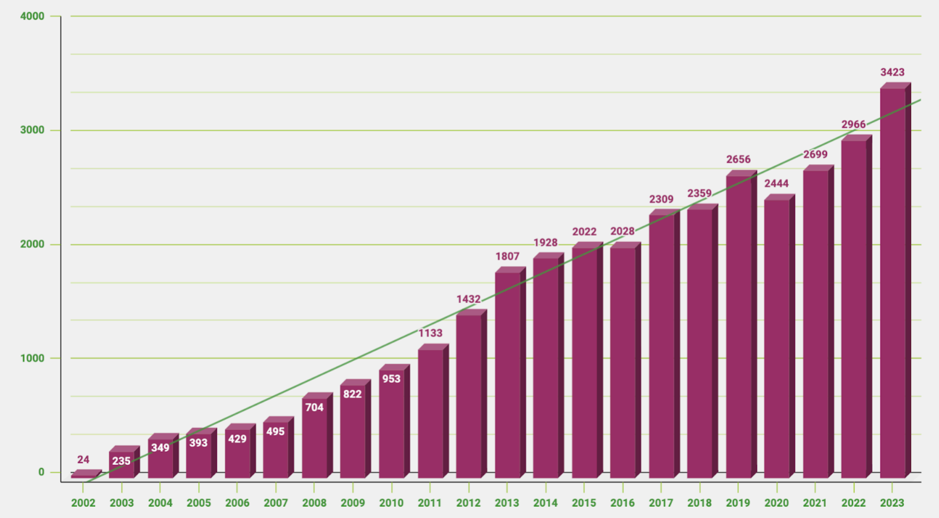
Reported Assisted Suicides in California (2016–2023)



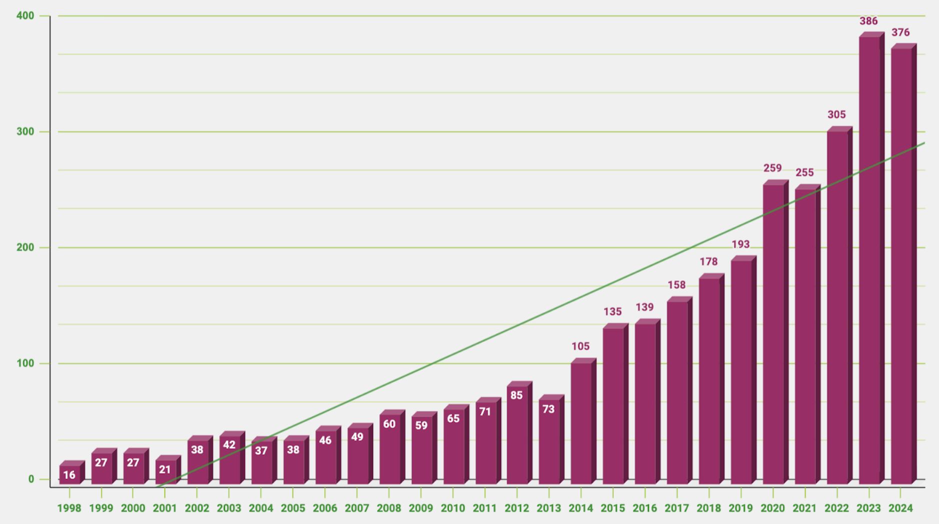
Reported Assisted Suicides in Washington (2009–2023)



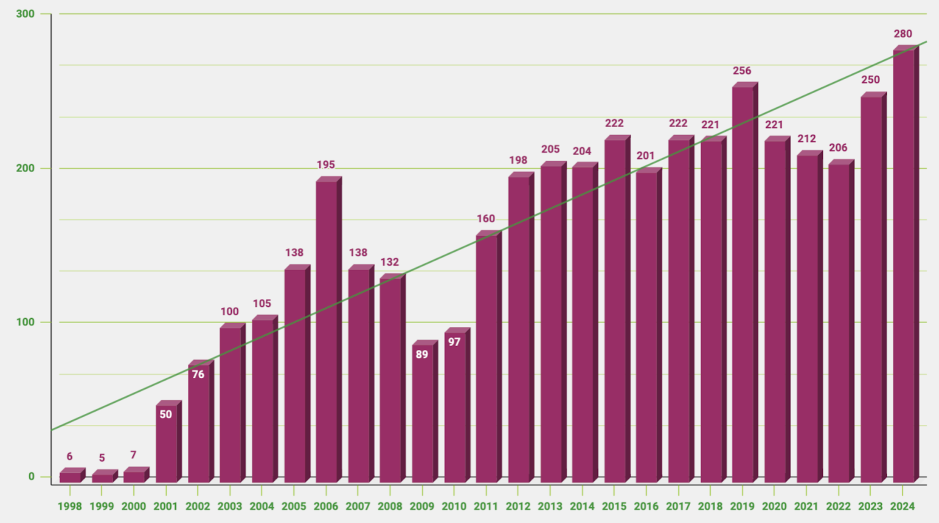
Reported Euthanasia / Assisted Suicide Deaths in the Netherlands (2002–2024)



