THE UNIVERSITY
of EDINBURGH

This thesis has been submitted in fulfilment of the requirements for a postgraduate degree (e.g. PhD, MPhil, DClinPsychol) at the University of Edinburgh. Please note the following terms and conditions of use:

This work is protected by copyright and other intellectual property rights, which are retained by the thesis author, unless otherwise stated.
A copy can be downloaded for personal non-commercial research or study, without prior permission or charge.
This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author.
The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.
When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.
Reforming the Criminal Law on Assisted Dying: A Proposal for new Defences

Chrystala Fakonti

Presented for the degree of Doctor of Philosophy

University of Edinburgh

2021
ABSTRACT

This thesis proposes the creation of new defences to reform the criminal law of England on assisted death. Life is considered an overriding value, but sometimes it should be ended when death is in our best interests due to the experience of intense suffering along with an autonomous wish to die. This argument has been widespread in many foreign jurisdictions with right-to-die legislation. Foreign jurisdictions often limit their legislation to physician-performed assisted death. Nonetheless, there are also cases in which untrained individuals assist loved ones to die motivated by compassion. Our current legal system criminalises both physician-assisted death and compassionate killings, even though it is often considered that they deserve more lenient treatment. This thesis proposes new defences for each of these different types of conduct.

A more lenient approach might be achieved by applying one of the existing defences of diminished responsibility, necessity or consent. Then we can continue to recognise the wrong of killing, but we can also exonerate partly or fully the offenders based on the exceptional circumstances present. Diminished responsibility, due to its current medicalised nature after its 2009 reform, is unlikely to be successful in such cases. While necessity is generally inapplicable to killings, there is an argument to be made for its exceptional application to euthanasia. However, it is unlikely that this will be accepted by the courts and there are practical problems with its application that might be dangerous to vulnerable individuals. While consent is generally inapplicable to assisted deaths, there are good public interest reasons to allow its exceptional application to physician-assisted deaths. This is the most plausible of the existing defences to use. But because it is not specifically designed for this context, there are important problems when assessing competence, information and voluntariness of the assisted death decision, and it should thus be rejected. Nonetheless, it can provide a useful reference point for creating a new legislative reform proposal on physician-assisted death.
In constructing a reform proposal on physician-assisted death, different conceptual theories on defences and offences are valuable. However, it is often difficult at the level of law-making to agree on whether something should be a new defence or an exception to existing offences. A better analysis is given through the required evidential support, as it is desirable to place at least some burden on the grantors of the wish to die, through shaping this as a defence. Upon accepting that life can be overridden by a request to die along with that being in the requestor’s best interests, this would make more sense as a justification defence, as we will be potentially content to have this conduct performed. Physician-assisted deaths represent exceptional cases that there is no essential value in punishing. Thus, this defence should provide full removal of criminal liability. To better protect vulnerable individuals, there must be strict safeguards to assess the assisted death request and the requestor’s medical condition that causes intense suffering. Finally, for the required evidential support a reverse burden of proof is not justified. The legal burden should be on the prosecution to prove that the grantor of the assisted death request cannot be absolved on the ground of this defence.

While motives are generally deemed irrelevant to criminal liability, we can reform the current law to create a specific offence or defence for compassionate killings, as they are different from other cases in the law of homicide and often deserve more lenient treatment. However, it is difficult at the level of law-making to decide how this should be constructed, as there are valid arguments for having this either as an offence or as a defence. Taking infanticide as a comparison, compassionate killing could work as a separate offence, a sub-category of homicide, but also as a partial excusatory defence. Unlike for the physician-assisted death defence, a death request is not essential since it is not entailed in the interpretation of compassion. Creating effective safeguards to ensure the experience of intense suffering and that the actor and the sufferer had a close relationship which prompted their compassionate motives are important. When this is used as an offence, the burden of proof will be on the prosecution to prove it beyond a reasonable doubt. However, when used as a defence, a reverse burden of proof on the actor is justified, since it will be very hard for the prosecution to adduce enough evidence to disprove their compassionate motives.
LAY SUMMARY

Euthanasia is the practice of killing someone at their request, and assisted suicide is assisting someone to commit suicide. Together euthanasia and assisted suicide are often referred to as assisted death. There has been generally much discussion and debate on whether assisted death should be allowed. In England, even though there have been numerous reform attempts that aimed to legalise both euthanasia and assisted suicide, they remain illegal and are punishable with very serious sentences. Nonetheless, many foreign jurisdictions, such as the Netherlands, Belgium, Canada, Switzerland and Oregon (USA) have proceeded in legalising these practices in some form.

This thesis adopts the perspective, which has often been followed in foreign jurisdictions and past English reform Bills, that assisted death should be allowed if it has been requested and if the requestor’s life is extremely bad as they are experiencing intense suffering. Much foreign legislation on assisted death and past reform attempts have limited their proposals to these requirements and insist that assisted death should be performed by a trained individual such as a physician. Physician-performed assisted death is differentiated because medical professionals due to their expertise can ensure that the procedure is successful and does not cause further pain.

However, this thesis also identifies another important category that might deserve more lenient treatment, which is compassionately motivated assisted deaths. Compassionate motives, ethically differentiate such cases. These are often found in close relationships of love and affection when seeing a loved one suffer. A mother who is compassionately motivated and kills her son who had a very serious accident and is under agonising pain is ethically very different from an aggressive and malicious killer.

It is very hard to find a legal mechanism through the current English criminal law to facilitate a more lenient approach to these cases. Particular problems are presented
since assisted deaths often involve vulnerable individuals, and thus there must be strict procedures to ensure their protection. Since there is no existing legal rule to use specifically for assisted deaths, this thesis examines what reform proposals can be created to address cases of physician-assisted death and compassionate killings. Different mechanisms from the current criminal law are used as examples to inform these proposals.

This thesis proposes the creation of a physician-assisted death defence which will allow physicians who perform euthanasia or assisted suicide to avoid criminal liability provided they have acted after a competent, well-informed and voluntary request to die, which was made because of the experience of intense suffering. For compassionate killings, it is proposed that we should create a new offence that will also work as a defence. This will have a separate label and will result in a reduced sentence compared to the mandatory life imprisonment of the offence of murder. Compassion could also be a factor that the court will consider in assisted suicide cases to mitigate sentence.
DECLARATION

I, Chrystala Fakonti, do declare that this thesis has been composed solely by myself, that the work in it is my own, and that it has not been submitted for any other degree or professional qualification.

Chrystala Fakonti
Edinburgh
December 2021
ACKNOWLEDGEMENTS

My greatest thanks to my supervisors Professor Gerry Maher and Dr Andrew Cornford as without them this thesis would have not been possible. From our first meeting during my masters when I told them I wanted to undertake a PhD they have been amazingly generous and patient, providing great feedback, always happy to read numerous drafts and constantly giving me support and encouragement. They have made this journey an immeasurably enjoyable one.

This thesis would not have been possible without the support of my parents Rakis, and Vrionitsa and grandparents Lucas and Chrystala. Their many sacrifices for my education including their financial support for the past years allowed me to undertake this PhD. They always provide me with constant love, care and advice. They are truly the most important part and greatest motivation in my life and I cannot thank them enough for all they have done for me and continue to do.

I am extremely grateful to my colleagues and friends in Old College, especially Dr Katerina Kalaitzaki, Alvaro Garcia Martinez, Alice Krzanich, Dr Fernando Pantoja Nunez and Dr Francesca Soliman. They made this journey more special with their support, understanding and many conversations.

I would also like to thank my friends in Scotland, particularly Simos, for their much-needed mental and emotional support, for encouraging me through this research and sharing so many amazing moments and memories.
# TABLE OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBC</td>
<td>British Broadcasting Corporation</td>
</tr>
<tr>
<td>BOP</td>
<td>Belgian Order of Physicians</td>
</tr>
<tr>
<td>CFCE</td>
<td>Commission Fédérale de Contrôle et d'évaluation de l'euthanasie [Federal Control and Evaluation Commission] (Belgium)</td>
</tr>
<tr>
<td>CPS</td>
<td>Crown Prosecution Service</td>
</tr>
<tr>
<td>DPP</td>
<td>Director of Public Prosecutions</td>
</tr>
<tr>
<td>DPP’s Policy</td>
<td>Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide: Issued by the Director of Public Prosecutions</td>
</tr>
<tr>
<td>Dutch Act</td>
<td>Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 (Netherlands)</td>
</tr>
<tr>
<td>ECHR</td>
<td>European Convention on Human Rights</td>
</tr>
<tr>
<td>ECtHR</td>
<td>European Court of Human Rights</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>OPHD</td>
<td>Oregon Public Health Division</td>
</tr>
<tr>
<td>RAF</td>
<td>Royal Air Force</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
</tbody>
</table>
TABLE OF CASES

Belgium
Acmannne and Others v Belgium App no 10435/83 (Eur Comm HR, 10 December 1984)

Canada
Carter v Canada (Attorney General), 2015 1 SCR 331

European Court of Human Rights
Brown v the United Kingdom Apps no 21627/93 (ECtHR, 19 February 1997)
Gross v Switzerland App no 67810/10 (ECtHR, 14 May 2013)
Haas v Switzerland App no 31322/07 (ECtHR, 20 January 2011)
Koch v Germany App no 497/09 (ECtHR, 19 July 2012)
Mikulić v Croatia App no 53176/99 (ECtHR, 7 February 2002)
Pretty v the United Kingdom App no 2346/02 (ECtHR, 29 April 2002)
X & Y v The Netherlands App no 8978/80 (ECtHR, 26 March 1985)

Netherlands
Alkmaar Case Nederlandse Jurisprudentie 1985 No.106, Supreme Court 27 Nov 1984
Hoge Raad (Strafkamer) [Supreme Court (Criminal Division)] 27 November 1984 reported in Nederlandse Jurisprudentie 1985
Office of Public Prosecutions v Chabot, Nederlandse Jurisprudentie 1994 No 656, Supreme Court
Rechtbank Alkmaar (Prins) [District Court of Alkmaar] 26 April 1995 reported in Nederlandse Jurisprudentie 1995
Rechtbank Groningen (Kadijk) [District Court of Groningen] 13 November 1995 reported in Nederlandse Jurisprudentie 1996

Switzerland
United Kingdom
Abraham [1973] 1 W.L.R. 1270
Airedale NHS Trust v Bland [1993] A.C. 789
Connolly v Croydon Health Services NHS Trust [2015] EWHC 1339
CPS v Shabbir [2009] EWHC 2754 (Admin)
DPP v Morgan [1976] A.C. 182
Hill v Baxter [1958] [1958] 1 Q.B. 277
Montgomery v Lanarkshire Health Board [2015] UKSC 11
R (Burke) v General Medical Council [2005] [2005] EWCA Civ 1003
R (Nicklinson) v Ministry of Justice [2012] EWHC 2381 (Admin)
R (Pretty) v DPP [2001] UKHL 61
R (Purdy) v DPP [2009] UKHL 45
R v Aitken and Others [1992] 1 W.L.R. 1006
R v Bourne [1938] 3 All E.R. 615
R v Brown [1994] 1 A.C. 212
R v Bunch [2013] EWCA Crim 2498
R v Carr-Briant [1943] KB 603
R v Dudley and Stephens (1884) 14 Q.B.D. 273
R v Gill [1963] 1 W.L.R. 841
R v Golds [2016] UKSC 61
R v Graham [1982] 1 W.L.R. 294
R v Inglis [2011] 1 W.L.R. 1110

