



# Assisted Dying Bill [HL]: ignorance within the House?

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## ABSTRACT

Another assisted dying Bill has come and gone in the Parliament of England & Wales. The Assisted Dying Bill [HL] 2021–2022 was debated in the second reading of the House of Lords and amendments were being considered in the Committee Stage before the Bill ran out of time in the parliamentary session. Identical to previous attempts to permit assisted dying, it would have allowed patients to receive assistance to end their own life if they have a terminal illness, are expected to die naturally within six months and (among other criteria) are experiencing unbearable suffering. In light of developments within other foreign jurisdictions, the similarities and, perhaps more significantly, differences between legislative measures provide an interesting comparative discussion. The Canadian Medical Assistance in Dying legislation has been in force since 2016 and has experienced several amendments. As Canada is somewhat further down the ‘legal road’ in regulating assisted dying, it may prove a fruitful endeavour to use the Canadian developments to evaluate attempts to change the law in England & Wales. Features of the Bill reflected similar provisions that have been adjusted or removed in the Canadian legislation, features that are of significant importance and solemnity in the context of those wishing to access assistance in dying. Evaluating the approach taken in England & Wales using the precautionary principle can demonstrate where the road to implementing an effective assisted dying framework can be made less arduous, particularly with help from international comparisons.

**Keywords:** assisted dying; assisted suicide; euthanasia; health; healthcare law; law reform; Canada; comparative law; precautionary principle.

## INTRODUCTION

This commentary argues that a poor understanding of assisted dying in England & Wales is producing legislative Bills which would create an ineffective permissive framework. The latest legislative attempt to permit assisted dying, the Assisted Dying Bill [HL] 2021–2022 (henceforth referred to as the ADB) had the same route of failure of previous Bills in England & Wales. There are significant differences between the ADB and Canada’s medical assistance in dying (MAiD)

legislation, initially passed in 2016 and which has been amended since. The amendments to the original Canadian legislation demonstrate how the practical realities of providing assistance in death have been confronted: such as the removal of waiting periods, the inclusion of those whose death is not reasonably foreseeable, and amended safeguards. An analysis of these differences shows that England & Wales would benefit from paying more attention to global developments in assisted dying regulation, if creating a permissive framework is a serious objective. Furthermore, the precautionary principle will be employed to show that, although there are justified concerns of potential harms, the absolute prohibition of assisted dying is ineffective, inconsistent and disproportionate.

## COMMONWEALTH COMPARATORS

The intersection between healthcare law and comparative law continues to be very prominent within academic research. Due to the nature of healthcare law research, it is a natural companion to comparative considerations and the assessment of similarities and differences of other legal systems. Although contextual factors cannot, and should not, be discounted, the issues within healthcare law can be found to be common across seemingly similar and strikingly different societies and communities. Meaning that a comparative analysis of issues such as assisted dying can provide effective insight. For example, individuals will always be engaged in a discourse regarding bodily and personal (in its more abstract meaning) autonomy,<sup>1</sup> and this is where the contextual influences can be accounted for. Comparisons of different approaches to healthcare regulation can be found very easily amongst the literature.<sup>2</sup> Therefore, it is perhaps time to give appropriate consideration to the comparative methodology that healthcare law research might employ. Being mindful of the issues comparatists are attempting to reconcile could prove beneficial in providing effective and meaningful comparative healthcare research.

It is prudent to identify the essential elements of this comparative objective. A functionalist approach to evaluating the recent ADB<sup>3</sup>

1 Peter De Cruz, *Comparative Healthcare Law* (Taylor & Francis 2001) xxviii.

2 Maurice Adams and Herman Nys, 'Comparative reflections on the Belgian Euthanasia Act 2002' (2003) 11(3) *Medical Law Review* 353; Ruth Stirton, 'The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: a litany of fundamental flaws?' (2017) 80(2) *Modern Law Review* 299; Margaret Brazier and Jonathan Montgomery, 'Whence and whither "modern medical law"?' (2019) 70(1) *Northern Ireland Legal Quarterly* 5; Cressida Auckland and Imogen Gool, 'Resolving disagreement: a multi-jurisdictional comparative analysis of disputes about children's medical care' (2020) 28(4) *Medical Law Review* 643.