Reported Euthanasia / Assisted Suicide Deaths in Belgium (2002–2023)



Reported Assisted Suicides in Oregon (1998–2024)



Reported Assisted Suicides in Switzerland (1998–2024)

Not only is assisted suicide a direct threat to suicide prevention, it is also demonstrably antagonistic to an important area of medicine that obviates suicidal ideation in those who who are terminally ill: palliative care. In a response to the House of Commons Health and Social Care Committee 2024 Report on Assisted Dying / Assisted Suicide that they '*did not see any indications of palliative and end-of-life care deteriorating in quality or provision following the introduction of AD / AS; indeed the introduction of AD / AS has been linked with an improvement in palliative care in several jurisdictions*', Professor David Albert Jones showed the data on which they were basing this conclusion was variously irrelevant, outdated and speculative. By contrast, he showed that better and more recent evidence clearly indicated that in several jurisdictions palliative and end-of-life care deteriorated in quality and provision following the introduction of assisted suicide or euthanasia, and was not improving as quickly in jurisdictions which had introduced those practices as it is in those which had not[112].

Whilst the palliative care system in England and Wales (and the UK more generally) consistently tops world league tables such as the Economist Intelligence Unit's *Quality of Death Index*, it is still a post-code lottery as to the quality and provision of access to palliative care. The Equality and Human Rights Commission notes that[113]:

> '*Marie Curie's 2024* Better End of Life report *found 'patchy and inconsistent provision of care'. This regional variability could put some people in a position where they consider assisted dying where they may not otherwise have done so if there was a viable alternative to alleviate suffering and end their life in dignity. As such, to ensure that assisted dying is compatible with Article 2 and Article 3 rights (as stated in paragraphs 3 and 4), high-quality palliative care should be available to all who need it. Patients must also be informed about its availability. We note that clause 35 of this bill recommends after five years 'an assessment of the availability, quality and distribution of appropriate health services to persons with palliative care needs'. However, the bill currently recommends no such assessment before bringing this legislation into force.*'

It is for this reason that the aforementioned Dr Ilora Finlay, one of the UK leading palliative care specialists and former President of the BMA, in her capacity as Lady Finlay of Llandaff, has introduced her Access to Palliative Care and Treatment of Children Bill in the House of Lords in recent years, the prescriptions in which illustrate where many of the current deficits in the UK system lie[114]. The evidence suggests that rather than addressing these deficits, legalising assisted suicide would seriously contribute to a decline in the quality of UK palliative care, as has happened in those jurisdictions which have introduced assisted suicide or euthanasia. Such findings clearly vindicate the concerns that have

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[112] Professor David Albert Jones, Evidence of Harm: Assessing the Impact of Assisted Dying / Assisted Suicide on Palliative Care, Anscombe Bioethics Centre (November 2024).

[113] Parliamentary Briefing: Terminally Ill Adults (End of Life) Bill: House of Commons Second Reading, Equality and Human Rights Commission (21 November 2024).

[114] Access to Palliative Care and Treatment of Children Bill (2019–2021).

reportedly been raised by the Health Secretary Wes Streeting as to the effect on vulnerable patients who upon finding a lack of access to palliative care might choose to end their lives prematurely[115].

A contributing element to these problem is the effect that assisted suicide has on thinking around medical resource distribution, especially in the context of contemporary rationing. In 2020, a paper was published in the journal *Clinical Ethics*[116] which argued that granting terminally-ill patients help to die would both save money and potentially release organs for transplant. One of the authors, the ethicist David Shaw, described the potential savings of allowing assisted suicide as '*the elephant in the room*', and the paper went on to assess the extent to which licensing euthanasia could help patients using the same formula which bodies such as NICE deploy to weigh up the expense and benefits of new drugs.

Research has suggested that such attitudes are not merely hypothetical, but already part of clinical practice. One study showed that organ donors in Belgium (including 23.5% of all lung donors) had been euthanised, raising concerns that patients may be given an emotional inducement to be killed, believing that they can be better use being euthanised and harvested[117]. This prospect of voluntary euthanasia as a source of organ donation, despite the instrumentalisation and exploitation of patients this may often involve, has prompted concerns from north American doctors[118], as the possibility opens up in Canada (the Canadian Medical Association Journal having released guidance on the issue[119] just as others have anticipated this new source[120]).