R v Lambert [2001] UKHL 37

R v McQuade [2005] NICA 2

R v McShane (1978) 66 Cr. App. R. 97

R v Quayle [2005] 1 W.L.R. 3642


R v Woollin [1999] 1 A.C. 82


Re B (Adult: Refusal of medical treatment) [2002] 2 All E.R. 449

Re C [1994] 1 All E.R. 819

Re F (mental patient: sterilisation) [1990] 2 A.C. 1

Re J (A Minor) (Wardship: Medical Treatment) [1990] 3 All E.R. 930

Re MB (Medical Treatment) [1997] 2 F.L.R. 426

Re T (Adult: Refusal of Treatment) [1992] 4 All E.R. 649

Richardson and Irwin [1999] 1 Cr. App. R. 392

Sheldrake v DPP [2005] 1 A.C. 264

Woolmington v DPP [1935] A.C. 462

<table>
<thead>
<tr>
<th>Country</th>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Belgian Act on Euthanasia 2002</td>
</tr>
<tr>
<td></td>
<td>[Act Concerning Palliative Care] MB 26 October 2002</td>
</tr>
<tr>
<td>Canada</td>
<td>Canadian Criminal Code</td>
</tr>
<tr>
<td>Colombia</td>
<td>Colombian Penal Code</td>
</tr>
<tr>
<td>Germany</td>
<td>German Penal Code</td>
</tr>
<tr>
<td>Oregon (USA)</td>
<td>Oregon Revised Statutes</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Swiss Penal Code</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Assisted Dying Bill 2013</td>
</tr>
<tr>
<td></td>
<td>Assisted Dying Bill 2014-15</td>
</tr>
</tbody>
</table>
Assisted Dying Bill 2015
Assisted Dying Bill 2016
Assisted Dying Bill 2019-21
Assisted Dying Bill MP Rob Marris 2015
Assisted Dying for the Terminally Ill Bill [HL], Volume III – Evidence (Individual Submissions) (2004-05, HL86-3)
Assisted Dying for the Terminally Ill Bill 2004
Assisted Dying for the Terminally Ill Bill 2005
Coroners and Justice Act 2009
Criminal Justice Act 2003
Homicide Act 1957
Infanticide Act 1938
Larceny Act 1916
Mental Capacity Act 2005
Patient (Assisted Dying) HL Bill (2002-03)
Road Traffic Act 1988
Sexual Offences Act 2003
Suicide Act 1961
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>LAY SUMMARY</td>
<td>iv</td>
</tr>
<tr>
<td>DECLARATION</td>
<td>vi</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>vii</td>
</tr>
<tr>
<td>TABLE OF ABBREVIATIONS</td>
<td>viii</td>
</tr>
<tr>
<td>TABLE OF CASES</td>
<td>x</td>
</tr>
<tr>
<td><strong>BELGIUM</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>CANADA</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>EUROPEAN COURT OF HUMAN RIGHTS</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>NETHERLANDS</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>SWITZERLAND</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>UNITED KINGDOM</strong></td>
<td>XI</td>
</tr>
<tr>
<td>TABLE OF LEGISLATION</td>
<td>xiii</td>
</tr>
<tr>
<td><strong>BELGIUM</strong></td>
<td>XIII</td>
</tr>
<tr>
<td><strong>CANADA</strong></td>
<td>XIII</td>
</tr>
<tr>
<td><strong>COLOMBIA</strong></td>
<td>XIII</td>
</tr>
<tr>
<td><strong>GERMANY</strong></td>
<td>XIII</td>
</tr>
<tr>
<td><strong>INTERNATIONAL CONVENTION</strong></td>
<td>XIII</td>
</tr>
<tr>
<td><strong>NETHERLANDS</strong></td>
<td>XIII</td>
</tr>
<tr>
<td><strong>OREGON (USA)</strong></td>
<td>XIII</td>
</tr>
<tr>
<td><strong>SWITZERLAND</strong></td>
<td>XIII</td>
</tr>
<tr>
<td><strong>UNITED KINGDOM</strong></td>
<td>XIII</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>xv</td>
</tr>
</tbody>
</table>

Chapter 1: Introduction ........................................ 1

Chapter 2: The English Law on end-of-life choices and medical consent ........ 1

2.1 INTRODUCTION ........................................... 1

2.2 THE LAW ON ASSISTED DEATH ................................ 3

2.2.1 Euthanasia .......................................... 4

2.2.2 Assisted suicide ...................................... 7

2.3 COMPETENT PATIENTS AND MEDICAL TREATMENT .................. 13

2.3.1 The role of consent ................................... 13

  Competence ............................................. 14
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.7 CONCLUSION</td>
<td>250</td>
</tr>
<tr>
<td>Chapter 8: Conclusion</td>
<td>253</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>258</td>
</tr>
<tr>
<td>BOOKS</td>
<td>258</td>
</tr>
<tr>
<td>MATERIAL IN EDITED VOLUMES</td>
<td>260</td>
</tr>
<tr>
<td>JOURNAL ARTICLES</td>
<td>262</td>
</tr>
<tr>
<td>OTHER SOURCES</td>
<td>269</td>
</tr>
</tbody>
</table>
Death remains an inevitable destiny despite the tremendous advancements of modern medicine. Death is a very emotional issue with various viewpoints on the value of life and the many principles which should dictate its cessation. While currently both euthanasia and assisted suicide are prohibited under English criminal law, this prohibition has become subject to ever-intensifying scrutiny. There have been many reform attempts in England and Wales aimed at legalising some form of these practices, but they have been unsuccessful. Nonetheless, often cases of euthanasia are treated with much sympathy in court, while cases of assisted suicides are often not prosecuted, as no proceedings are instituted except with the consent of the Director of Public Prosecutions, which is rarely granted. This thesis sets out to explore how we can achieve a more sympathetic and lenient approach to cases of euthanasia and assisted suicide. To do this it focuses on four main research questions.

Firstly, it is questioned whether the prohibition of euthanasia and assisted suicide in England is satisfactory. To address this question, this thesis will examine whether the law as it currently stands is legally and ethically defensible and whether is consistent and coherent in the approach it follows. Secondly, this thesis enquires into the issue of when ending life is not wrong. Through arguments in the debate about the legalisation of assisted death, such as autonomy and best interests, this thesis will engage in the debate of when life should cease to be an overriding value and whether a more lenient legal approach than the current prohibition is possible.

The third question that this thesis will answer is how we can reform the substantive law to achieve a more lenient approach to physician-performed assisted death cases.
This question aims to assess whether the existing criminal law can be used to achieve a more acceptable approach for euthanasia and assisted suicides, or whether this can provide a reference point for creating a specific reform proposal for these cases. Fourthly, it will look into whether there needs to be a more acceptable approach for compassionately motivated killings. This question aims to highlight that compassionate motives make a substantial difference to the defendants' actions. Therefore, they might need to be legally taken into consideration in some cases.

The original contribution of this research to the existing literature is that it explores alternative reform suggestions for the law of euthanasia and assisted suicide in England and Wales which have not been explored at length before. It will eventually advance two original reform proposals, namely the creation of a physician-assisted death defence along with a compassionate killing offence/defence, which uses infanticide as a reference point. Although euthanasia and assisted suicide are much debated, most of the existing discussion has come from medical law and ethics scholars. Part of this thesis' original contribution derives from the fact that it uses criminal law theory to explain and construct these reform proposals, which has not been traditionally used in this debate. It must be also noted that the proposal for the creation of a compassionate killing offence/defence is core to the originality of this research. Motives are not generally taken into consideration in determining criminal liability in England, while most of the past reform proposals have been limited to physician-performed assisted deaths.

To construct these reform proposals and answer the above-presented research questions, this thesis will start by addressing in chapter 2 the scope of the present English law on end-of-life choices and medical consent. The purpose of this is to explore different rationales and principles that are important for assisted death. Different meanings of euthanasia and assisted suicide will be explored to find the most appropriate definitions. Particular reference will be made to the case of Purdy\(^1\) which is important because it led to the publication of the policy for prosecutors in respect of cases of encouraging or assisting suicide. This chapter will further focus on the idea of medical consent to treatment since assisted death is also largely a medical decision.

\(^1\) R (Purdy) v DPP [2009] UKHL 45
It will be highlighted that medical treatment generally does not proceed without competent, informed and voluntary consent by the patient. Important moral questions will be raised regarding the current prohibition of assisted deaths when contrasted with cases of omissions and double effect. Finally, since issues on the right to die have been repeatedly dealt with under human rights law, this chapter will discuss the cases of Pretty, Haas, Koch, and Gross and draw conclusions on the overall spirit of the Convention and assisted death.

After establishing the different rationales and principles which will be useful for this thesis, chapter 3 will examine some of the arguments in the debate for and against the legalisation of assisted death. This is to evaluate whether the current prohibition of euthanasia and assisted suicide under the English criminal law is ethically and normatively defensible. Much of the discussion will focus on examining arguments from Keown, Glover and Williams, as these have been some of the most influential scholars in discussion about the potential legalisation of assisted death. One of the most important arguments here will be that assisted death should be allowed on the basis that it is in our best interests to die in some situations in order to stop the experience of intense suffering. But this should be also accompanied by an autonomous decision to die. It is important to note that terms such as ‘requestor’ and ‘grantor’ will often be used in this thesis. ‘Requestor’ will refer to the person making a request to die, while ‘grantor’ will refer to the person granting this request either through euthanasia or assisted suicide. Autonomy will thus be viewed as a side-constraint to action and we must choose what promotes our human flourishing. Killing will still be a pro tanto wrong, but the importance of life will be overridden and assisted death could be allowed.

Another core principle for this thesis which will be introduced in this chapter is the idea of compassion. Often loved ones assist a person with whom they have a very close relationship of love, care or affection to die because they cannot bear to see them in extreme suffering. Lastly, among the arguments that will be discussed is the principle

---

2 Pretty v the United Kingdom App no 2346/02 (ECHR, 29 April 2002)
3 Haas v Switzerland App no 31322/07 (ECHR, 20 January 2011)
4 Koch v Germany App no 497/09 (ECHR, 19 July 2012)
5 Gross v Switzerland App no 67810/10 (ECHR, 14 May 2013)
of a slippery slope, which is one of the core principles against assisted death. However, slippery slope concerns will be rejected mainly on the basis that they arise only when suffering and autonomy are considered separately. There is no valid reason to believe that we would not be able to create and enforce effective safeguards upon a potential legislative reform on assisted death.

After this thesis has established that there is a good normative basis for more lenient treatment of assisted death, the argument will proceed to discussing whether we can achieve this through existing criminal law defences. Chapter 4 will argue that since assisted deaths are at least a pro tanto wrong, by applying a defence in these cases we recognise that there are some special reasons to act in that way. The discussion will focus on the potential application of diminished responsibility, necessity or consent. Diminished responsibility was chosen as in the past it has been used for euthanasia cases. The Dutch equivalent of necessity, noodtoestand, provided the foundation for effectively legalising euthanasia in the Netherlands. Consent is discussed since a request to die is generally one of the most important elements of assisted death.

However, it will be concluded that these defences cannot be successfully applied to assisted deaths and thus they should be rejected. Diminished responsibility after its 2009 reform became more formalised and it is thus very hard to plead successfully in compassionate killing cases. For necessity, it will be argued that there is validity to its exceptional application to euthanasia cases upon a redefinition of the value of life. However, it should be rejected as a potential defence since its application is very hard to accept practically, and important safeguards are not guaranteed in its interpretation. For consent, it will be argued that even if is not currently used for assisted deaths, it might be extended to such cases based on public interest reasons. Nonetheless, while in principle this is the most suitable of the existing defences to use, there are important limitations as it was not specifically designed for assisted deaths. Consequently, it will be concluded that consent should also be rejected as such problems make it not an ideal defence to assisted death.

This discussion on consent will be used in chapter 5 as a reference point to construct a more sympathetic reform proposal for physician-assisted deaths. It will be argued
that a substantive law reform is preferable to prosecutorial discretion, as is the current approach by the DPP for cases of assisted suicide, although it will be noted that the publication of the prosecutorial policy was a positive development bringing much needed clarity in this complicated area of the law. Then, since a substantive law reform is preferable, it will be considered how the English criminal law in this area should change to facilitate a more sympathetic approach to physician-assisted death. It will be supported that since physician-assisted death is a *pro tanto* wrong and there were special reasons to offend, we should recognise this by creating a specific defence of physician-assisted death. If the importance typically attributed to life can be overridden by a combination of death being in our best interests along with a death request, then this defence would make more sense as justification since there are justifying circumstances. The physician-assisted death defence will provide full removal of criminal liability, as there is essentially no value in punishing these cases due to their special circumstances. Then the discussion will proceed to examine the necessary safeguards for this defence in ensuring competent, informed and voluntary requests for assisted death and examining the requestor’s medical condition. It will be argued that this defence should uphold the presumption of innocence and impose the legal burden on the prosecution.

After establishing this proposition for the physician-assisted death defence, chapter 6 will consider how the English criminal law can be reformed to facilitate a more lenient approach to cases of compassionate killing. It will be argued that taking motives into consideration is important for reasons of justice. There is validity in creating a partial excusatory defence of compassionate killing to facilitate a more lenient approach towards these cases. Nonetheless, based on the fair labelling argument it will be shown that there are also strong reasons that these cases need to have a different label. This chapter will use the offence/defence of infanticide as an example to provide a useful model of how to have both a partial defence of compassionate killing and a separate offence label. It will be eventually argued that we need to create a new compassionate killing offence/defence which will be both a separate offence, a sub-category of homicide, and a separate partial defence, which when pled successfully will reduce murder to compassionate killing. When this is charged as an offence, the burden of proving the *actus reus* and *mens rea* will be on the prosecution. When used as a defence, due to the considerable proof imbalances between the parties, placing
a legal burden on the defendant will be justified as there will be nothing external for
the prosecution to find. Necessary safeguards for this defence will be considered to
establish a close relationship that prompted the compassionate motives and the
actor’s belief in the loved one’s suffering.