3 ADB 13.

can provide a good framework to evaluate Parliament's attempt to regulate assisted dying. The functionalist approach is recognised as the first comparative method, put forward by Zweigert and Kötz in their seminal piece, *An Introduction to Comparative Law*.<sup>4</sup> As the first, somewhat, comprehensive method for conducting comparative legal research, it is of no surprise that the scope of its focus is narrow. The objective, using this approach, will be to assess the effectiveness of legal rules and/or institutions. This tends to be to the exclusion of societal, political, economic, constitutional and other contextual factors that may influence the operation of a legal rule. The isolation of the ADB and the Canadian MAiD federal legislation from the contextual factors is necessary for the focus of this commentary. Although these factors are extremely significant for successful regulation of an issue such as assisted dying, when evaluating specific pieces of legislation or parliamentary Bills we can engage in a fruitful investigation of the specifics of regulation, and this is the intention of the comparative enquiry of this discussion as a pragmatic approach.

The starting point is establishing a '*praesumptio similitudinis*'<sup>5</sup> – a presumption of similarities. This presumption underpins the approach to argue that 'the only things which are comparable are those which fulfil the same function'.<sup>6</sup> England & Wales and Canada have produced measures which intend to permit and regulate forms of assisted dying, with different degrees of success between the jurisdictions. The pivotal elements of the debate on assisted dying regulation will be a consideration of a patient's right to make choices about their life (including their death, if that right exists) and the protection of those that may be vulnerable to a permissive regime of assisted dying.<sup>7</sup> The extent in which Canada has achieved this balancing exercise can be assessed through the legislative measures that have been produced. Although the substance has already been said to be different between

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4 Konrad Zweigert and Hein Kötz, *An Introduction to Comparative Law*, Tony Weir (tr), 3rd edn (Oxford University Press 1998).

5 Ibid 34.

6 Ibid.

7 Within the context of the Commonwealth, other jurisdictions have also recently experienced legal change in their stance on assisted dying. Namely, Australia and New Zealand have passed legislation permitting voluntary active euthanasia and assisted suicide in the last two years. While the comparative discussions made in this commentary could also be relevant for these jurisdictions, the focus remains on Canada due to the development of the assisted dying framework and amendments that have been made to the legislation. Canada, as a case study, provides a more substantial legal analysis and therefore a preferred comparative enquiry.

the two jurisdictions, the ‘basis of comparison’ can be established as similar.<sup>8</sup>

So, the final question to justify the comparative enquiry becomes: why compare England & Wales and Canada? Within healthcare law research legal systems are often compared regardless of whether they are similar or different; this is not an issue for comparative enquiries. However, the decision to choose similar or different legal systems will largely affect or depend on the objective of the comparative enquiry.<sup>9</sup> The differences between the MAiD legislation and the ADB elicit questions regarding the justification as the two legal systems are seemingly similar. Both are historical and prominent members of the Commonwealth of Nations (the Commonwealth), ensuring the advancement and development of human rights. They also belong to what is coined as a ‘legal family’.<sup>10</sup> Comparative literature shows that there is often a recognition of a family of English common law systems,<sup>11</sup> within which that of England & Wales is considered the parent legal system. The Canadian system was initially created from the English common law system and has shown very similar characteristics even in the modern era.<sup>12</sup>

The comparative stage is set. On a macro level England & Wales and Canada are sufficiently similar legal systems through their membership of the same ‘legal family’. The question then becomes, why have differences emerged through the respective legislative measures of the legal systems? If these intrinsically human issues are prevalent across all societies, why is Parliament not being prudent in taking valuable lessons from more experienced jurisdictions?

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8 In his description of the three stages of a comparative enquiry, Gerhard Danemann explains that identifying the ‘basis of comparison’ and the legal systems to be compared constitute the first stage: selection. See Gerhard Danemann, ‘Comparative law: study of similarities or differences?’ in Mathias Reimann and Reinhard Zimmermann (eds), *The Oxford Handbook of Comparative Law* 2nd edn (Oxford University Press 2019) 411–415. There is strong agreement amongst comparatists that at this stage (selection) of the comparative enquiry one should strive for similarity.

9 See n 7 above.

10 Uwe Kischel, *Comparative Law* (Oxford University Press 2019) 201. The benefit of classifying legal systems into families, for the healthcare comparatist, is that it makes conducting comparisons less burdensome in that there is less work to be done to establish a connection between the legal systems: see Peter De Cruz, *Comparative Law in a Changing World* 3rd edn (Routledge-Cavendish 2007) 27.

11 Zweigert and Kötz (n 4 above) 63–67; De Cruz (n 10 above) 35; Jaakko Husa, ‘Legal Families’ in Jan M Smits (ed), *Elgar Encyclopedia of Comparative Law* 2nd edn (Edward Elgar 2012).