Similarly, in October 2020, the Canadian Parliamentary Budget Officer (PBO) released a Cost Estimate Report[121] for Bill C-7, which expanded euthanasia and assisted suicide in Canada beyond the terminally-ill (see previous section). This looked at projected 'Medical Assistance in Dying' (MAiD) deaths in 2021, as well as likely costs and savings due to them, estimating that under the law as it stood, 6,465 people would die by MAiD in 2021 – 2.2% of all deaths – with net healthcare savings of $86.9 million, and that expanding the law would add 1,164 deaths in the first year alone, leading to increased healthcare savings in 2021 of $149 million (an extra saving of almost £87 million).

$149 million is almost exactly ten times the annual value of the official funding which was withdrawn from the Delta Hospice Society in British Columbia, after it refused to offer euthanasia and

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[115] Denis Campbell, 'Legalisation of assisted dying may force NHS cuts, Wes Streeting warns', *Guardian* (13 November 2024).

[116] Shaw and Morton, 'Counting the cost of denying assisted dying', *Clinical Ethics*, Vol 15, Issue 2, 2020: https://doi.org/10.1177/1477750920907996

[117] Van Raemdonck *et al*, 'Initial experience with transplantation of lungs recovered from donors after euthanasia', *Applied Cardiopulmonary Pathophysiology* 15:38-48 (2011).

[118] See for example, Ely, E.W. 'Death by organ donation: euthanizing patients for their organs gains frightening traction'. *Intensive Care Med* 45, 1309–1311 (2019). https://doi.org/10.1007/s00134-019-05702-1

[119] Downar *et al*, 'Deceased organ and tissue donation after medical assistance in dying and other conscious and competent donors: guidance for policy', *CMAJ* 2019 June 3;191:E604-13. doi: 10.1503/cmaj.181648

[120] Ball *et al*, 'Voluntary Euthanasia — Implications for Organ Donation', *N Engl J Med* 2018; 379:909-911 DOI: 10.1056/NEJMp1804276

[121] Cost Estimate For Bill C-7 "Medical Assistance In Dying", Officer of the Parliamentary Budget Officer (20th October 2020).

assisted suicide. The funding met 94% '*of the society's costs to operate 10 beds at the Irene Thomas Hospice*'[122]. This illustrated the corruption of the medical system in Canada, in which economic efficiency and institutional discrimination against those with conscientious objection to euthanasia combined to undermine genuine patient choice and palliative care.

The PBO went on to acknowledge that:

> '*Our estimates have only taken into consideration the health care costs from the perspective of provincial governments. Therefore, out-of-pocket costs paid by patients or their relatives have not been considered. For example, palliative care is usually free of charge when provided in a hospital or a government funded hospice, but there could be costs billed to patients in nursing homes or wanting to receive palliative care at home*'.

Not only in academic theory, but in public policy practice, assisted suicide and euthanasia risks dehumanising patients by treating the ending of their lives as an economic and medical benefit, and the implications for a stretched National Health Service are clear, especially when it comes to supporting a palliative care sector which is often funded charitably rather than from Government.

The Logical Cliff: Euthanasia

We have hitherto largely considered the details of the Oregon system, but the implications of other jurisdictions which have introduced euthanasia are worthy of consideration. This is because one extra problem with the limited eligibility criteria within the Leadbeater Bill is that it carries within itself the seeds of its own incremental extension. We have seen that the Oregonian system has been extended in law and practice, and this is because the logic of the idea of 'assisted dying' ineluctably leads to a more 'inclusive' practice.

After all, if we have a 'right to die' as is typically claimed by supporters of assisted suicide, how could it make sense to limit it to any one cohort of suffering people? Why should the terminally ill have such a right, but not the chronically ill? The case of Tony Nicklinson and others who are paraplegic or tetraplegic are perhaps the hardest cases and the most obvious 'candidates' for physician-enabled death, and yet they would not be given access to it by the Leadbeater Bill: they are not terminally ill and they would require euthanasia (the doctor injecting them with lethal drugs) as they cannot move their limbs. The push for extension of assisted suicide to euthanasia and for access to it being given to the disabled, the elderly, and anyone suffering from mental trauma would be inevitable. If the key principles in considering assisted suicide are 'choice' and suffering, then the experiences of others beyond the terminally ill could not be ignored.

If you introduce a choice for some, you have to introduce it to everyone. Once we set the precedent of doctor-involvement in the death of patients therefore, there are no rational grounds to restrict it. If we opt to recognise the opportunity to choose the timing and manner of our deaths as a

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[122] 'Government ends Delta Hospice Society service agreement', *BC News* (25 February 2020).

'human right', then it must apply universally and without discrimination. The 'eligibility criteria' in the Leadbeater Bill (and indeed, any such limiting criteria) are discriminatory and invidious. Moreover, once physician involvement in a patient's death is introduced for only a few, there will be constant militating for expansion as demand in remaining unaccommodated 'hard cases' will still exist. Such a situation is not merely a 'slippery slope', but a *logical cliff*.