Lastly, chapter 6 will consider how the existing DPP’s guidelines on cases of assisted
suicide need to be amended if the proposed reforms of creating a compassionate
killing offence/defence and a physician-assisted death defence, are not accepted. The
current prosecutorial guidelines must be amended to facilitate the objectives described
as important in these reform proposals. Proposals for changes in the guidelines will
be made, such as making provisions for considering the victim’s health condition, and
making reference to the existence of a close relationship when considering
compassionate motives. A detailed table of the proposed reforms to the DPP’s
guidelines will be provided at the end of chapter 6 at Table 2.
Chapter 2: The English Law on end-of-life choices and medical consent

2.1 Introduction

This chapter will set out the scope of the present English law on end-of-life choices and medical consent. Also, most importantly it will explore the different rationales and principles behind assisted death which will be important later on in this thesis. The first part of this chapter will analyse the law of assisted death, which will include both euthanasia and assisted suicide. While it is clear that euthanasia is currently prohibited under the law of homicide, its exact definition is riddled with confusion. Different meanings of euthanasia will be explored, with particular reference to Keown’s definitions. Reference will also be made to how foreign jurisdictions with the right to euthanasia such as the Netherlands and Belgium define this. In the interest of using as straightforward language as possible, it will be argued that euthanasia refers to cases of active intentional termination of someone’s life at their request. Assisted suicide’s definition is more straightforward than euthanasia. It will generally refer to the action taken to assist, aid, help, encourage or facilitate the suicide of another person, where the final act which causes death is taken by the person wanting to die rather than the agent who is assisting. The case of Purdy\(^1\) will be examined. This is important because it led to the publication of the Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide. There will be a brief outline of the different factors tending in favour of and against prosecution under this policy (Table 1).

The notion of consent to medical treatment is important, as death requests are vital in euthanasia’s and assisted suicide’s definitions and such decisions are often dictated by poor medical condition, making this largely a medical decision. Thus, in the next section, this chapter will explain what the current law is for competent patients and medical treatment in England. Medical treatment generally does not proceed without

---

\(^1\) R (Purdy) v DPP [2009] UKHL 45
competent, informed and voluntary consent by the patient. These important features of consent will be analysed in further detail. Regarding competence, it will be noted that the current test of competence under the Mental Capacity Act 2005 presents some potential problems. Furthermore, there will be some explanation of the legal framework for incompetent patients and medical treatment. The notion of best interests is very important in this discussion, as when a patient is incompetent often decisions are made on their behalf based on their best interests. What is more important for this thesis is that best interests are often used to dictate which procedures are allowed. Assisted deaths are generally prohibited because they are considered against our best interests.

The debate about what is morally appropriate in medical treatment dilemmas has also turned upon the distinction between acts and omissions. This chapter will explore the debate about the justifications of the legality of omissions. It will be noted that the distinction between acts and omissions is flawed both in terms of definitions, but also to some degree on their moral standing. Often some omissions seem more like acts, and can be equally or more painful. Withdrawing treatment results in a slow death through starvation or dehydration which is more painful than lethal injection.

Furthermore, the notion of double effect will be explained. It will be argued that the distinction between intention and foresight makes sense on a legal level, and the doctrine of double effect should be preserved in law in some form. Morally, foreseeing death is culpable to some extent even if, legally, it is not as blameworthy. Important moral questions will be thus raised regarding the current prohibition of assisted death when compared with cases of double effect. Also, it might not always be legally wrong to kill someone in certain situations in assisted death cases, in the same way that it is not considered legally wrong to kill someone in terms of the double effect principle.

Finally, this chapter will consider how issues of assisted death have been dealt with under human rights law. In particular, four important cases will be discussed, which
are Pretty, Haas, Koch and Gross and conclusions will be drawn on the overall spirit of the European Convention on Human Rights. It will be noted that although there is no positive obligation to guarantee assisted death in domestic jurisdictions, any interference with the right to request to die must be justified. It is thus worth examining whether we can find a less restrictive approach than the current prohibition in England.

2.2 The Law on Assisted Death

By the term assisted death this thesis will refer to the practices of both euthanasia and assisted suicide. These are currently illegal in England, although there have been many attempts to reform the law. Several foreign jurisdictions have legalised some form of assisted death. In the Netherlands both euthanasia and assisted suicide were legalised with the enactment of the Termination of Life on Request and Assisted Suicide Act 2001 (‘Dutch Act’). This made the Netherlands the first country in the world to legalise both euthanasia and assisted suicide. This Act allowed physicians to perform euthanasia or assisted suicide under a set of ‘due care’ criteria. Belgium was the second country in the world to legalise euthanasia under specific conditions through the Belgian Act on Euthanasia 2002. Although assisted suicide has not been expressly included in the Act, the Belgian Federal Control and Evaluation Commission accepted that such cases are included.

---

2 R (Pretty) v DPP [2001] UKHL 61
3 Haas v Switzerland App no 31322/07 (ECtHR, 20 January 2011)
4 Koch v Germany App no 497/09 (ECtHR, 19 July 2012)
5 Gross v Switzerland App no 67810/10 (ECtHR, 14 May 2013)
7 Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding van 12 april 2001 [Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 12 April 2001] Stb 2001 194
9 Dutch Act (n 7)
Under the Swiss Penal Code, assistance in suicide is only criminalised when there are selfish motives.\textsuperscript{12} Almost all assisted suicides in Switzerland involve the self-administration of a lethal dose of barbiturates, taken by mouth that has been prescribed by a requestor’s family physician or by a physician affiliated with a right-to-die organisation.\textsuperscript{13} Swiss law only permits physicians to prescribe barbiturates if it is ‘accepted professional practice’.\textsuperscript{14} Switzerland is a country that facilitates many assisted suicides of British citizens through right-to-die organisations such as Dignitas.\textsuperscript{15} These organisations have independent procedures. Oregon became the first USA state to legalise physician-assisted suicide under the Death with Dignity Act.\textsuperscript{16} This allows physicians to prescribe lethal drugs to terminally ill adult residents of Oregon under certain requirements.\textsuperscript{17} Finally, Canada became the first common law country that legalised physician-assisted death in the Supreme Court decision of \textit{Carter v Canada}.\textsuperscript{18} In 2016 federal legislation was passed to allow eligible Canadians under certain requirements to request a medical assisted death.\textsuperscript{19}

\subsection*{2.2.1 Euthanasia}

Euthanasia is not expressly mentioned by English law. However, depending on the circumstances, it is generally prohibited under the law of murder and manslaughter.\textsuperscript{20} Usually, euthanasia offences are premeditated and planned advance, thus prosecution is likely to be brought for murder, which carries a mandatory sentence of life imprisonment.\textsuperscript{21} However, the defendant might use a defence, such as diminished

\begin{itemize}
  \item \textsuperscript{12} Swiss Penal Code Article 115
  \item \textsuperscript{13} Georg Bosshard et al, ‘Assisted Suicide Bordering on Active Euthanasia’ (2002) 117(2) International Journal of Legal Medicine 106, 106
  \item \textsuperscript{15} Margaret Branthwaite and David Jeffrey, ‘Should patients be able to choose physician-assisted suicide at the end of their lives?’ (2006) 7(7) Lancet Oncology 602
  \item \textsuperscript{16} Susan Martyn and Henry Bourguignon, ‘Now is the Moment to Reflect: Two Years of Experience with Oregon’s Physician-Assisted Suicide Law’ (2000) 8(1) The Elder Law Journal 1
  \item \textsuperscript{17} Oregon Revised Statutes § 127.800
  \item \textsuperscript{18} \textit{Carter v Canada} (Attorney General), 2015 1 SCR 331
  \item \textsuperscript{19} Canadian Criminal Code s 241.1
  \item \textsuperscript{20} Jonathan Herring, Criminal law: text, cases, and materials (Oxford, Oxford University Press, 2012) 264
  \item \textsuperscript{21} ibid
\end{itemize}
responsibility, and be convicted of manslaughter, resulting in a lesser sentence.\textsuperscript{22} The meaning of the term euthanasia is riddled with confusion. Depending on the circumstances surrounding the action, different forms of euthanasia have been identified. ‘Voluntary euthanasia’ involves a request from an individual to die. ‘Non-voluntary euthanasia’ is performed on those who are not competent to request it such as babies or incompetent adults.\textsuperscript{23} ‘Involuntary euthanasia’ is euthanasia performed against the wishes of a competent individual.\textsuperscript{24} Furthermore, euthanasia might be categorised as ‘active’ or ‘passive’, depending on whether the death was caused by an act such as lethal injection or supposed omission such as withdrawing life support.\textsuperscript{25}

John Keown explained how the term euthanasia is used by pro assisted death campaigners to suggest that physicians should sometimes be allowed to ensure a painless death by killing their patients.\textsuperscript{26} The first definition used states that euthanasia is the active intentional termination of life by a physician who believes that death would benefit the patient.\textsuperscript{27} Keown prefers the second definition which includes both the active termination of life by an act, but also the termination of life by an omission. Termination of life through omissions is often called passive euthanasia.\textsuperscript{28} Keown believes that if what characterises euthanasia is an intention to end life it makes no moral difference whether this is carried out by an omission or by an act.\textsuperscript{29} On both occasions, the intention is the same: to kill the patient.\textsuperscript{30} The differentiation between acts and omissions will be further explained below.

The final definition explained by Keown is that euthanasia also includes acts and omissions that have the foreseen consequence of shortening life. He rejects this definition as he did with the first one as he believes that intention is different from mere

\begin{footnotesize}
\begin{enumerate}
  \item ibid
  \item John Keown, Euthanasia, Ethics and Public Policy: An Argument Against Legalisation. (Cambridge, Cambridge University Press, 2018) 7
  \item ibid 9
  \item ibid 12
  \item ibid 9
  \item ibid 13
  \item ibid 13
  \item ibid 13
  \item ibid 13
  \item ibid 14
\end{enumerate}
\end{footnotesize}
Aiming to bring about a consequence is not the same as mere awareness that it may or will occur.\textsuperscript{32} It is assumed as morally blameable when someone intends the bad consequence, but not to simply foresee it as a mere side effect of their actions.\textsuperscript{33} This will also be analysed below.

All of Keown’s definitions involve an understanding that death is benefitting the patient, typically because they suffer gravely. This is one of the elements somewhat differentiating euthanasia from other crimes in the law of homicide.\textsuperscript{34} Foreign jurisdictions with right to die legislation have followed a narrow meaning of the term euthanasia which denotes active medical killing on request. In the Netherlands, euthanasia is thought to be performed when the attending physician administers a fatal dose of a suitable drug to the patient on their express request.\textsuperscript{35} In Belgium, euthanasia is defined as the intentional termination of life by someone other than the person concerned at the latter’s request and is legal when performed by a physician under certain conditions.\textsuperscript{36} These examples only include active intentional termination of life after a request. Incidents of omissions, and of acts and omissions which have the foreseen consequence of shortening life, are not included in their definition.

In this thesis, the term ‘euthanasia’ is used to refer just to cases of active intentional termination of someone’s life at their request. These will include a wide number of cases, performed both by trained medical professionals and untrained individuals, provided the termination of life was consensual. Whether both medically performed euthanasia and euthanasia performed by untrained individuals should be legal or not is a separate question to answer.

\textsuperscript{31} ibid 14
\textsuperscript{32} ibid 22
\textsuperscript{33} ibid 37
\textsuperscript{34} ibid 10
\textsuperscript{35} Government of the Netherlands, ‘Euthanasia, assisted suicide and non-resuscitation on request’\url{https://www.government.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request} accessed 11 June 2021
\textsuperscript{36} Belgian Act on Euthanasia 2002 s 2 and s 3
2.2.2 Assisted suicide

The meaning of the term ‘assisted suicide’ is less complex than euthanasia. It generally refers to the action taken to assist, aid, help, encourage or facilitate the suicide of another person, where the final act causing death is taken by the person wanting to die rather than the agent who is assisting.37 Under English criminal law assisted suicide is prohibited by the Suicide Act of 1961.38 A person commits an offence if they do an act that is capable of encouraging or assisting suicide or attempted suicide.39 This offence carries a maximum sentence of imprisonment for a term not exceeding 14 years.40 However, ‘no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions’ (DPP).41

The absence of published considerations that were taken into account in decisions to prosecute caused great uncertainty in the law of assisted suicide.42 As Dyer noted in 2009, up to that point 115 Britons had travelled abroad to die since 2002, but no one who had accompanied a loved one or helped with arrangements was prosecuted.43 This is why in 2009, Debbie Purdy, who was diagnosed with Multiple Sclerosis and anticipated that she might want to go to Switzerland to have assisted suicide and wanted her husband to accompany her, sought clarification from the DPP of his policy on prosecutions in these cases.44

Lord Hope stated that our laws must satisfy the tests of accessibility and foreseeability: individuals were entitled to know which acts and omissions would incur criminal liability and to be able to foresee the consequences a given action may entail.45 It was thus argued that for a ‘highly unusual and extremely sensitive case’, like Purdy, the Code

38 Suicide Act 1961 s 2(1)
39 ibid s 2
40 ibid s 2
41 ibid s 2
42 Purdy (n 1) para 56
43 Clare Dyer, ‘Debbie Purdy Lodges Appeal with House of Lords to Prevent Husband’s Prosecution in Assisted Suicide Case’ (2009) 338 British Medical Journal Publishing Group 2298
44 Purdy (n 1)
45 ibid
offered almost no guidance. Consequently, the Court ordered the DPP to create an offence-specific policy outlining when prosecutions will occur. Following this decision, the DPP published the policy on assisted suicide which included 22 public interest factors in favour of and against prosecution, listed below in Table 1. Today, despite the formal prohibition on assisted suicide, the number of cases prosecuted are still interestingly very low. From 2009 to 2021, there have been 171 cases recorded as assisted suicides referred to the Crown Prosecution Service (CPS). Of these cases, 111 were not prosecuted and 32 were withdrawn by the police. Only three cases of encouraging or assisting suicide have been successfully prosecuted. The DPP’s policy will be further analysed in chapters 5 and 6; however, the low numbers of prosecutions indicate an apparent reluctance to punish offenders of assisted suicide.