12 Zweigert and Kötz (n 4 above) 221–222.

## KEY DIFFERENCE BETWEEN THE ASSISTED DYING BILL [HL] AND THE MAiD LEGISLATION

With the comparative objective established, focus shifts to the content analysis of the two legislative measures to show how assisted dying regulation is being approached from the perspective of England & Wales and Canada. Without the capacity in this commentary to bring other significant factors for successful regulation into the fore, the key differences between the ADB and the MAiD legislation can still help to determine where Parliament should be paying more attention to global developments.

The ADB is the fourth attempt in the recent history of England & Wales to reform the law and decriminalise some form of assistance in dying. It was introduced in 2021 and officially fell in May 2022 due to running out of time in the parliamentary session. Introduced by Baroness Meacher, a life peer in the House of Lords, the ADB contained provisions and clauses that strongly resembled previous attempts such as Lord Falconer's Bill.<sup>13</sup> Canada experienced a similar history of several failed assisted dying Bills introduced in 2005, 2006 and 2009. However, following the decision in *Carter* (2015)<sup>14</sup> that the ban on assisted dying was unconstitutional, the Canadian Bill C-14<sup>15</sup> found success in reforming the federal law. The two legislative measures contain a collection of differences, but some stand out to show a significant divergence of understanding of the issue of assisted dying. Where some deal with practical challenges of a permissive framework, others confront the difficulties of balancing rights and providing adequate protection. Some issues are not easily reconcilable and, despite Canada's progress in the global space of assisted dying regulation, solutions may ultimately have to be contextual. The approach taken by a jurisdiction may be justifiable against the wider societal context which the law is operating within. Various panels, committees and groups formed in Canada have discussed some of the problematic elements of assisted dying regulation in an attempt to assist the formation of legislation.<sup>16</sup>

However, there are some differences between the legislative measures which seem to be more arbitrary or misguided, specifically

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13 Assisted Dying Bill [HL] (2014–2015) 6.

14 *Carter v Canada (Attorney General)* [2015] SCC 5.

15 Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* 1st session, 42nd Parliament, 2015.

16 Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report* (November 2015); Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach* (February 2016); Health Canada, *Final Report of the Expert Panel on MAiD and Mental Illness* (2022).

in the context of the *Annual Reports on Medical Assistance in Dying*<sup>17</sup> published by the Canadian Minister of Health as required by the MAiD legislation. These reports provide insightful and significant statistical data on the engagement with MAiD services provided in Canada, making it seemingly more difficult for Parliament to justify the approach taken in the ADB.

### **Assisting suicide, not dying**

The most striking and obvious difference between the two is that the ADB proposed only to permit health professionals to provide assistance to a patient to end their own life, where the patient performs the final act themselves.<sup>18</sup> Approval for assistance in dying would also have to be given by the High Court (Family Division). Initially, this distinction between a patient self-administering and the final act being performed by a health professional might not seem that problematic. I would argue that it conveys a misunderstanding from Parliament as to why patients seek assistance. Furthermore, the practical implications this has on patients who are attempting to access the provision of assistance in dying could be monumental in the broader context of their battle with the medical challenges they are facing.

Canada, even from the first draft of the MAiD legislation, defines ‘medical assistance in dying’ to include situations where the patient and the medical/nurse practitioner could perform the final act.<sup>19</sup> The *Annual Reports* providing data on the engagement of MAiD in Canada show that nearly all cases of MAiD were administered by a medical/nurse practitioner.<sup>20</sup> In 2020, there were still fewer than seven cases of self-administered MAiD deaths, despite a 34 per cent increase of total MAiD deaths compared to the previous year.<sup>21</sup> The data provided by the *Annual Reports* is overwhelming in the context of how the final act is performed, almost to the point that we could question the necessity of a framework that allows the patient to self-administer. A determination that this option is unnecessary would still be an incorrect one to make. Despite almost all Canadians who accessed MAiD requesting the medical professional to administer the medication, the option for the

17 Health Canada, *First Annual Report on Medical Assistance in Dying in Canada 2019* (2020); Health Canada, *Second Annual Report on Medical Assistance in Dying in Canada 2020* (2021).

18 ADB 13, cl 4(4)(c).

19 Bill C-14: *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* SC 2016, c 3, s 241.1. For the purposes of this commentary, ‘medical assistance in dying’ refers to the final act of the medical professional or the patient administering the life-ending medication.