It should be said that the fall down this sheer precedential drop would likely be legislative, not judicial. Whilst the principle of Parliamentary Sovereignty holds as constitutional bedrock in the United Kingdom, judges could not force Parliament to change the law. Nonetheless, it is likely that Parliament would do so in any case: whilst the hardest of cases would not be catered for in the law were the Leadbeater Bill to be passed, and whilst Dignitas would offer access to those who wished to avail themselves of their services and who could not receive assisted suicide in the UK, the same arguments would apply *a fortiori* for an expansion of the law to wider cohorts of people and to euthanasia not just assisted suicide.

This can be confidently predicted as the attitudes and lobbying for such an expansion already exist. It has been reported that '*as many as 38 Labour politicians, including 13 who hold government roles, are understood to back proposals for the bill to go further and to apply not just to the terminally ill, but more broadly to those "incurably suffering". They are among a cross-party group of 54 MPs calling for the scope of the bill to be widened, according to Humanists UK, which has long called for a change in the law*.'[123] Meanwhile, in 2021, Professor A.C. Grayling, a Patron of Dignity in Dying (formerly the Voluntary Euthanasia Society, but which now campaigns only for assisted suicide for the terminally ill as in the Leadbeater Bill) and a member of Dignitas in Switzerland, stated he supported assisted suicide 'for any reason', arguing[124]:

> '*[T]here is no ground for restricting the kind of suffering that society is going to allow people to escape… If as an act of compassion you wanted to help somebody escape suffering, then why only in the last six months of a terminal illness? Why not for somebody who simply cannot come to terms with being wheelchair bound let us say? Or who is clinically depressed and is never going to be independent of medications for the rest of their lives?*'

We see the practical illustration of the inexorable logic of assisted suicide / euthanasia in the two jurisdictions which have practised euthanasia for the longest: Belgium and the Netherlands.

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[123] Camilla Turner, 'Extend assisted dying to those without terminal illness, say Labour MPs', *Telegraph* (05 October 2024).

[124] NSS Podcast Ep 56: The Assisted Dying Bill 2021, National Secular Society (07 September 2021). Grayling had been discussing the then Assisted Dying Bill in the House of Lords with the then-sponsor of the Bill, Baroness Meacher, who is Dignity in Dying's Honorary President, and who commented that High Court judicial approval of assisted suicides (as has also been included in the Leadbeater Bill) was '*[J]ust another safeguard. I'm not sure that we need it personally, and it would be a matter for Parliament whether they want to pull that out or keep it… There's so many safeguards…you can overdo it and make the thing pretty unusable*.' Given the North American experience of removing initial safeguards, this suggests that those proposing assisted suicide would be quite happy with removing this provision in the future.

Both countries licensed euthanasia and assisted suicide (EAS) together in the early 2000s, the Dutch[125] and Belgian[126] laws respectively requiring that a patient presenting for euthanasia be in a '*medically futile condition of constant and unbearable… mental suffering that cannot be alleviated*', or be experiencing suffering that is '*lasting and unbearable*'. This has led to a number of cases in the last few years in which people have in the Low Countries been euthanised, who in current UK practice would otherwise have been given the help they need to heal the mental health problems from which they suffer[127]:

	**Godelieva De Troyer (64)**, a healthy Belgian woman who was living with depression, was killed by lethal injection at her own request in a Brussels hospital in 2012, despite at least two of the experts who assessed not agreeing that she was beyond treatment. Her son was not contacted until after his mother had been euthanised, when a hospital rang asking him to retrieve her body from the morgue.
	**Marc and Eddy Verbessem (45)**, a pair of deaf twins, were euthanised in 2013 due to the fear that with the onset of blindness they would be unable to communicate with each other.

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[125] Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.

[126] Euthanasia Act 2002.

[127] Bruno Waterfield, 'Son challenges Belgian law after mother's 'mercy killing'', *Telegraph* (02 February 2015). Cf. Rachel Aviv, 'The Death Treatment', *The New Yorker* (22 June 2015).
Eline Gordts, 'Marc And Eddy Verbessem, Deaf Belgian Twins, Euthanized After Starting To Turn Blind', *Huffington Post* (14 January 2013).
Steve Doughty, 'Sex abuse victim in her 20s allowed to choose euthanasia in Holland after doctors decided her post-traumatic stress and other conditions were incurable', *Daily Mail* (10 April 2016).
Eline Gordst, 'Nathan Verhelst Chooses Euthanasia After Failed Gender Reassignment Surgeries', *Huffington Post* (10 May 2013).
Steve Doughty, 'Dutch euthanasia law is used to kill alcoholic, 41, who decided death was the only way to escape his problems', *Daily Mail* (29 November 2016).
Andy Furniere, 'Controversial case re-opens euthanasia debate', *Flanders Today* (04 February 2016).
Matt Payton, 'Sex abuse victim in her 20s allowed by doctors to choose euthanasia due to 'incurable' PTSD', *Independent* (11 May 2016).
Amanda Cassidy, 'Noa Pothoven: The complicated death of a little girl who didn't want to grow up', *Image* (20 December 2019).
Linda Pressly, 'The troubled 29-year-old helped to die by Dutch doctors', *BBC News* (08 August 2018).