46 ibid para 53
47 ibid
50 ibid
51 ibid
Table 1: *Public interest factors listed within the DPP’s Policy*

<table>
<thead>
<tr>
<th>Factors tending in favour of prosecution (numbered as per DPP’s Policy, para 43)</th>
<th>Factors tending against prosecution (numbered as per DPP’s Policy, para 45)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The victim:</strong></td>
<td><strong>The victim:</strong></td>
</tr>
<tr>
<td>(1) was under 18 years of age.</td>
<td>(1) had reached a voluntary, clear, settled and informed decision to commit suicide.</td>
</tr>
<tr>
<td>(2) did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide.</td>
<td></td>
</tr>
<tr>
<td>(3) had not reached a voluntary, clear, settled and informed decision to commit suicide.</td>
<td></td>
</tr>
<tr>
<td>(4) had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect.</td>
<td></td>
</tr>
<tr>
<td>(5) did not seek the encouragement or assistance of the suspect personally or on his or her own Initiative.</td>
<td></td>
</tr>
<tr>
<td>(10) was physically able to undertake the act that constituted the assistance him or herself.</td>
<td></td>
</tr>
<tr>
<td>The suspect:</td>
<td>The suspect:</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>(6) was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim. (On the question of whether a person stood to gain, the police and the reviewing prosecutor should adopt a common sense approach. It is possible that the suspect may gain some benefit - financial or otherwise - from the resultant suicide of the victim after his or her act of encouragement or assistance. The critical element is the motive behind the suspect’s act. If it is shown that compassion was the only driving force behind his or her actions, the fact that the suspect may have gained some benefit will not usually be treated as a factor tending in favour of prosecution. However, each case must be considered on its own merits and on its own facts.)</td>
<td>(2) was wholly motivated by compassion.</td>
</tr>
<tr>
<td>(4) had sought to dissuade the victim from taking the course of action which resulted in his or her suicide.</td>
<td>(6) Reported the victim’s suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.</td>
</tr>
<tr>
<td>(3) although sufficient to come within the definition of the offence, were of only minor encouragement or assistance.</td>
<td>The actions of the suspect:</td>
</tr>
<tr>
<td>(5) may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide.</td>
<td></td>
</tr>
<tr>
<td>(7) pressured the victim to commit suicide.</td>
<td></td>
</tr>
</tbody>
</table>
(8) did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide.

(9) had a history of violence or abuse against the victim.

(11) was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication.

(12) gave encouragement or assistance to more than one victim who were not known to each other.

(13) was paid by the victim or those close to the victim for his or her encouragement or assistance.

(14) was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care.

(15) was aware that the victim intended to commit suicide in a
public place where it was reasonable to think that members of the public may be present.

(16) Was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.
2.3 Competent Patients and Medical Treatment

2.3.1 The role of consent

Consent to medical treatment is important, as death requests are vital in the definitions of euthanasia and assisted suicide. Requests are often legally referred to as and related to consent. Consent is important in criminalisation across many legal contexts, such as assaults, medical law and sexual offences. In the law of assault, consent can be a defence to prevent state intervention in situations where the harm in question is self-regarding and autonomously consented to.\(^{52}\) Similarly, in sexual offences, if sexual intercourse occurs in the absence of consent, and reasonable belief in consent, then the offence of rape is committed.\(^{53}\)

In medical law consent to treatment is referred to as informed consent and is used to grant permission for medical treatment.\(^{54}\) otherwise, there might be an action for damages or assault.\(^{55}\) Administering medical treatment without a patient’s consent would be unlawful and would amount to trespass, possibly leading to a criminal charge of assault or battery or a civil battery in the law of tort, regardless of whether the treatment was intended to aid the patient.\(^{56}\) Grover described informed consent as a voluntary and sufficiently informed decision that shields the right of the competent patient to be involved in medical decision-making.\(^{57}\)

Thus, it is evident that often consent is used legally to differentiate between permissible and impermissible conduct.\(^{58}\) Hence, it has the power to determine the

\(^{53}\) Sexual Offences Act 2003 s 1
\(^{55}\) *Airedale NHS Trust v Bland* [1993] A.C. 789, 864
\(^{56}\) ibid 864
rightness of one’s actions, even if that involves their ‘harm’.\textsuperscript{59} In this sense, the absence of consent is also used to identify criminal wrongdoing.\textsuperscript{60} Overall, it has been largely recognised by the common law that every individual has the right to have their bodily integrity protected against invasion by others.\textsuperscript{61} It has been established as a general rule that consent must be competent, informed and voluntary.\textsuperscript{62}

\textit{Competence}

There is much significance in respecting people’s right to determine what happens to their own bodies, which is considered an integral part of a democratic society.\textsuperscript{63} But our consent can be negated by lack of competence. Not all people enjoy the same ability to decide freely without interferences, which might preclude their objective taking of decisions. Therefore, in the course of assessing a person’s consent, their competence is a fundamental consideration. Ensuring competent decision making is important to avoid mentally fragile individuals from making important medical decisions about their future.\textsuperscript{64} If a patient is judged to be competent, then they have an indisputable and absolute right to refuse medical treatment.\textsuperscript{65} According to Dame Elizabeth Butler-Sloss P in \textit{Re B}, we ‘should not confuse the question of mental capacity with the nature of the decision made by the patient, however, grave the consequences’, our decisions may ‘reflect a difference in values rather than an absence of competence’.\textsuperscript{66} Thus, regardless of whether or not we agree with someone else’s decision, this has no impact on their mental capacity. This has much significance for the discussion of assisted death since just because someone is making a death request which seems immoral or wrong to others, this does not necessarily imply that they are also incompetent.

\begin{thebibliography}{9}
\bibitem{61} YF v Turkey (2004) 39 E.H.R.R. 34
\bibitem{62} John K. Mason and Graeme T. Laurie, \textit{Law and Medical Ethics} (Oxford, Oxford University Press, 2016) 69
\bibitem{63} Sarah-Louise Bingham, ‘Refusal of treatment and decision-making capacity’ (2011) 19(1) Nursing Ethics 167, 167
\bibitem{64} ibid
\bibitem{65} ibid
\bibitem{66} \textit{Re B (Adult: Refusal of medical treatment)} [2002] 2 All E.R. 449 para 100
\end{thebibliography}
According to section 2 of the Mental Capacity Act of 2005:

1) ‘For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

2) It does not matter whether the impairment or disturbance is permanent or temporary.

3) A lack of capacity cannot be established merely by reference to:
   a) a person's age or appearance, or
   b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.’\(^{67}\)

Furthermore, according to section 3 of the Mental Capacity Act 2005:

1) ‘A person is unable to make a decision for himself if he is unable:
   a) to understand the information relevant to the decision,
   b) to retain that information,
   c) to use or weigh that information as part of the process of making the decision, or
   d) to communicate his decision (whether by talking, using sign language or any other means).’\(^{68}\)

It is evident that for someone’s consent to be valid, it must be given freely with decision-making capacity.\(^ {69}\) The importance of capacity for assisted death is evidenced by the fact that under the DPP’s guidelines on cases of assisted suicide it is mentioned as a factor in favour of prosecution that the victim ‘did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide’.\(^ {70}\)

\(^{67}\) Mental Capacity Act 2005 s 2
\(^{68}\) ibid s 3(1)
\(^{69}\) Bingham (n 63) 168
\(^{70}\) Director of Public Prosecutions ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 48)
Nevertheless, this test of competence as described in the Mental Capacity Act 2005 presents some important issues. The first requirement of the above test, stating that a person is deemed unable to decide for themselves if they cannot understand the information relevant to the decision, could be problematic.\textsuperscript{71} Our capacity to make certain decisions about our health is largely influenced by the way we understand the nature, purpose and effects of the medical treatment.\textsuperscript{72} This requirement seems somewhat subjective and potentially easily manipulated by the provider of the information, who is the one in control of the amount of information provided and the way in which it is received. If they disagree with the patient’s decision, they might deliberately provide them with confusing information. Another problem that this test of competence might present is that it does not require psychological or psychiatric assessment for determining capacity. This means that individuals with mental disorders which impair their decision-making capacity, such as clinical depression, might remain undetected. Such problems will be further analysed in this thesis.

It is worth noting that gradually, informed consent has been extended further by the establishment of advance decisions.\textsuperscript{73} These are legal documents that allow individuals to carry out their wishes about end-of-life decisions and the care they want to receive if they subsequently lose capacity.\textsuperscript{74} Nonetheless, this thesis will not consider the extension of potential assisted death legislation to include the possibility of advance directives. Since much time might pass from their drafting, the requestor might change their mind but neglect to update it accordingly.\textsuperscript{75} Even if someone, while competent, thinks that they would not wish to live with profound disabilities, their decision might change and they could be content in a state which would have previously seemed unbearable to them.\textsuperscript{76} This considerable lapse of time from an advance directive to the time it is carried out is one of the reasons that it would be

\textsuperscript{71} Mason and Laurie (n 62) 83
\textsuperscript{72} Re C [1994] 1 All E.R. 819
\textsuperscript{73} Adam E. M. Eltorai and Richard W. Besdine, ‘Mandating advance directives’ (2014) 26(3) Aging Clinical and Experimental Research 315, 315
\textsuperscript{74} ibid
\textsuperscript{75} Mary Donnelly, ‘Best Interests, Patient Participation And The Mental Capacity Act 2005’ (2009) 17(1) Medical Law Review 1, 24
\textsuperscript{76} ibid 24
doubtful whether they are a valid representation of an assisted death request at the time it is performed.

**Information**

Another important consideration under medical law that can negate consent is misinformation. For the patient to be able to make an informed decision regarding their future, they must be given all of the information in terms of what treatment involves.\(^77\) According to the Supreme Court in *Montgomery*, doctors have a legal duty to advise patients of any anticipated benefits and risks involved in a recommended treatment and reasonable alternative treatments.\(^78\) In this way, a competent adult would be able to determine what shall be done with their own body.\(^79\) Failure to provide a patient with sufficient information for an informed decision or giving inaccurate or misleading information may found an action of negligence.\(^80\) Implicit within this duty to provide sufficient information is the obligation to provide accurate information.\(^81\)

Reaching an informed decision is also important in the context of DPP’s policy on assisted suicides as the factors in favour of prosecution include that the victim ‘had not reached a voluntary, clear, settled and informed decision to commit suicide’.\(^82\) Also, it is considered as a factor against prosecution that the victim ‘had reached a voluntary, clear, settled and informed decision to commit suicide’. If for surgery or medical treatment a patient is required to be given all the relevant information, then it is only natural for the same to apply to assisted suicide which is a far more important decision as it involves terminating life.

**Voluntariness**

---

\(^{77}\) NHS choices (n 54)
\(^{78}\) *Montgomery v Lanarkshire Health Board* [2015] UKSC 11
\(^{79}\) *Re B* (n 66)
\(^{80}\) *Connolly v Croydon Health Services NHS Trust* [2015] EWHC 1339
\(^{81}\) ibid
\(^{82}\) Director of Public Prosecutions ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 48)
The third element comprising informed consent is voluntariness. The validity of our decisions depends on whether we have been free without external duress or pressure. Evidence of pressure gives rise to questions of whether the patient willingly made the decision, as, without the freedom to choose, the validity of our choice will be negated. This is also evident in criminal law, as according to Shabbir consent can be expressed or implied, but its absence can be also implied where the victim has been under violence. Also, according to Purdy, in informed consent, the prime objective must be to protect vulnerable people from different sorts of pressure.