20 Health Canada, *First Annual Report* (2020) (n 17 above) 18; Health Canada, *Second Annual Report* (2021) (n 17 above) 13.

21 Health Canada, *Second Annual Report* (2021) (n 17 above) 13.

patient to self-administer has important symbolic implications. This is to communicate that, throughout the process, the patient has respected notions of autonomy, control and dignity.<sup>22</sup> Therefore, this must be the minimum. On the other hand, to not provide the option for a medical professional to perform the final act causes more complications than it provides effective safeguarding. In a purely practical argument, allowing medical professionals to perform the final act means that there is a significantly lower chance of the procedure going wrong. Although the patient would be supervised in situations of self-administration, this would not eliminate that possibility. In the scenario where an issue does occur while the patient is self-administering, and the medical professional must intervene to correct the patient, would this be enough to incur liability? Furthermore, the act of self-administering will not be an easy one to perform as the patient is entirely aware of the purpose of the procedure and the purpose being fulfilled by the substance being used. The patient would likely experience more comfort and relaxation during the procedure if they were not required to end their own life.

There may also be specific complications caused by the nature of the patient's condition. For example, there will be a proportion of patients that will be afflicted with conditions or diseases that will affect their cognitive and motor ability. These patients may be forced to end their lives prematurely as they must ensure that they can physically perform the final act. Patients could continue to live what they consider a meaningful life after losing physical abilities but when the time comes that they are suffering unbearably, they will be forced to endure that suffering. The time period that could exist between these two situations may be short. However, it would be time taken away from patients in a situation where every minute could be extremely valuable. The ADB gives the impression that Parliament is accepting that assistance in dying is an important right to recognise but is reluctant to take all the responsibility in giving the option for doctors and nurses to administer the assisting substance. A justification for this approach cannot be obviously seen, particularly when there are practices that are considered 'good' or 'common' within the field of medicine that

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22 Lord Mance, in the second reading of the ADB, highlights that the principles of 'autonomy and dignity in life and in dying' are essential to recognise and protect in the conversation of assisted dying. As one of the presiding judges in the case of *Nicklinson (R (Nicklinson) v Ministry of Justice* [2014] UKSC 38), heard in England & Wales, he expresses his support for a change in the law with a carefully considered and informed approach to the issue: HL Deb 22 October 2022, vol 815, col WA409.

are not ethically distinct from assisted dying, such as measures used in palliative care.<sup>23</sup>

### **The devil is in the (lack of) detail**

Overall, a comparison of similar sections of the ADB and the MAiD legislation give further indication that the understanding of assisted dying in Parliament is misguided. Firstly, one of the largest sections in the ADB gives details regarding the declaration to be given by the High Court (Family Division) after an application has been given for a patient to receive assistance in dying. The section detailed the necessity of obtaining a declaration from a patient, the requirements of the countersignature and who may provide the countersignature for the patient's declaration, what the response is to be in the event of doubt as to the patient's consent and other small details about the process.<sup>24</sup> Whereas, when we look to where the ADB describes the qualification for assisted dying, there is not as much detail. The ADB, in two sub-points, states that a person must have a 'terminal illness' which is defined as 'an inevitably progressive condition which cannot be reversed by treatment' and as a result the patient is 'reasonably expected to die within 6 months'.<sup>25</sup> This is in conjunction with the requirement that the person has capacity, is 18 or over and has been ordinarily resident in England & Wales for at least one year.<sup>26</sup> Despite the ADB setting out that death is reasonably expected to occur within six months, the circumstances are not as clear as the MAiD legislation. Even in the original MAiD legislation an arbitrary timeframe of six months was not included, simply that 'death be reasonably foreseeable' – which could be interpreted in a way so that the unbearable suffering experienced by a patient would not be simply dismissed by a qualifying time-period.<sup>27</sup>

Within the ADB there is no consideration of the patient's suffering. This is central to the framework in Canada as, once having met all the

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23 The principle of 'double effect' is well-established in allowing medical practitioners to hasten the death of a patient for the primary purpose of the relief of suffering: see Jonathan Glover, *Causing Death and Saving Lives: The Moral Problems of Abortion, Infanticide, Suicide, Euthanasia, Capital Punishment, War and Other Life-or-death Choices* (Penguin 1990) 86–91. Furthermore, it can be argued that the use of continuous deep sedation (CDS) and the refusal of artificial hydration and nutrition is another method that cannot be ethically or morally distinguished from acts of euthanasia: see Clive Seale, 'Continuous deep sedation in medical practice: a descriptive study' (2010) 39(1) *Journal of Pain and Symptom Management* 44.