	**Ann G (44)**, a Dutch woman who asked for euthanasia for psychological pain in 2016 after being sexually exploited by her psychiatrist who was treating her for anorexia.
	**Nathan Verhelst (44)**, born Nancy, was euthanised in 2013, after a series of failed gender reassignment surgeries.
	**Mark Langedijk (41)**, a Dutch alcoholic, ended his life in 2016 by fatal injection as a means of escaping his condition.

	**Tine Nys (38)**, who had experienced the break-up of a relationship, was euthanised in 2009 on the basis that she had autism. Her family have recently complained about the 'nonchalant' way she was treated.
	**An unnamed Dutch woman in her 20s**, who had suffered sexual abuse from the age of five to 15 and suffered from post-traumatic-stress disorder (PTSD) and chronic depression amongst other mental health problems, was euthanised in 2016. Doctors judged her to be "totally competent" and that there was "no major depression or other mood disorder which affected her thinking".

Noa Pothoven (17), who suffered from PTSD after being raped, and consequent depression and anorexia, was allowed to starve herself to death in the Netherlands in 2019. As such, hers was not a case of active euthanasia, but one of her complaints before she died was that the Netherlands does not have specialised institutions or clinics where teenagers can go for psychological aid. Here then, is where a medical and general culture allows a young person to experience a failure in care, but allows her to take her own life in a context of normalised suicide.

Aurelia Brouwers (29), committed assisted suicide in the Netherlands due to psychiatric suffering. She said, "When I was 12, I suffered from depression. And when I was first diagnosed, they told me I had Borderline Personality Disorder... Other diagnoses followed – attachment disorder, chronic depression, I'm chronically suicidal, I have anxiety, psychoses, and I hear voices". The BBC report on her case (see footnote) mentioned another woman, Monique Arend, who suffered from serious mental health issues after sexual abuse, but avoided committing assisted suicide, having found a therapist specialising in trauma.

More such cases exist, and include people who have been given permission to be euthanised for borderline personality disorder, and chronic-fatigue syndrome[128]. Others have publicly called for or almost had access to euthanasia:

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[128] *Op. cit.*, 'The Death Treatment', by Rachel Aviv. An excellent account, further information, and cases discussed therein.

- A then 52-year old Belgian serial rapist and murderer **Frank Van Den Bleeken** was meant to be euthanised in prison in 2015[129]. Van Den Bleeken claimed that was experiencing "unbearable psychological suffering" in prison, where he had already spent 30 years. His wish was initially granted, but the decision was reversed[130].
- A 39-year old gay man in Belgium pseudonymously called **'Sébastien'**, tried to end his life in 2016 because he could not accept his sexuality[131]. He had said of euthanasia, "For me, it's just a kind of anaesthesia".
- **Emily**[132] (who went under the pseudonym 'Laura' when her story was being reported) was approved for lethal injection in 2015[133], even though she was physically healthy and only 24-years-old. She said, "*Leven, dat is niets voor mij*" ("Life, that's not for me"). Ultimately, she changed her mind.

Such is the situation in the Netherlands that, whilst voluntary euthanasia is defined as ending life *on request*, euthanasia has been extended to occurring without request to newborn infants with disabilities[134]. Cases where children have been euthanised have also occurred in Belgium[135], a development which has caused international concern[136].

A similar situation has developed in Canada, which introduced 'assisted dying' (euthanasia as well as assisted suicide) for the terminally ill in 2016. In 2021, the Canadian Parliament passed Bill C-7[137], which extended the law beyond those whose death is "reasonably foreseeable" (the terminally ill, to whom the original limitation of the Canadian legislation was limited) to those whose death is not foreseeable, opening up euthanasia to patients who are chronically ill, or who have disabilities. This act has been described as a 'stunning reversal of the central role of the medical and legal concept of the standard of care'[138]. The sunset clause contained in Bill C-7 which prevents MAiD from being available to those with

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[129] Roisin O'Connor, 'Belgian rapist Frank Van Den Bleeken 'to be euthanised' in prison this week', *Independent* (05 January 2015).