The DPP’s policy follows a similar provision mentioning as a factor in favour of prosecution that the suspect ‘pressed the victim to commit suicide’, and that the suspect ‘did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide’. It also states that prosecution is more likely to be required if the suspect ‘had a history of violence or abuse against the victim’ and that the suspect ‘was motivated by the prospect of gaining something from the death of the victim’. In such situations, it is possible that in the prospect of gaining they might have pressured the victim into requesting assisted suicide.

But it is important to note that such pressure does not always exist: it is not always the case that someone gains something after assisted death. This is acknowledged in the DPP’s policy on assisted suicide, which states that:

> ‘On the question of whether a person stood to gain, the police and the reviewing prosecutor should adopt a common-sense approach. The suspect may gain some benefit - financial or otherwise - from the resultant suicide of the victim after his or her act of encouragement or assistance. The critical element is the motive behind the suspect's actions. If it is shown that compassion was the only driving force behind his or her actions, the fact that the suspect may have gained some

---

83 Purdy (n 1) para 65
84 ibid
85 ibid
86 CPS v Shabbir [2009] EWHC 2754 (Admin)
87 Purdy (n 1) para 65
88 Director of Public Prosecutions ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 48)
89 ibid
90 ibid
benefit will not usually be treated as a factor tending in favour of prosecution. However, each case must be considered on its own merits and its facts’.\textsuperscript{91}

2.4 Incompetent patients and medical treatment

English law permits physicians to withdraw or withhold life-sustaining treatment from incompetent patients if they determine that this is in their best interests.\textsuperscript{92} In 1994, the House of Lords in \emph{Bland} held that a physician’s duty towards a patient in a permanent vegetative state does not extend to prolonging their life at all costs.\textsuperscript{93} Over 10 years later in 2005 in the case of \emph{Burke}, it was reiterated that treatment that placed an intolerable burden on an incompetent patient may be withdrawn if it is clinically determined to be futile and unlikely to be in the patient’s best interests.\textsuperscript{94} The withdrawal or withholding of treatment may be appropriate when physicians determine that the burdens outweigh the benefits of treatment.\textsuperscript{95} The Court further stated that the ‘best interests test is an objective one, and what physicians consider to be in a patient’s best interests may conflict with their wishes’.\textsuperscript{96}

There are very limited exceptions where a physician might proceed without patients’ consent.\textsuperscript{97} In cases of non-voluntary treatment, the physician treats without consent because the patient is unavailable or not in a position to express their views.\textsuperscript{98} This means that the patient might be unconscious or lacking capacity. In cases of involuntary therapy, there is treatment without consent, possibly against the patient’s expressed wishes.\textsuperscript{99} This is because in certain situations the patient does not understand that a specific treatment is in their best interests, so the doctor’s decision to treat despite the patient’s lack of consent is perceived as serving the patient’s welfare, and thus being in their best interests.\textsuperscript{100} These actions are justified despite

\begin{footnotes}
\item \textsuperscript{91} ibid
\item \textsuperscript{92} \emph{Bland} (n 55)
\item \textsuperscript{93} ibid
\item \textsuperscript{94} \emph{R (Burke) v General Medical Council} [2005] EWCA Civ 1003, paras 29-30
\item \textsuperscript{95} ibid
\item \textsuperscript{96} ibid
\item \textsuperscript{97} Mason and Laurie (n 62)
\item \textsuperscript{98} ibid
\item \textsuperscript{99} ibid
\item \textsuperscript{100} ibid
\end{footnotes}
the patients’ lack of consent, based on the conviction that this is what the patients would want if they were fully rational.\textsuperscript{101} In \textit{Re MB} a woman withdrew her consent to a caesarean section which was necessary to save her baby’s life, because of her needle phobia.\textsuperscript{102} After a court order, the hospital carried out the procedure, overriding her decision.\textsuperscript{103} According to the Court of Appeal, the hospital had acted lawfully as she suffered temporary impairment of the mind due to fear and panic, which prevented her from taking in and weighing up the information.\textsuperscript{104}

This example can be contrasted to the case of Emma Gough, who was a Jehovah’s Witness and died hours after giving birth because medical practitioners followed her wish to refuse blood transfusions due to her religious beliefs.\textsuperscript{105} The crucial distinction between the two cases lies in the ‘competence’ of the two patients, although both decisions could be viewed as irrational.\textsuperscript{106} In \textit{Re MB} the doctors carried out the operation against the patient’s expressed wishes, to benefit her baby to be born alive and prevent harm to her health.\textsuperscript{107} It was thought that the patient wanted her baby to be born alive more than she wished to avoid the needle, therefore carrying out the operation was justified as it was in her best interests at a time when she temporarily lacked capacity.\textsuperscript{108} But in Emma Gough’s case, health professionals acted on their duty to respect and follow her wishes.\textsuperscript{109} In Emma’s case more harm may have resulted if her wishes were not being respected since this would have violated her fundamental right to decide how to live her own life.\textsuperscript{110} She may have thought that suffering eternal damnation by receiving a blood transfusion would have been worse than death.\textsuperscript{111}

\textsuperscript{101} iibid
\textsuperscript{102} Re MB (Medical Treatment) [1997] 2 F.L.R. 426, 432
\textsuperscript{103} ibid
\textsuperscript{104} ibid
\textsuperscript{105} Clare Murphy, ‘The right to die for Jehovah’ \textit{BBC News} (5 November)
http://news.bbc.co.uk/1/hi/health/7078673.stm accessed 2 December 2021 accessed 20 December 2021
\textsuperscript{106} Bingham (n 63)
\textsuperscript{107} Re MB (Medical Treatment) (n 102)
\textsuperscript{108} Bingham (n 63) 169
\textsuperscript{109} ibid
\textsuperscript{110} ibid
\textsuperscript{111} Raanan Gillon, ‘Ethics needs principles: four can encompass the rest and respect for autonomy should be ‘first among equals’ (2003) 29(5) Journal of Medical Ethics 307, 307
2.4.1 Best interests

The notion of ‘best interests’ mentioned above is perhaps one of the most frequently used terms in medical law. The best interest of the patient appears to be one of the basic elements that influence whether or not treatment is lawful. It would be wrong to try to identify any structure to the law of informed consent without accepting the possibility that best interests will be a decisive concern. The notion of best interests is linked to personal welfare and is used in medical law to prohibit certain procedures even in cases in which the patient has consented.112

Section 4 of the Mental Capacity Act 2005, states that:

‘1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of:
   a) the person's age or appearance, or
   b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests’.113

It is also explained under section 4 that the person making the determination of best interests:

‘6) He must consider, so far as is reasonably ascertainable:
   a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
   b) the beliefs and values that would be likely to influence his decision if he had capacity, and
   c) the other factors that he would be likely to consider if he were able to do so.114

7) He must take into account, if it is practicable and appropriate to consult them, the views of:

---

112 Mason and Laurie (n 62) 69
113 Mental Capacity Act 2005 (n 67) s 4(1)
114 ibid s 4(6)
a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
b) anyone engaged in caring for the person or interested in his welfare,
c) any donee of a lasting power of attorney granted by the person, and
d) any deputy appointed for the person by the court,
as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).  115

There are generally two different uses of the idea of best interests. Firstly, as briefly explained, some procedures are prohibited when a patient is presumed incompetent and a decision should be made on their behalf based on their best interests.  116 Secondly, there are some procedures that we would never allow because they are not in our best interests and they cause harm to the patient for no good reason.  117 This second idea of best interests is the one which this thesis is mainly concerned with. Just as amputation procedures that are not required for medical purposes are prohibited,  118 or the law prohibiting the circumcision of females  119 unless it is carried out for valid medical reasons,  120 assisted death is generally considered against our best interests.

Even valid consent to treatment is not always legally effective. This is analogous to the fact that under criminal law not all autonomous choices are respected, since we cannot consent to most activities that cause actual bodily harm, such as sadomasochism.  121 Furthermore, occasionally best interests can be also used to overrule a competent patient’s decision to refuse treatment,  122 when they do not understand that this treatment is to their benefit,  123 and when it is an emergency and

---

115 ibid s 4(7)
116 ibid s 1(5)
117 Female Genital Mutilation Act 2003 s 1(2)
119 Female Genital Mutilation Act 2003 (n 117) s 1(1)
120 ibid
121 R v Brown [1994] 1 A.C. 212
122 Mason and Laurie (n 62) 69
123 ibid
the physicians do no more than what is reasonably required for the patient’s best interests.124

The best interests notion is used to justify why requests for euthanasia and assisted suicide are not allowed since the notion is often perceived to imply that you cannot request your death as it is against your personal welfare.125 Assisted death is seen to represent the absolute end of your options.126 Continuing life means having options even though you might not realise it. Thus, achieving the end of your options through assisted death is not typically considered beneficial to your personal welfare.127

2.5 Omissions

The debate about what is morally appropriate at the end of life has also turned upon the legal and moral distinction between acts and omissions. It is legal for health care professionals to bring about death via an omission once their duty to treat has expired, but not to take active measures.128 Tony Bland was a patient in a permanent vegetative state who would never regain consciousness and was fed by nasogastric tube, his excretory functions regulated by catheter and enemas.129 His doctor and parents wanted to stop the feeding and antibiotics on the ground that neither served any useful purpose, thus they applied for a declaration that it would be lawful to do so.130 The Court of Appeal and the House of Lords unanimously affirmed this application, on the basis that continued feeding was no longer in the patient’s interests, and the physicians were under no duty to continue it.131 The treatment was judged not to be in his best interests because it was futile as the patient was unconscious and there was no prospect of any improvement of his condition.132

124 Re MB (Medical Treatment) (n 102)
126 Kate Greasley, ‘R(Purdy) v DPP and the Case for Wilful Blindness’ (2010) 30(2) Oxford Journal of Legal Studies 301, 316
127 ibid 316
128 Bland (n 55)
129 ibid
130 ibid
131 ibid
132 ibid
One justification for allowing omissions is that the agent who actively harms causes the harm to occur; whereas the agent who allows harm does not cause it, but simply fails to prevent it where they could have done so.\textsuperscript{133} In choosing between killing and letting die, you are essentially choosing between doing wrong and not doing wrong. Doing harm is considered worse than allowing harm because allowing harm is simply a matter of not interfering or letting nature take its course.\textsuperscript{134} If something bad happens when you are not there, then you are not responsible for it. If you were present your contribution would have been the same and you would not be responsible.\textsuperscript{135}

This is particularly important for assisted death as a distinction is drawn between letting die and actively killing. The former is sometimes justified while the latter is not. On this issue, Glover wonders whether it is worse to actively kill someone than to let them die.\textsuperscript{136} Both have the same bad consequences, but active killing is generally considered morally worse than letting someone die.\textsuperscript{137} He suggests that perhaps this differentiation derives from our intuitive responses.\textsuperscript{138} If omission and acts were treated the same, it would be too much of a burden to people.\textsuperscript{139} We tend to resent hostile acts more than equally hostile omissions.\textsuperscript{140} The resentment felt against a man who does not care enough to raise an old-age pension to keep people alive is nothing to the one felt against a man who commits a massacre intending to kill as many as possible.\textsuperscript{141}

Supporters of the act/omission distinction have argued that many acts can reasonably be said to be worse than their corresponding omissions.\textsuperscript{142} This is because their bad consequences are either less avoidable or even worse.\textsuperscript{143} We consider probable death

\textsuperscript{134} ibid
\textsuperscript{135} ibid
\textsuperscript{137} ibid 92
\textsuperscript{138} ibid 93
\textsuperscript{139} ibid 93
\textsuperscript{140} ibid 99
\textsuperscript{141} ibid 99
\textsuperscript{142} ibid 98
\textsuperscript{143} ibid 98
to be preferable to certain death.\textsuperscript{144} We tend to feel less guilty about allowing something to happen than doing it.\textsuperscript{145} Permitting active killings also might to some extent undermine our sense of security in a way that omissions do not.\textsuperscript{146} It seems that the law on omissions could have some of its roots in the religious tradition where acting seems worse in the eyes of God than letting something happen.\textsuperscript{147} This is why treating omissions and acts the same would be too much of a burden for us, and we tend to resent the second more than the first.

Furthermore, supporters of the distinction argue that an act of killing targets a particular person and thus is generally considered morally worse than an omission.\textsuperscript{148} In a case of murder, the defendant has often chosen the victim. However, in omissions cases, when letting people die, we are not able to say advance which people will lose their lives. Even after their death, there is often no clear way of saying which people could have been saved by acting. Thus, it is generally believed that killing some particular person is worse than allowing some unidentified individual to die.\textsuperscript{149}

Responding to this argument Glover rightly argues that this is not entirely correct.\textsuperscript{150} Even if it is clear that an omission added to the number of deaths, it is not a mitigating factor that I cannot tell which deaths were caused by me.\textsuperscript{151} Also, in cases of medical omissions we know which person will die. When withdrawing treatment, the physician knows which patient will be indirectly killed, in the same way that they would know if they gave them a lethal injection.