24 ADB 13, cl 3.

25 Ibid cl 2.

26 Ibid cl 1.

27 Bill C-14 (n 19 above) c 3.



other elements of the eligibility criteria, it is the patient's decision alone shaped by the acceptability of possible treatment or symptom relief whether their life is no longer worth living, regardless of any discernible timeframe with their condition. The ADB only required a person to be terminally ill and be expected to die soon. A speech given in the second reading of the ADB by Baroness Fraser of Craigmaddie provided a good explanation on how this perspective is problematic, using examples of those suffering from conditions such as motor neurone disease: 'The ADB implies that if you cannot speak, eat, dress yourself or move around without assistance and you require intimate personal care, your life is less worthy than others.'<sup>28</sup> It is arguable when comparing the difference in perspectives of the legislative measure that the ADB is misguided. Firstly, a prognosis of a patient's likely death is notoriously unreliable and puts medical professionals in a difficult position in being forced to predict a timeframe. Secondly, and more importantly, the reasons a patient will engage with assisted dying are often intrinsically connected to notions of personhood and quality of life. The mere existence of a terminal illness that may bring about a person's death within six months does not automatically mean that the patient determines their life is no longer worth living. The amendments in Canada have shifted the focus from arbitrary time periods which cannot be argued to be reflecting the essential principles for allowing people to receive assistance in death. A framework should be respecting autonomy. All the while more importance is placed on death occurring within six months than a patient's subjective decision about their life and their condition, England & Wales is drafting legislation in ignorance.

### **Waiting periods of prolonged suffering**

The ADB contained a requirement that the medicines can be given to the patient after a period of at least 14 days, unless the patient is expected to die within one month in which case it can be reduced to six days.<sup>29</sup> Interestingly, Canada's framework included a similar waiting period of 10 days after approval was given before providing assistance to the patient. Initially, a waiting period after receiving approval for assistance in dying seems to be a sensible and logical safeguard for patients. It could provide the opportunity for the patient to reflect on their decision and the process to ensure they believe this is the right decision for them. Furthermore, it could allow certain arrangements to be put in place for the patient personally and the medical professionals facilitating the patient's assisted death. However, this has since been removed from the Canadian Criminal Code in the first set of

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<sup>28</sup> HL Deb 22 October 2022, vol 815, col WA428.

<sup>29</sup> ADB 13, cl 4(2)–(3).

amendments made to the MAiD legislation in March 2021.<sup>30</sup> Data from the *Annual Reports* gives an insight as to the practical effectiveness of a waiting/reflection period after being approved. Of the patients that had submitted a written request for MAiD and died of another cause, over 50 per cent died in less than 10 days prior to when they were due to receive MAiD or self-administer.<sup>31</sup> Additionally, around 23 per cent of these patients died between 11 to 30 days prior.<sup>32</sup> These statistics could contain cases where patients had had their request for MAiD approved but died before a scheduled later date for MAiD. However, what this shows is that, despite the provision of assistance in dying, it can become counterproductive if the patient is forced to endure unnecessary suffering in a waiting period. With the proposed waiting period of 14 days in the ADB, there is the potential for a significant number of patients to die before receiving medical assistance. In comparison to the benefits that may be experienced from having a waiting period, the process of being assessed and approved to receive MAiD can be burdensome. The physicians and medical practitioners must be sufficiently confident that the patient meets all of the criteria, including those that speak to the patient's genuine and informed desire to end their life. Before the supply or administration of the medicines to the patients there will always be a final question asked to the patient if they still want to go through with the procedure which, after the extensive process of being granted assistance in dying, should be sufficient without a waiting period.

Canada has responded appropriately to the data that has been collected from patients engaging with MAiD in that country to remove the unnecessary waiting period. Perhaps introducing a framework that does not contain any safeguards ensuring that the patient's wishes are definite is not minimising the risks to those that are at a heightened risk of ending their life. A waiting or reflection period, however, would not serve this purpose. The process of ascertaining the patient's wishes, taking into account the full extent of their condition (including areas of their lives that are adversely affected such as their social and financial abilities) can ensure that the risks to vulnerable people are minimised.