[130] Bruno Waterfield and Andrew Marszal, 'Belgian serial rapist will not be euthanised', *Telegraph* (06 January 2015).

[131] Jonathan Blake, 'Man seeks euthanasia to end his sexuality struggle', *BBC News* (09 June 2016). An interview with 'Sébastien' can be found here on *The Victoria Derbyshire Show* (09 June 2016).

[132] '24 and Ready to Die', *The Economist* (10 November 2015).

[133] Rose Troup Buchanan, 'Right to die: Belgian doctors rule depressed 24-year-old woman has right to end her life', *Independent* (03 July 2015).

[134] A description of the 'Groningen Protocol', through which this extension took place, is given by two authors who helped develop this practice in A. A. E. Verhagen and P. J. J. Sauer, 'End-of-Life Decisions in Newborns: An Approach From the Netherlands', *Pediatrics* (September 2005), 116(3):736-739.

[135] Arya Hodjat, 'Belgium Approved Euthanasia of 3 Minors, Report Finds', *VOA News* (25 July 2018).

[136] Siegel AM, Sisti DA, Caplan AL. 'Pediatric Euthanasia in Belgium: Disturbing Developments'. *JAMA*. 2014;311(19):1963–1964. doi:10.1001/jama.2014.4257; Brian S. Carter, 'Why Palliative Care for Children is Preferable to Euthanasia', *The American Journal of Hospice & Palliative Care* 33(1), July 2014. DOI: 10.1177/1049909114542648

[137] Bill C-7 (March 2021).

[138] 'How Bill C-7 will sacrifice the medical profession's Standard of Care', *Policy Options*, IRPP (11 February 2021).

psychiatric conditions will expire in 2023. Unless the clause is extended, those suffering with such conditions will then be able to access euthanasia and assisted suicide.

In just five years in Canada, the original limitation of the law there to those with conditions which are incurable, irreversible, causing them grievous suffering, and where death is 'reasonably foreseeable', was already being objected to, with efforts to expand it to those not at the end of life[139], who cannot[140] or are too young to consent[141], or who suffer from psychiatric disorders[142] such as Alzheimer's[143]. Even outside the strict construction of the law, Canada has seen euthanasia approved for a 77-year-old woman with osteoarthritis[144], a man with Motor Neurone Disease who ended his life due to the poor hospital care he was receiving[145], and a 90-year-old woman who could not accept the prospect of another COVID-related lockdown in her retirement home[146].

Another progress down the 'logical cliff' is the spectre of *involuntary* euthanasia. A study in 2013 that looked at opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands found an increase in support for euthanasia or assisted suicide for non-terminal conditions. Among professionals, a significant minority (24%-39%) were found to be in favour of ending the lives of individuals who experience mental suffering due to loss of control, chronic depression or early dementia. Further, a third of doctors and 58% of nurses were in favour of euthanasia in the case of severe dementia, given the presence of an advance directive[147].

In March 2012, the Dutch introduced mobile units to deal with what they call the 80% of people with dementia or mental illness currently being 'missed' – their words – by the country's euthanasia laws[148]. Similarly, the 2011 annual report of the five Dutch Regional Euthanasia Review Committees[149] found that 13 psychiatric patients were killed by euthanasia in 2011, up from 2 in 2010. This again, despite

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[139] 'Montrealers file legal action contesting restrictions on medical aid in dying', *Global News* (14 June 2017).

[140] Raquel Fletcher, 'Quebec appoints experts to weigh in on expanding assisted-dying law', *Global News* (24 March 2017).

[141] Keith Gerein, 'Young patients, their parents now asking for medical aid in dying: pediatricians' group', *Edmonton Journal* (26 October 2017).

[142] Catrina Franzoi, 'Adam Maier-Clayton's death renews debate on assisted-dying access for those with mental illness', *Globe and Mail* (16 April 2017).

[143] Aaron Derfel, 'Most caregivers favour assisted dying for Alzheimer's patients: survey', *Montreal Gazette* (22 September 2017).

[144] Mia De Graaf, 'Woman, 77, with osteoarthritis approved for euthanasia in Canada after confusion over wording of assisted dying law', *Daily Mail* (27 June 2017).

[145] 'One man committed suicide to not go back: Doctors quit Montreal hospital after allegations of shoddy care', *Vancouver Sun* (08 October 2016).

[146] Avis Favaro, 'Facing another retirement home lockdown, 90-year-old chooses medically assisted death', *CTV News* (19 November 2020).

[147] Kouwenhoven *et al*, 'Opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands: A mixed methods approach', *Palliative Medicine* (March 2013), 27:3:273-280.

[148] Simon Caldwell, 'Go-ahead for world's first mobile euthanasia unit that will allow patients to die at home', *Daily Mail* (10 February 2012).