Furthermore, it does not seem always entirely convincing that it is worse to actively cause harm than to allow harm. If we could have prevented the bad upshot and did not, this is a consequence of how we have exercised our agency and should have implications for the morality of our behaviour.\textsuperscript{152} As Glover notes, some omissions

\begin{footnotes}
\item \textsuperscript{144} ibid 98
\item \textsuperscript{145} ibid 99
\item \textsuperscript{146} ibid 99
\item \textsuperscript{147} ibid 99
\item \textsuperscript{148} ibid 100
\item \textsuperscript{149} ibid 101
\item \textsuperscript{150} ibid 101
\item \textsuperscript{151} ibid 101
\item \textsuperscript{152} ibid 101
\end{footnotes}
create just as strong a probability of a certain result occurring as their corresponding acts.\textsuperscript{153} For example, a person whose treatment is withdrawn will eventually die, as will a person who is given a lethal injection. Thus, harmful acts are intrinsically at least to some degree morally the same as equally harmful omissions.\textsuperscript{154}

Glover further asserts that some omissions might have even worse consequences than active killings.\textsuperscript{155} When a physician removes life-sustaining treatment from a patient, then they die slowly from starvation or dehydration.\textsuperscript{156} Glover’s argument seems convincing in that the extra suffering involved in the latter could outweigh the bad effects of the first.\textsuperscript{157} As Rachels opines, the process of being ‘allowed to die’ can be slow and painful, but a lethal injection can be relatively quick and painless.\textsuperscript{158}

Nonetheless, even if some do not accept the argument that omissions and acts are in some situations morally the same, their differentiation on a definitional level can be challenged.\textsuperscript{159} When treatment is removed it is this which practically causes the patient’s death. Thus, in a sense, active killing is taking place in the same way that it would for euthanasia. For this reason, calling the withdrawal of treatment an omission is somewhat of a fiction, since stopping the feeding and antibiotics or switching off life support is an action.

This discussion shows that the distinction between acts and omissions is flawed not only in terms of their definitions, but also to some degree their moral standing. While there are important arguments in favour of the distinction, their definitional differentiation seems somewhat of a fiction as often, omissions seem more like actions. The argument regarding their morality is somewhat more complicated. Much more persuasive considerations are needed to justify harming than to justify merely allowing harm.\textsuperscript{160} Allowing harm is considered simply a matter of not interfering or

\begin{footnotes}
\item[153] ibid 98
\item[154] ibid 100
\item[155] ibid 100
\item[157] Glover (n 136) 100
\item[159] Beauchamp (n 156) 439
\item[160] Woollard (n 133)
\end{footnotes}
letting nature take its course. Nonetheless, in some situations, harmful omissions can be the same as acts, and can be equally or more harmful. As noted above, occasionally an omission such as removing life-sustaining treatment can be more painful than active killing through lethal injection, since it results in the slow death of the patient from starvation or dehydration. This might be an indication that the law is not as strongly committed to an anti-assisted death stance as it initially appears to be.

2.6 Double effect

English law allows a physician to administer a patient palliative medication, to relieve pain, even if it is foreseen that the patient’s death will be hastened as a result of the medication administered.161 As Lord Goff noted in Bland a physician can administer painkilling drugs even if this means that an incidental effect of this will be to shorten the patient’s life.162 If the main purpose of medicine is the restoration of health and this cannot be achieved, there are still things for the physician to do to relieve pain and suffering, even if the actions taken could incidentally shorten life.163 Therefore, the important element in the double effect doctrine is the physician’s intention. If the physician had an intention to relieve suffering, the fact that they might have foreseen death as a virtually certain result of the medication provided does not matter.

Glover explains that it is usually wrong to intentionally do a bad act for the sake of a good consequence that will ensue. But it may be legally permissible to do a good act in the knowledge that bad consequences will ensue.164 The doctrine of double effect is explained in terms of the difference between intended and foreseen consequences.165 If you attack me, I may, if necessary, defend myself by striking you so hard that your death might result.166

---

162 Bland (n 55)
164 Glover (n 136) 87
165 ibid 87
166 ibid 89
Keown also supports the double effect doctrine by arguing that intention is different from mere foresight, as aiming to bring about a consequence is not the same as mere awareness that it may or will occur.\textsuperscript{167} Whether someone intends or foresees an event makes a big difference to the morality of one’s conduct.\textsuperscript{168} This is because it is assumed to be morally blameable when someone intends the bad consequence, but not as blameable to simply foresee it as a mere side effect of their actions.\textsuperscript{169}

It is argued that the justifications for the distinction between direct intention and foresight make sense to some degree, in terms of their legal differentiation, and the doctrine of double effect should be preserved in law in some form. This distinction is a very important one for this thesis. The intention to kill an individual when performing euthanasia is currently punishable under the law of murder, but a physician who foresees the death of their patient as virtually certain, is justified under the double effect doctrine.

Nonetheless, there are important tensions between this doctrine and the law of murder. Duff disagrees with this justification of the double effect doctrine and argues that when there is the foresight of a virtually certain death there is ‘an utter indifference to [the victim’s] rights or interests’.\textsuperscript{170} In the case of \textit{Woollin}, English courts have recognised that knowledge of a virtually certain consequence could be used by a jury to infer intention.\textsuperscript{171} Thus, intention and foresight of virtual certainty, are often treated legally as equivalent, and it is not evident why double effect should be an exception to this. This raises significant questions on why giving narcotics to patients foreseeing that they will die is justified, but giving a lethal injection with the intention of killing someone under intense suffering to relieve their pain is not.\textsuperscript{172}

Williams rightly argued that when you know that your conduct will have two consequences, one in itself evil, you are compelled as a moral agent to choose

\textsuperscript{167} Keown (n 23) 22
\textsuperscript{168} ibid 22
\textsuperscript{169} ibid 37
\textsuperscript{170} Antony Duff, \textit{Intention, agency and criminal liability: philosophy of action and the criminal} (Oxford, Blackwell, 1990) 114
\textsuperscript{171} \textit{R v Woollin} [1999] AC 82
\textsuperscript{172} Glanville Williams, \textit{The sanctity of life and the criminal law} (London, Faber and Faber, 1958) 286
between acting and not acting by making a judgement of value.\textsuperscript{173} In a sense, you are deciding whether the good is more to be desired than the evil.\textsuperscript{174} According to Williams this attitude of keeping your mind off one of the consequences can only encourage a hypocritical attitude towards moral problems.\textsuperscript{175} Following this reasoning foresight of virtual certainty is at least morally a form of intention to some degree.\textsuperscript{176}

Glover further criticises the double effect doctrine for being largely immoral and religious-based. A man trapped in the cabin of a blazing lorry, with no hope of being freed, asks a bystander to shoot him to save him from further agony. It seems that the moral thing to do is to shoot him. But this is illegal under the double effect doctrine since it is wrong intentionally to kill an innocent man, even as a means of saving him from pain. Double effect is essentially identifying a class of ‘bad’ acts that that can never be justified by appeals to consequences as if they were laid down by God. Glover notes, many things are religiously considered ‘bad’, such as lying, but they are not legally prohibited. For Glover what we consider bad, is a matter of degree, and largely depends on the circumstances. Hence, even if euthanasia is generally considered bad, an absolute prohibition may not be entirely justified when compared to the double effect principle.\textsuperscript{177}

Another important question besides the morality of intention and foresight of certainty is how easy it is to tell the two apart. As Rothschild argued, the doctrine of double effect could be manipulated to cover an intention to end the patient’s life.\textsuperscript{178} Although we are not legally permitted to request lethal medication, if a lethal quantity of palliative treatment is administered by the physician, it will be hard to determine the actual legality of such actions.\textsuperscript{179} The courts will have to understand whether the physician intended to end the patient’s life or merely to alleviate their pain. Correctly identifying mere side effects from intended means is very hard.

\textsuperscript{173} ibid 286
\textsuperscript{174} ibid 286
\textsuperscript{175} ibid 286
\textsuperscript{176} ibid 286
\textsuperscript{177} Glover (n 136) 89
\textsuperscript{178} Alan Rothschild, ‘Just When You Thought the Euthanasia Debate Had Died’ (2008) 5(1) Bioethical Inquiry 69, 74-75
\textsuperscript{179} ibid 74-75
Their divergence can be based simply on a question of how we define intention. In double effect cases, even though the physicians might foresee that their actions will hasten death, they do not describe them as killing, but alleviating suffering. Glover notes that the double effect doctrine is largely based on consequences.\textsuperscript{180} Truly identifying which were the intended means and which were the foreseen inevitable consequences is very difficult.\textsuperscript{181} If a political protestors throws a bomb and kills several people it is questionable whether these deaths are an intended means to their protest or inevitable consequences of it.\textsuperscript{182} Their deaths were virtually inevitable and the double effect doctrine tells us that there can be consequences that are foreseen to be inevitable, yet which do not count as intended means.\textsuperscript{183}

In conclusion, the distinction between direct intention and foresight makes sense to some degree, in terms of their legal differentiation. The doctrine of double effect should be preserved in law in some form. Foreseeing death is morally culpable at least to some degree, even if not legally as blameworthy as intentional killing. The lack of direct intention might be a form of mitigation but it is still not morally proper to take advantage of the foreseen fact. This discussion raises important moral questions regarding the current prohibition of assisted death when contrasted with cases where it is perceived that the physician does not intend killing even if this is a virtually certain consequence of providing palliative medication.

There are contrasting opinions on whether intention should be considered different than foresight of a virtually certain consequence or if they should be considered the same. Whilst physicians cannot lawfully respond to a direct request for assisted death, under the doctrine of double effect they can knowingly hasten a patient’s death by relying on the fact that it is a mere side effect of palliative medication and not the physician’s intention to end life. Foreseeing death could be morally wrong at least to some extent, even if it cannot be widely accepted as equally blameworthy to euthanasia. Furthermore, it might not always be legally wrong to kill someone under

\textsuperscript{180} Glover (n 136) 91
\textsuperscript{181} ibid 91
\textsuperscript{182} ibid 91
\textsuperscript{183} ibid 91
specific circumstances in assisted death, in the same way that is not considered legally wrong to presumably kill someone through the double effect principle. Hence, as it was noted above in the discussion for omissions, this might suggest that the law is not as strongly dedicated to a position against assisted death as it first appears to be.

2.7 The ECtHR and assisted death

Both euthanasia and assisted suicide cases give rise to different arguments across many different legal areas and in various situations. One legal area which has dealt with issues arising from cases of assisted death is the law of human rights. In recent years several cases have been brought to the European Court of Human Rights (ECtHR) seeking further clarifications on the issues arising from assisted death cases. Most of the cases have mainly focused their arguments on Article 2 and Article 8 of the European Convention on Human Rights (ECHR).184

Article 2 of the ECHR is also known as the ‘Right to life’ and provides that:

1. ‘Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;
(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
(c) in action lawfully taken for the purpose of quelling a riot or insurrection.’185

---

184 European Convention on Human Rights Article 2 and Article 8
185 ibid Article 2
Article 2 imposes positive obligations on the Member States such as the obligation to effectively criminalise offences against the person, the obligation to protect an individual whose life is at risk, and, under certain circumstances, even the obligation to protect individuals against themselves.\textsuperscript{186} This obliges the state not only to abstain from inflicting death but also to protect life, which the state accomplishes notably by prohibiting euthanasia through the law of murder and assisted suicide.\textsuperscript{187}

Article 8 of the ECHR is also known as the ‘Right to respect for private and family life’ and provides that:

1. ‘Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.’\textsuperscript{188}

‘Private life’ is a very broad notion and does not have an exhaustive definition.\textsuperscript{189} The meaning of ‘private life’ is in a state of continuous evolution and covers aspects of a person’s physical and social identity,\textsuperscript{190} such as gender identification, name, sexual orientation, etc.\textsuperscript{191} It includes the ability to pursue activities thought to be of a physically or morally harmful or dangerous nature for the individual concerned,\textsuperscript{192} such as sadomasochism\textsuperscript{193} or refusal of medical treatment.\textsuperscript{194} More importantly, it covers the

\textsuperscript{187} Gregor Puppinck and Claire de La Hougue ‘The right to assisted suicide in the case law of the European Court of Human Rights’ (2014) 18 (7-8) The international journal of human rights 735, 735
\textsuperscript{188} European Convention on Human Rights (n 184) Article 8
\textsuperscript{189} X & Y v The Netherlands App no 8978/80 (ECtHR, 26 March 1985) para 22
\textsuperscript{190} Mikulić v Croatia App no 53176/99 (ECtHR, 7 February 2002) para 53
\textsuperscript{191} Daria Sartori, ‘End-of-life issues and the European Court of Human Rights. The value of personal autonomy within a ‘proceduralized’ review’ (2018) 52 Questions of International Law 23, 26
\textsuperscript{192} Pretty (n 2) para 62
\textsuperscript{193} Brown v the United Kingdom Apps no 21627/93 (ECtHR, 19 February 1997) paras 35-36
\textsuperscript{194} Acmanne and Others v Belgium App no 10435/83 (Eur Comm HR, 10 December 1984) 253
physical and psychological integrity of a person and their choices about their own body.\footnote{195}