### **'Foreseeability of death', a dark and narrow corridor**

Perhaps one of the biggest developments to occur within Canada's MAiD regulation is the introduction of safeguards allowing patients to access

30 Bill C-7: *An Act to amend the Criminal Code (medical assistance in dying)* SC 2021, c 2.

31 Health Canada, *First Annual Report* (2020) (n 17 above) 37; Health Canada, *Second Annual Report* (2021) (n 17 above) 33–34.

32 Health Canada, *First Annual Report* (2020) (n 17 above) 37; Health Canada, *Second Annual Report* (2021) (n 17 above) 33–34.

assistance in dying when their death is not reasonably foreseeable.<sup>33</sup> This introduction is a stark contrast to the ADB's proposition that a person is expected to die within six months which, I have argued above, is an arbitrary line drawn to qualify a person's suffering.

Along with other amendments made in Canada's 2021 C-7 Bill, such as the removal of a waiting period for those whose death is reasonably foreseeable, this addition seems to be more accurately reflecting the rationale behind key decisions in the Canadian Supreme Court.<sup>34</sup> Unsurprisingly, in this context of requesting assistance in dying there are more stringent safeguards. For instance, there must be a waiting period of 90 days, a specialist or expert in the patient's condition must be consulted, and that the alternative options of symptom relief or trial treatments for the patient be discussed and seriously considered (this includes counselling and support services that focus on living with the condition in an acceptable way).<sup>35</sup> These safeguards are designed to allow the medical professionals dealing with a patient's request to assess their condition holistically and take into account all aspects of the patient's life. I think the safeguards for these circumstances are justified in their stringency. When death is not foreseeable, there will be more risk management involved with providing assisted dying to the patient. However, the mere existence of risk should not preclude the creation of a framework or legislation in the face of scientific uncertainty.<sup>36</sup> What should be of central importance is if the patient is suffering in a way that cannot be relieved or cured – which can be appropriately assessed in the 90-day period with the evaluation of at least one medical professional specialising in the patient's condition. The decision to require a patient's death to be reasonably foreseeable or expected to occur within six months (as proposed by the ADB) is arbitrary. Lord Morrow, in the second reading of the ADB, highlighted how this qualification for assisted dying is misguided by using an example of a diabetic who could be deemed as having six months to live without treatment.<sup>37</sup> Suddenly, the ADB sought to include those who most would agree should not even be considered for an assisted death.

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33 Bill C-7 (n 30 above) c 2.

34 Following the case of *Carter* (n 14 above), the initial C-14 Bill was heavily critiqued as the narrow eligibility criteria would not have permitted Kay Carter from being able to access assisted dying. Furthermore, the case of *Truchon v Canada (AG)* [2019] QCCS 3792 challenged the 'reasonable foreseeability of natural death' and 'end of life' requirements in the federal and Quebec legislations.

35 Bill C-7 (n 30 above) c 2.

36 Nicolas de Sadeleer, *Environmental Principles: From Political Slogans to Legal Rules* 2nd edn (Oxford University Press 2021); Anne-Marie Farrell, *The Politics of Blood: Ethics, Innovation, and the Regulation of Risk* (Cambridge University Press 2012) 168.

37 HL Deb 22 October 2022, vol 815, col WA416.

This is the absurdity that an arbitrary requirement such as a projected timing of the person's death can lead to. There is a thin line to tread, but the legislation must be composed with a well-founded and vigilant core understanding of the issue of suffering and autonomy, which is what assisted dying is centrally concerned with.

It is particularly problematic when considering that a patient's natural death being reasonably foreseeable may be satisfied due to their age alone. Of those who received MAiD in Canada in 2020 (data is before the implementation of additional safeguards for patients whose death is not reasonably foreseeable), 95 per cent of patients were over 56 years old with around 50 per cent being over 76 years old.<sup>38</sup> Furthermore, those between the ages of 18 and 45 who received MAiD accounted for only 6 per cent.<sup>39</sup> In light of the ADB's proposition that a patient's death be foreseeable within six months, two significant events will occur. First, the six-month requirement would create a group of people who will be specifically vulnerable by prognosis to over-inclusion, alongside meeting the rest of the eligibility criteria. Second, patients within that group may apply to receive assisted dying for reasons that should not be permitted. Patients whose death can be predicted to occur within six months that do not consider themselves to be suffering unbearably, although still suffering by some qualification, may be motivated because they do not want to continue to be a burden on their family, friends, or carers. Coupled with inadequate safeguards, this is merely one example of how problematic providing assistance in dying can be if the focus within the framework is not properly aligned with the issue.