[149] Regional Euthanasia Review Committees Report (2011).

a notional legal requirement that the patient should be mentally competent. In 2017, the number of such deaths had risen to 83 which represents a 500% increase in just five years.

In 2013, more than 1 in 60 deaths in the Flanders region of Belgium occurred *with no consent* from the patient – those who are in comas, confused, or the elderly whose deaths were facilitated because their lives are considered not 'worth living'[150]. In 2013, 6.3% of total annual deaths in Flanders were a result of 'physician assisted-dying', of which 25% constituted 'hastening of death without explicit request from patient'[151]. The cruel irony of this path is that legislation introduced with the good intention of enhancing patient choice actually diminishes or disregards choice for the most vulnerable.

Conclusion

The analysis made in this paper of the Leadbeater and McArthur Bills and the Oregon model on which they are based shows the profound dangers inherent in even the most minimal system of medicalised suicide, the gross insufficiency of 'safeguards' to obviate abuse, and the inevitable even if incremental extension of assisted suicide to wider cohorts of people than first envisaged. It has also surveyed where this leads to in the darker situations of Belgian, Canadian and Dutch euthanasia. Whilst the principle of receiving or preventing suffering is laudable, the consistent evidence shows the tragic reality of the Law of Unintended Consequences.

This corruption of culture engendered by assisted suicide and euthanasia necessarily includes the relationships that family members have towards their elderly, sick and weaker relatives. When medicine encourages and further enables vulnerable people who are at their lowest ebb of personal strength and autonomy to feel a 'burden' on others, and perhaps denies them the analgesic access and holistic palliative care that they need, such an option is not a real choice but a 'Hobson's Choice' – an apparent set of options where only one is truly palatable or presented. The dark incentives to chivvy an older and / or sicker family member to assisted suicide due to considerations of resources – whether money, capital, or even just personal time and emotional energy – have been noted.

If euthanasia and / or assisted suicide compromises family solidarity by introducing the possibility and temptation of further elder abuse, it also violates the integrity and solidarity of the family by preventing the opposite: the support and the preventative dissuasion that family involvement might engender. Nothing in the Bill mandates that the family of a person who wishes to procure assisted suicide be told of their family member's intentions. Worse, such a deficit risks repeating the heartbreak such as that experienced by Godelieva de Troyer's son, Tom Mortier, after his mother had been euthanised for depression, he only being told so that he could retrieve her body from the morgue. By reducing a patient to an individual isolated from his or her closest relations, it is not only him or her who is hurt, but his or her family also.

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[150] Cohen-Almagor R. 'First do no harm: intentionally shortening lives of patients without their explicit request in Belgium', *J Med Ethics* 2015;41:625– 629. DOI: 10.1136/medethics-2014-102387

[151] *Ibid*., cf. Chambaere *et al*, 'Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium', *N Eng J Med* 2015; 372:1179-1181: DOI: 10.1056/NEJMc1414527.

Added to this is the dire effect on vulnerable individuals when physician-enabled suicide meets attitudes towards the dying caused by callous economic calculations or ableism. The Equality and Human Rights Commission have argued that[152]:

> '*Parliament should also appreciate that coercion or pressure is not necessarily only something which is applied directly by other individuals. In a UN report about assisted dying and disability, UN experts highlighted that 'people with disabilities, older persons, and especially older persons with disabilities, may feel subtly pressured to end their lives prematurely due to attitudinal barriers as well as the lack of appropriate services and support'. It is important that all practicable social conditions, support, care and services are in place so that people with serious or terminal illnesses can decide how and when to end their life freely and without feeling coerced, and therefore in a way which is compatible with Article 2 rights.*'

Given the evidenced erosion of suicide prevention and palliative care by assisted suicide and euthanasia, it is clear that no legal safeguards can protect from pressure being put on patients if not directly from relatives then from a system that fails to adequately care for them. As Akiko Hart, the Director of Liberty (a centre-left human rights group that supports legalisation of assisted suicide in principle) has noted[153]:

> '*What's really important is to look not just at who might benefit from assisted dying, but at who this Bill might harm… Ultimately, the safeguards in this Bill are just not robust enough, and leave too many details to be decided later, particularly at a time when there is already great inequality in our healthcare system. We know that the impact of these decisions often falls sharpest on disabled people and communities of colour, who are already less likely to receive good quality of care… some people in marginalised communities could feel pressured into an assisted death.*'

These realities expose the shallowness of the narrative of 'choice', 'option' and 'autonomy'. We are not atomised individuals separate from our family and the society around us. When some people procure assisted suicides, these are not merely 'personal choices' bur rather are social practices, which when embedded in society and healthcare change culture – medical and societal – for everyone. This affects a fundamental change in social attitudes, not only towards suicide but towards those who, being vulnerable, may take up resources due to the care necessary for them. In the words of Lord Williams of Oystermouth[154]:

> '*The freedom of one person to utilise in full consciousness a legal provision for assisted suicide brings with it a risk to the freedom of others not to be manipulated or harassed or simply demoralised when in a weakened condition.*

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[152] *Op. cit.*, EHRC Parliamentary Briefing (21 November 2024).