\subsection*{2.7.1 Pretty v UK}

The issue of whether we should have the right to decide when and how to die was brought to the ECtHR in the case of \textit{Pretty v UK}.\footnote{196} The Court examined a claim relating to whether termination of life was in \textit{Pretty}'s best interests. More specifically, in this case, the applicant was completely paralysed and wished to end her life but was physically unable to commit suicide. Her husband was willing to assist her, but under English law, he could face prosecution for doing so. \textit{Pretty} argued in the ECtHR that Article 2 of the ECHR does not protect life itself.\footnote{197} It should rather be read as including the ‘right to choose whether or not to go on living’. She also argued that Article 8 protected the right to self-determination and that it embraced the ability to decide when and how to die. According to \textit{Pretty} the English blanket ban on assisted suicide was disproportionate as it failed to take into account that she was not vulnerable and in need of protection. She was a competent woman, acting voluntarily who made an informed decision.\footnote{198}

The court found the argument that Article 2 does not protect life itself unconvincing.\footnote{199} Article 2 ‘is unconcerned with issues to do with the quality of living’ and cannot ‘without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die.’\footnote{200} Thus, no right to die from a third person or a public authority is derived from this.\footnote{201} Regarding \textit{Pretty}'s arguments on Article 8, the court held that while the concept of private life is very broad and cannot be precisely defined,\footnote{202} the essence of the Convention is respecting human dignity.\footnote{203} \textit{Pretty} was seeking to avoid

\footnotesize
\begin{itemize}
  \item 195 X \& Y (n 189)
  \item 196 Pretty (n 2)
  \item 197 ibid
  \item 198 ibid para 35
  \item 199 ibid para 35
  \item 200 ibid para 39
  \item 201 ibid para 40
  \item 202 ibid para 61
  \item 203 ibid
\end{itemize}
degradation and suffering as her condition progressed.\textsuperscript{204} Being prevented from exercising her choice by the state was a potential interference with Article 8.\textsuperscript{205} Such interference could be compatible with the Convention if it is in accordance with the law, has a legitimate aim of protecting security and public health and is necessary in a democratic society.\textsuperscript{206} Protecting those vulnerable to abuse is a necessary safeguard for any relaxation of the law.\textsuperscript{207} The court dismissed Pretty's application and held that the ban on assisted suicide was not a violation of Article 8, as the interference was justified.\textsuperscript{208}

\textbf{2.7.2 Haas v Switzerland}

As already noted, in Switzerland assisted suicide is illegal only when carried out for selfish motives. Mr Haas was suffering from a serious bipolar affective disorder, had attempted suicide twice and was numerous times admitted to psychiatric clinics. Convinced that he could no longer live in a dignified manner, he approached many physicians and health authorities to obtain the medication required to kill himself but was unsuccessful and all his appeals to the courts were rejected. The Swiss Federal Court stated that a psychiatric report would be required to determine whether his wish was autonomous, capable and considered. More than 170 psychiatrists that Haas wrote to agreed to his request.\textsuperscript{209} He complained that the refusal of the Swiss State to allow him to access a substance required for his suicide violated his rights under Article 8.\textsuperscript{210}

The ECtHR quoted Pretty and held that the choice to avoid a potentially undignified and distressing end to life fell within the scope of Article 8. Therefore, Haas's decision to die was one aspect of the right to private life.\textsuperscript{211} However, Pretty and Haas are very different. Haas was not terminally ill as Pretty was, and was able to kill himself on his

\textsuperscript{204} ibid para 37
\textsuperscript{205} ibid
\textsuperscript{206} ibid para 67
\textsuperscript{207} ibid para 4
\textsuperscript{208} ibid para 37
\textsuperscript{209} Haas (n 3)
\textsuperscript{210} ibid para 32
\textsuperscript{211} ibid para 51
own by other means. Nonetheless, he required the State to be obligated under Article 8 to make a substance required for suicide available without prescription to him. The ECtHR held that States have a wide margin of appreciation regarding the lawfulness of assisted suicide.\textsuperscript{212} The Court commented that national authorities should prevent an individual from taking his or her own life ‘if the decision has not been taken freely and with full understanding of what is involved’.\textsuperscript{213} Requiring a medical prescription to get the substance was to prevent abuse and incapable individuals from obtaining a lethal drug.\textsuperscript{214} Also, the requirement for a psychiatric report further fulfilled these conditions.\textsuperscript{215} Even if the Member States had a positive obligation to adopt measures to facilitate suicide with dignity, Switzerland had not failed to comply with that obligation.\textsuperscript{216}

\subsection*{2.7.3 Gross v Switzerland}

Mrs Gross was an elderly woman in Switzerland, who wished to end her life to avoid the suffering connected to the progressive decline of her physical and mental faculties. Despite a psychiatrist’s report stating that her decision to die was capable, voluntary and informed, and had persisted for several years, she was unable to obtain a prescription for the lethal drug from any medical practitioner. Switzerland’s medical ethics guidelines only applied to requestors who would die within weeks.\textsuperscript{217} Before the ECtHR, she invoked Article 8 complaining of a violation of her ‘right to decide by what means and at what point her life would end’.\textsuperscript{218}

The court held that private life was a broad concept encompassing the right to personal autonomy and personal development.\textsuperscript{219} In an era of growing medical sophistication combined with longer life expectations, many people were concerned that they should not be forced to linger on in old age or in states of advanced physical or mental

\textsuperscript{212} ibid para 55
\textsuperscript{213} ibid para 54
\textsuperscript{214} ibid para 55
\textsuperscript{215} ibid para 58
\textsuperscript{216} ibid paras 60-61
\textsuperscript{217} Gross (n 5)
\textsuperscript{218} ibid para 38
\textsuperscript{219} ibid para 58
decrepitude which conflicted with strongly held ideas of self and personal identity.\textsuperscript{220} Provided that an individual is competent, the right to decide their death is one of the aspects of Article 8.\textsuperscript{221} The court commented that the lack of sufficient guidelines defining the circumstances under which medical practitioners could give lethal medication to an individual in Gross’s condition in Switzerland was likely to cause ‘a chilling effect on doctors’, and a ‘considerable degree of anguish’ to her.\textsuperscript{222} The Court concluded that there was a violation of Article 8 while pointing out that this conclusion related only to the absence of clear and comprehensive legal guidelines.\textsuperscript{223}

\textbf{2.7.4 Koch v Germany}

Mr Koch’s wife was left a quadriplegic after an accident and wished to end her life but could not obtain a prescription for lethal drugs under German law as euthanasia was illegal. After having helped her to commit suicide in Switzerland, Mr Koch had complained before German courts of the refusal to provide his wife with the lethal substance. His complaint had been rejected without examination of its merits because of his lack of \textit{locus standi}.\textsuperscript{224} Mr Koch alleged before the ECtHR that the domestic courts’ refusal to examine the merits of the complaint infringed both his late wife’s and his rights under Article 8 of the Convention.\textsuperscript{225}

Only a person who is the victim of a violation of the Convention may apply to the court and thus Mr Koch could theoretically not apply in his wife’s regard.\textsuperscript{226} However, the ECtHR acknowledged his \textit{locus standi} in light of ‘the exceptionally close relationship’ with his wife and ‘his immediate involvement in the realisation of her wish to end her life’.\textsuperscript{227} He was directly affected by the institute’s refusal to grant authorisation to acquire a lethal dose of medication for his wife.\textsuperscript{228} The institute's decision to reject his wife’s request and the administrative courts' refusal to examine the merits of Koch’s

\begin{itemize}
\item \textsuperscript{220} ibid para 58
\item \textsuperscript{221} ibid para 60
\item \textsuperscript{222} ibid paras 65-66
\item \textsuperscript{223} ibid paras 67 and 69
\item \textsuperscript{224} Koch (n 4)
\item \textsuperscript{225} ibid paras 27 and 63
\item \textsuperscript{226} European Convention on Human Rights (n 184) Article 34
\item \textsuperscript{227} Koch (n 4) para 50
\item \textsuperscript{228} ibid paras 50 and 54
\end{itemize}
motion interfered with his right to respect for his private life.\(^{229}\) This expansion of the concept of the victim could be because exercising assisted suicide requires the involvement of another person and the grantor of the wish to die is the one who provides the means by which the requestor can actualise their right to take their life under Article 8.

### 2.7.5 The Spirit of the Convention

The right to life under Article 2 is the one that significantly conditions all other rights under the European Convention of Human Rights.\(^{230}\) As the court in \textit{Pretty} argued assisted death is not a right that is protected under Article 2.\(^{231}\) However, it is evident from these cases that the ECtHR has gradually accepted the expansion of the concept of human rights and particularly of Article 8 to facilitate a more liberal position on assisted death. \textit{Pretty} somewhat brought the choice of assisted death under the protection of Article 8. Any State limitations in exercising this choice must be justified. It is the State’s responsibility to assess the risk of abuse if the law were relaxed. The exercise of the right to choose your death under Article 8 is conditioned by the demands of security and public health.\(^ {232}\) Thus, States could use criminal law to regulate activities that are detrimental to our safety, even against autonomy.\(^ {233}\) The more serious the harm involved, the more heavily public health and safety weighed against individual autonomy.\(^ {234}\) \textit{Haas} shows that it is our right under Article 8 to decide how and when to end our life, provided that we are in a position to make up our minds and to take the appropriate actions. But States which relax the relevant law must have appropriate safeguards to prevent abuse. \textit{Gross} upheld that we have the right to decide how and when to end our life under Article 8. But the State should issue comprehensive and clear guidelines on the circumstances in which we may be granted assistance to do this. Finally, \textit{Koch} expanded the concept of the victim, as the German courts’ refusal to examine the husband’s complaint about the refusal to give his paralysed wife lethal medication had infringed his right to private life.

\(^{229}\) ibid paras 50 and 54
\(^{230}\) European Convention on Human Rights (n 184) Article 2
\(^{231}\) \textit{Pretty} (n 2)
\(^{232}\) Puppinck and de La Hougue (n 187) 728
\(^{233}\) \textit{Pretty} (n 2) para 38
\(^{234}\) ibid
These cases gradually create the legal framework for choosing the time and manner of your death through assisted death. The court in *Haas* noted ‘the Convention must be read as a whole’ and ‘it is appropriate to refer, in the context of examining a possible violation of Article 8, to Article 2 of the Convention’.235 If the state chooses to allow assisted death, then it has the positive procedural obligation, under Article 2, to ‘establish a procedure capable of ensuring that a decision to end one’s life does indeed correspond to the free wish of the individual concerned’, to prevent ‘an individual from taking his or her own life if the decision has not been taken freely and with a full understanding of what is involved’.236 Therefore, there is a requirement of having a procedure of confirming that the decision of the requestor is voluntary and autonomous.237 Autonomy is thus both the source of the right to assisted death and its condition.238

It must be clarified that there is no positive obligation to guarantee a right to assisted death in domestic jurisdictions. Although the ECtHR has recognised a ‘right to die’, states enjoy a considerable margin of appreciation on deciding which infringements of this right are necessary for a democratic society.239 The structure that has been developed in the above cases shows that when there is an interference with Article 8 and the right to choose your own death, that needs a justification that must have a legitimate reason behind it. The courts will ask whether the interference was proportionate and necessary, meaning whether there was a less restrictive interference with this right which will bring about the same end.

There are legitimate objectives of restricting this right to die under Article 8 in the interest of health, safety and avoiding abuse. This is something that the current approach in England is doing by prohibiting both assisted suicide and euthanasia. Therefore, the English legislation does not violate our right to private life. While states enjoy a wide margin of appreciation as to which infringements of rights are necessary, the general approach to these rights is that even if there is a legitimate objective for

---

235 *Haas* (n 3) para 54
236 ibid paras 58 and 54
237 Puppinck and de La Hougue (n 187) 746
238 ibid 746
239 *Haas* (n 3) para 55
infringing them, states should prefer less restrictive means of achieving those objectives. As the ECtHR has effectively recognised a right to end your own life in the time and manner of your choosing, it must be examined whether we can achieve avoiding abuse in a way that is less restrictive of that right even if, in practice, states are granted a margin of appreciation as to that judgement. Thus, it is worth examining whether we can find an approach to our assisted dying legislation that is less restrictive of our Convention rights. We always need to be careful in ensuring that we meet the objectives we want to achieve such as preventing abuse and ensuring safety. Complete legalisation without appropriate safeguards to guard against abuse of assisted death would not be compatible with these limitations.