### MEASURES OF PRECAUTION?

The opposition to the ADB in the House of Lords, and opposition to permitting assisted dying generally, is largely characterised by the fear of potential harm that may be inflicted to those who are considered vulnerable.<sup>40</sup> The employment of the precautionary principle not only calls into question the data showing possible dangers to vulnerable people, but also presupposes that proactive action can still be taken

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38 Health Canada, *Second Annual Report* (2021) (n 17 above) 19.

39 Ibid.

40 In the second reading of the Bill in the House of Lords the word 'vulnerable' is referenced 72 times. The references are a mixture of those arguing that in the proposed Bill there is adequate protection of vulnerable people, there is inadequate protection of vulnerable people, and other general references to vulnerable groups in the context of assisted dying.

‘notwithstanding the absence of full scientific certainty about the nature and scope of such threats’.<sup>41</sup>

The origins of the precautionary principle can be found in environmental policy regulation of the 1970s and has even gone as far as to obtain recognised legal status in the European Union.<sup>42</sup> The principle is naturally congruous with health law research, specifically when the threat of harm is gravely serious or irreversible, making it especially appropriate to use in the context of assisted dying.<sup>43</sup> Risk regulation and risk management are the key objectives related to the assessment of precautionary measures, then specifically trying to reach some reconciliation in regards to risk acceptability.<sup>44</sup> In ‘highly politicised environments’ where decisions have to be made about how to balance competing rights of different groups of people and what risks can be minimised or permissible, both morally and practically, the precautionary principle in this sense can help bridge the gap between the political and the scientific.<sup>45</sup> However, one of the criticisms of the principle is that it can lead to legislators adopting an ‘all or nothing’ approach that is informed by speculation and fear rather than appropriate risk assessments.<sup>46</sup> It can be argued that this is the current situation in England & Wales based on the analysis of the ADB. An observation of the debates in the House of Lords on the ADB shows this sentiment of fear and uncertainty all too plainly. The use of case examples from other jurisdictions permitting assisted dying in the debates does not show a rational discussion about how to minimise risk and avoid the pitfalls that other countries have made. Rather that there is speculative evidence of some problems that are deemed impossible to circumvent or to eradicate, and this should defeat any attempt to permit assisted dying.<sup>47</sup>

So, what should be the appropriate utilisation of the precautionary principle for assisted dying regulation? Friderik Klampfer uses David Resnik’s criteria for employing the precautionary principle (considering certain principles such as effectiveness, consistency

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41 Farrell (n 36 above) 168.

42 For a description of the origins and background of the precautionary principle, see Sonja Boehmer-Christiansen, ‘The precautionary principle in Germany ± enabling government’ in T O’Riordan and J Cameron (eds), *Interpreting the Precautionary Principle* (Taylor & Francis 1994); Sadeleer (n 36 above).

43 John Harris and Søren Holm, ‘Precautionary principle stifles discovery’ (1999) 400 *Nature* 398.

44 Communication from the Commission on the precautionary principle COM/2000/0001.

45 Farrell (n 36 above) 167.

46 Cass Sunstein, *Laws of Fear: Beyond the Precautionary Principle* (Cambridge University Press 2005) 5.

47 HL Deb 22 October 2022, vol 815, col WA411.

and proportionality) to assess the merits of the ban on assisted dying generally.<sup>48</sup> Performing a similar exercise as Klampfer allows us to determine that the prohibition of assisted dying in England & Wales is unnecessarily precautionary, to the extent that it is counterintuitive. Empirical evidence shows that permitting active euthanasia or assisted suicide does not necessarily lead to an increase in other unacceptable forms of assisted dying (eg involuntary/non-voluntary euthanasia), nor is there an increase in the deaths of those among vulnerable groups.<sup>49</sup> This does not mean there do not exist flawed systems and ineffective ways to create a permissive regime, however, legislators should not be fear-mongered beyond rationality.<sup>50</sup> Naturally, as the empirical evidence shows, through the introduction of a permissive framework for assisted dying there will be an increase in assisted deaths. This is to be expected as those who need assistance in death can access this service, but, if legislation is properly informed to the nature of the issue, what will follow will not be an influx of over-inclusion of those who should not be encouraged to end their lives. Furthermore, the statistics will begin to show the transition of assisted dying practices conducted ‘in the shadows’ to practices that will then be medically supervised or facilitated. To subject those who are in unbearable suffering and are not expected to die within six months is a disproportionately precautionary measure against the possible, but uncertain, risk that there will be abuse towards the vulnerable groups. The objective of this commentary is not to establish that the concern of over-inclusion of vulnerable groups is unfounded. It is absolutely essential that robust and effective safeguards be of primary importance in a permissive framework. However, the prohibition is not effective, consistent or proportionate and therefore cannot be validly established as justifiably precautionary.