[153] Cited in Alex RK, 'Assisted dying – a tale of three Bills', *Mental Capacity Law and Policy* (22 November 2024).

[154] 'Full text: Archbishop of Canterbury's presidential speech', *Guardian* (9 February 2010).

> *Once the possibility is there, it will not only be utilised by the smallish number of high-profile hard cases but will also create an ethical framework in which the worthwhileness of some lives is undermined by the legal expression of what feels like public impatience with protracted dying and 'unproductive' lives*'.

The idea that the only thing that matters in the debate over assisted suicide is the abstract principle of liberty, irrespective of the effect providing this 'choice' has on others, is simply implausible. We limit personal freedom and choice frequently when doing so is necessary for the common good and particularly the welfare of the vulnerable. On an ordinary level, we put limits on medical autonomy when it comes to accessing antibiotics, because overuse of those drugs would make them less effective, and most seriously affect the most vulnerable patients. More extraordinarily, we accept the necessity of public health restrictions in cases where there has been a severe outbreak of disease. The UK Government amongst others imposed lockdowns in the wake of the COVID-19 pandemic to protect the health system from being overwhelmed and to prevent high 'excess death' rates of those most susceptible to serious illness due to the virus. Even those who faulted these strategies given their claimed inefficacy, or the social and economic side effects they engendered, would have to admit that other more virulent outbreaks more like the Black Death would surely make similar actions proportionate.

We therefore can, do, and should subordinate the desire of a few for an entitlement – being assisted to end their own lives due largely to the existential suffering they experience – to the duty we have to many more vulnerable people to protect them from suicidal ideation and anything that might enable it. To deny this is to adopt an extreme and myopic conception of the relative importance of individual choice and personal autonomy.

As Baroness Butler-Schloss, the former President of the High Court Family Division, once wrote on the issue of assisted suicide[155]:

> '*Laws, like nation states, are more secure when their boundaries rest on natural frontiers. The law that we have rests on just such a frontier. It rests on the principle that we do not involve ourselves in deliberately bringing about the deaths of others. Once we start making exceptions based on arbitrary criteria such as terminal illness, the frontier becomes just a line in the sand, easily crossed and hard to defend. We tinker with the law at our peril*'.

The natural frontier of the law when it comes to life and death is that which currently exists: no-one should involve themselves in the death of another, either by assisting their suicide or by ending their life through euthanasia. Only this integral principle serves to protect vulnerable people from lethal coercion; the deficits in the Leadbeater Bill and the appalling consequences of overseas experiments with 'assisted dying' illustrate that the introduction of assisted suicide cannot be anything other than a failure of safeguarding.

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[155] Baroness Butler-Schloss, 'Should we change the law for the terminally ill?, *The Times* (05 January 2012).

The meaningful choice we must consider is a social and political one and it is one that can only be between imperfect worlds, for perfection is a chimera. On the one hand, we have a world in which some very self-confident people, such as Dame Esther Rantzen or the late Sir Terry Pratchett, suffer because they are frustrated by their inability to be given lethal drugs by their doctor and die in this country at a time of their own choosing, but which nevertheless provides protection for those whose mental and physical condition, or even natural timidity, make them most vulnerable to coercion and abuse, or even just societal pressure where healthcare and social care systems are severely strained: the elderly, the chronically and terminally ill, the disabled, and others. On the other, we have a world in which those self-confident people are given what they want, but protections for those same vulnerable groups are removed, with all the consequences we have evidenced.

We should of course sympathise with the suffering of those who wish to access assisted suicide, and provide every form of pain relief as well as pastoral and palliative care that we can, but we should never countenance the legalisation of assisted suicide and euthanasia. The current law and medical system may not be perfect, but it can be greatly improved by the amplification of access to analgesic medicine and hospice provision, and creates a far better social situation than one in which so many may be put at profound risk. If we are serious about creating a society in which all may flourish and be protected, then this must be one that rejects doctor involvement in enabling or causing the death of their patients, and embraces not only a comprehensive extension and greater enhancement of compassionate treatment for those in pain or distress, but a culture in which everyone is made to feel valued and loved up until their dying breath.

Getting Help

If the issues discussed here affect you or someone close to you, you can call Samaritans on 116 123 (UK and ROI), visit their website or contact them on jo@samaritans.org.

If you are reporting or writing about a case of death by suicide, whether assisted or non-assisted, please consult media guidelines on how to do so responsibly.

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