A global observation of assisted dying regulation shows that jurisdictions move through various stages of precautionary measures that occur at various points creating a precautionary timeline. England & Wales and Canada have, up to this point, experienced very similar stages where Canada is further along the timeline. Initially, the theoretical debate will wrestle with competing rights both for and against permitting assisted dying practices, with the main arguments

48 Friderik Klampfer, ‘Euthanasia laws, slippery slopes, and (un)reasonable precaution’ (2019) 18(2) *Prolegomena* 121, 133–143.

49 Margaret Battin et al, ‘Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups’ (2007) 33 *Journal of Medical Ethics* 591, 597; Klampfer (n 48 above) 128.

50 John Keown critiques the Belgium and Dutch systems and describes them as examples of slippery slopes: see John Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legalization* 2nd edn (Cambridge University Press 2018).

being person's abstract right to die against the sanctity of life argument. Through case law, both jurisdictions have moved beyond this debate to recognise that a person's right to choose the manner in which they die can be found.<sup>51</sup> The difference between the two jurisdictions is that Canada has been successful in passing legislation to create a permissive framework for assisted dying, whereas England & Wales has not produced a parliamentary Bill that has come close to changing the law.<sup>52</sup> An explanation given by Agnes van der Heide in 2019 insightfully demonstrates how legislators are forced to pass restrictive and conservative versions of the law against political, religious and cultural opposition.<sup>53</sup> However, this arduous and prolonged route to legislation can be shortened by taking heed of how and why Canada has removed 'irrational obstacles' from the MAiD framework.<sup>54</sup> Legislators in England & Wales must employ precautionary measures sensibly and effectively and use the advantage of being able to learn from the developments in Canada to understand where measures will prove to be unnecessarily precautionary.

## CONCLUSION

There have been various failed attempts at galvanising a change in the law in England & Wales to permit any form of assisted dying. Parliamentary Bills in England & Wales continue to present themselves as being oblivious to the global engagement with assisted dying regulation. The domestic courts are also not willing to declare that the criminalisation of any form of assisted dying unjustifiably infringes a person's right to fully choose and control the manner in which they conduct their life – including the manner in which they choose to end their suffering. With the publication of the Director of Public Prosecution's Guidelines<sup>55</sup> for prosecuting those who assist someone in death coupled with medical practices that are not ethically or morally distinguishable from assisted dying, the excuses for not

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51 Within England & Wales, a person's right to choose the manner in which they die was found to be protected by art 8 of the European Convention on Human Rights respecting a person's right to their 'private and family life'. In Canada, a similar right was found to be protected by s 7 of the Canadian Charter of Rights and Freedoms which protected the right to 'life, liberty, and security of the person'.

52 Bills introduced in England & Wales such as the Assisted Dying Bill [HL] (2014–2015) 25, the Assisted Dying (No 2) Bill (2015–2016) 7 and the ADB 13 all failed to progress past the 2nd reading in their respective Houses.

53 Klampfer (n 48 above) 131.

54 Ibid 131.

55 See n 56 below.

creating a permissive framework are weak.<sup>56</sup> This commentary does not propose that the Canadian system is faultless. The widening accessibility of MAiD is currently being criticised as creating a slippery slope.<sup>57</sup> However, the relevance of the comparative analysis is not compromised as core understandings of key elements of assisted dying can still be extracted. The conclusion is that the ADB does not give any indication that Parliament is serious about permitting people to receive assistance in their death to relieve them of unbearable suffering. Moreover, there is only little indication that the true nature of this issue is being understood. To only allow circumstances where the patient performs the final act communicates cowardice, and the continued prohibition of assisted dying cannot be said to be justifiably precautionary. Unwillingness to face the realities of those who are in the position that forces them to consider ending their own life can only lead to unimaginable, unnecessary and prolonged suffering.

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56 For the guidelines, see Director of Public Prosecutions, 'Policy for prosecutors in respect of cases of encouraging or assisting suicide' (CPS 2010, updated 2014) published following the case of *Purdy – R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45.

57 Jocelyn Downie and Udo Schuklenk, 'Social determinants of health and slippery slopes in assisted dying debates: lessons from Canada' (2021) 47 *Journal of Medical Ethics* 662.