2.8 Conclusion

This chapter explained the scope of the present English law on end-of-life choices and medical consent, along with the different rationales and principles behind assisted death. It was noted that in this thesis, the term ‘euthanasia’ will refer to the action of the intentional ending of another person’s life at their request. When referring to ‘assisted suicide’, it means the action taken to assist, aid, help, encourage or facilitate the suicide of another person, where the final act which causes death is taken by the person wanting to die rather than the agent who is assisting. Reference was made to the case of Purdy which led to the publication of the DPP’s policy of factors for and against prosecution of assisted suicide cases. These factors were outlined in Table 1 above.

The idea of consent to medical treatment is very important for assisted death, as death requests are vital in euthanasia and assisted suicide. Thus, this chapter focused on explaining the current law on competent and incompetent patients and medical treatment in England. Medical treatment generally does not proceed without competent, informed and voluntary consent by the patient. The current test of competence set out in the Mental Capacity Act 2005 presents some important problems. These include that the provider of the information has much control over the outcome of the test and that it does not require an in-advance psychological or psychiatric assessment for determining capacity. The notion of best interests was also
explained, which is used when decisions are made on behalf of an incompetent patient, or to dictate which medical procedures are allowed. Assisted deaths are generally prohibited because they are considered against our best interests.

The debate about what is morally appropriate in medical treatment decisions has also turned upon the legal and moral distinction between acts and omissions. It was argued that the distinction between acts and omissions is flawed not only in terms of definition, but also to some degree their moral standing. Often some omissions seem more like acts, and sometimes harmful omissions could be morally the same as acts as often they can be equally or more painful. Withdrawing treatment may result in a slow death through starvation or dehydration, which can be more painful than lethal injection.

This chapter additionally focused on the notion of double effect by arguing that the distinction between intention and foresight makes sense on a legal level, and this doctrine should be preserved in law in some form. But morally, foreseeing death is culpable to some extent even if legally it is not as blameworthy. Thus, there are important moral questions regarding the justification of the current prohibition of assisted death when contrasted with cases of double effect. It was noted that it might not always be legally wrong to kill someone under certain situations in assisted death, in the same way that it is not considered legally wrong to presumably kill someone through the double effect principle. Consequently, despite the law’s apparent strong prohibition on euthanasia and assisted suicide, after the discussion in this chapter, it is argued that we do somewhat allow omissive and merely foreseen killings that, in practice, look very similar to euthanasia in disguise. This maybe suggests that the law is not as strongly committed to opposing assisted death as it first appears to be.

One legal area that has repeatedly dealt with issues of assisted death is the law of human rights. Thus, this chapter in its final part considered four important cases; *Pretty, Haas, Koch*, and *Gross*, and conclusions were made on the overall spirit of the ECHR. Although there is no positive obligation to guarantee assisted death in domestic jurisdictions, any interference with the right to request to die must be justified. It was argued that it is worth examining whether it is possible to find a less restrictive approach than the current prohibition in England, but there should always be regard to the avoidance of potential abuse.
Chapter 3: Arguments in the Debate for the Legalisation of Assisted Death

3.1 Introduction

Following the discussion in the previous chapter explaining the law on end-of-life choices and medical consent in England and Wales, this chapter will examine the different arguments in the debate about the legalisation of assisted death to evaluate whether the current prohibition of euthanasia and assisted suicide is ethically and normatively defensible. Firstly, there will be a discussion of the importance of life. It will be argued that assisted death should be allowed on the basis that it is in our best interests to die in some situations, to stop the experience of intense suffering. This needs to be accompanied by an autonomous decision to die.

For this reason, the second principle which will be examined is the idea of autonomy. Many supporters of the legalisation of assisted death argue that autonomy is of absolute importance. But often our decisions are limited by paternalistic rules to promote our best interests. Thus, there will be a discussion of whether assisted death’s criminalisation is a desirable form of paternalism. It will be argued that the current approach of prohibiting every assisted death request seems an overly intrusive form of paternalism as in some situations it might be in our best interests to die. Nonetheless, it is a justifiable form of paternalism to not allow all autonomous death requests and place some limitations on them to protect our best interests. Thus, it will be argued that autonomy needs to be viewed as a side-constraint to action and we must choose what promotes our human flourishing. Our autonomous request to die and that being in our best interests have equal and interdependent weight. Killing will still be a pro tanto wrong, but the importance of life will be overridden and assisted death could be allowed.

The third principle which this chapter will consider is the idea of dignity, as the dignity of our lives often depends on what happens to our bodies. It will be argued that our
dignity can be impaired when we have a very bad quality of life; thus, we must structure our legislation accordingly to avoid such feelings of indignity by offering assisted death. Then, this chapter will analyse the morality of suicide which is an argument that might lead us to understand why assisted suicides are currently criminalised. The morality of suicide is a complex matter with a long history. Upon considering the different arguments in this debate, it will be argued that suicide is not morally wrong and thus, assisted suicide is not morally wrong either.

A concept that is often important in many assisted death cases, especially those performed by loved ones who cannot bear to see someone close to them under intense suffering, is that of compassion. This chapter will discuss the best definition of compassion with a particular focus on Nussbaum’s definition. While it is easy to accept that a loved one feels compassion, it is harder to accept the same for a medical practitioner or a stranger. Thus, when talking about compassionately led assisted deaths there should also be a proper expression of compassion through our actions.

For those assisted deaths that are performed by medical practitioners, a concept that is important to consider is trust. Opponents of assisted death argue that our trust relationship with our physicians will be damaged by a relaxation of the law. But it will be argued that this relationship can be effectively shielded through certain safeguards, such as ensuring that assisted death is offered as part of a continuation of medical treatment and care. This leads to the final part of this chapter which will discuss the principle of a slippery slope which is divided between the empirical and the logical argument. For the logical argument, it will be argued that it is a problem that arises only when suffering and autonomy are considered separately. For the empirical argument, it will be argued that the available statistical data from foreign jurisdictions have important limitations, and that they are not adequate to indicate an empirical slippery slope. There is no valid reason to believe that we would not be able to create and enforce effective safeguards upon relaxation of the law.
3.2 The Importance of life

One of the most prominent arguments in the debate about the legalisation of assisted death is the importance attributed to life.¹ Often life can be considered as of self-evident importance, and any argument about this could be seen as pointless.² But this is not true, as there are certain circumstances where it is considered justifiable to kill,³ such as in war, or self-defence.⁴ A special explanation of why the killing occurred is usually needed.⁵ There are a lot of theories about the best way to explain the importance of human life.⁶ Keown attempted to clarify this by discussing three theories.⁷ These include ‘vitalism’, the ‘sanctity or inviolability of life’ and the ‘Quality of life’ positions.⁸

‘Vitalism’ argues that human life is an absolute moral value,⁹ which all other goods must be sacrificed to preserve.¹⁰ It is always wrong either to shorten life or to fail to strive to lengthen it.¹¹ Vitalism is against any form of life-ending; including treatment withdrawals. Taking a life is not acceptable as it can never lose its worth. Life-prolonging treatment must always be administered to keep patients alive.¹² However, this position seems extreme. As Keown rightly notes: ‘There is little to be said in favour of the vitalist view, which most would agree to be so extreme as to be absurd’.¹³ Arguing that taking life is always wrong is extremely strict and unrealistic since there are many cases where killing occurs such as in wars.¹⁴ By accepting vitalism we would commit ourselves to absolute pacifism.¹⁵

---

¹ John Keown, ‘Restoring Moral and Intellectual Shape to the Law after Bland’ (1997) 113 Law Quarterly Review 481, 481
³ ibid 39
⁴ ibid 39
⁵ ibid 39
⁶ ibid 41
⁸ ibid 37
⁹ ibid 37
¹⁰ ibid 37
¹¹ ibid 37
¹² ibid 37
¹³ ibid 49
¹⁴ Glover (n 2) 41-42
¹⁵ ibid 41-42
‘Sanctity of life’ supports the view that it is always wrong to intentionally kill an innocent person, but there is no duty to preserve life at all costs. We must never intentionally kill an innocent person, but it is often proper to withhold or withdraw treatment even when it is foreseen that death will come sooner. Innocent life is considered an overriding value that should be protected. All other values are overridden by this. Life should not be intentionally, actively ended; but there is no duty to preserve it when it is futile or excessively burdensome. Life is created in the image of God and is possessed of intrinsic dignity that entitles it to protection from unjust attack. This idea is evident both in vitalism and sanctity of life theories as they seem largely religious-based, thinking of human life as being created in the image of God, and that it would be wrong to take away what God has offered us.

However, religion, while important, has no proper place in secular law, as it is grounded on faith and not reason. Williams convincingly notes that theological beliefs should not be legally imposed on people who do not share the same opinions, and it is not necessary for societal welfare. Nonetheless, we should not dismiss an idea simply on the basis that historically it has religious roots, as this does not necessarily tell us anything about the merits of the idea itself.

The sanctity of life theory is what might explain the fact that euthanasia is currently punished with up to life imprisonment, but assisted suicide with only a maximum of 14 years. In assisted suicide life is not ended by the grantor of the wish to die, unlike with euthanasia. The sanctity of life remains intact as the requestor of assisted suicide is the one performing the final act and killing themselves. Thus, assisted suicide respects the sanctity of life more than euthanasia. This approach of life not being actively ended is followed in English law for allowing medical omissions.

---

16 Keown (n 7) 40-41
17 ibid 38
18 Keown (n 1) 481
19 Keown (n 7) 38
20 Keown (n 1) 481
21 Glanville Williams, The sanctity of life and the criminal law (London, Faber and Faber, 1958) 278-279
22 Chapter 2.2.2
23 ibid 2.5
distinguish withdrawing treatment, which is deemed to involve letting die, and murder, which involves actively killing. Withdrawal of treatment is allowed when treatment is futile and is no longer in the best interests of the patient. Then, according to the sanctity of life, there is no active killing, but letting nature take its course, and the patient dies naturally.

Keown notes that allowing someone to die in peace is not the same as intending them to die. The actor’s intention is simply that inevitable death should not be burdened by painful ventilation or other treatment. Merely bowing to the inevitability of death is not the same as intending that death should occur. This argument is also expressed in the double effect doctrine. A physician is allowed to administer patients with palliative medication, with the intention of relieving pain, even if they foresee that death will be consequently hastened. The physician’s intention is not killing, but alleviating pain. Hence, it is believed that the sanctity of life remains intact, as death is considered a mere side effect of palliative medication and there is no active killing.

Nonetheless, the validity of the sanctity of life position, allowing omissions and the double effect principle based on the idea that they are fundamentally different from intentional killing, is disputed. As was noted in chapter 2, the distinction between acts and omissions is flawed in terms of their definitions, but also to some degree on their moral standing. While there are important arguments in favour of their distinction, often omissions seem more like actions. When treatment is removed it is this which practically causes the patient’s death and calling this an omission is somewhat of a fiction. In some situations, omissions can be the same as acts, and can be equally or

---

26 ibid
29 ibid 343
30 ibid 343
31 Chapter 2.6
33 ibid 62
more harmful. Occasionally an omission such as removing life-sustaining treatment can be more painful than active killing through lethal injection since it results in the slow death of the patient from starvation or dehydration. In a sense, active killing is taking place in the same way that it would if they were given a lethal injection in a case of euthanasia.\textsuperscript{34}

Similarly, there are contrasting opinions on the doctrine of double effect on whether intention should be considered different than foresight of a virtually certain consequence or if they should be considered the same. But as noted in chapter 2, foreseeing death could be morally wrong at least to some extent, even if it cannot be widely accepted as equally blameworthy to euthanasia. Even if we accept that omissions and double effect cases are morally different from direct killing because they are done for humane reasons, in assisted death cases equally humane reasons might apply. As previously noted, usually an assisted death request is prompted by medical reasons which make death seem preferable to continuing life.

This sanctity of life theory is considered along with a third theory: that of ‘Quality of life’.\textsuperscript{35} This holds that the value of life is instrumental in providing a vehicle for a life of sufficient worth or quality.\textsuperscript{36} When certain lives fall below a minimum quality threshold, whether because of disease, injury or disability, they can justifiably be ended whether by act or deliberate omission.\textsuperscript{37} This theory is concerned with assessing the worthwhileness of the treatment, but also the worthwhileness of life itself.\textsuperscript{38} This is the difference between the ‘sanctity of life’ theory and the ‘Quality of life’ theory, as in the latter there is a judgment on the worthwhileness of life, while in the sanctity of life theory, innocent life is always an absolute value.\textsuperscript{39}

The ‘sanctity of life’ theory simply takes the patient’s condition into account in judging the worthwhileness of the proposed treatment.\textsuperscript{40} This means that to decide whether a

\textsuperscript{34} Chapter 2.5
\textsuperscript{35} Keown (n 7) 46
\textsuperscript{36} ibid 42
\textsuperscript{37} ibid 42
\textsuperscript{38} ibid 42
\textsuperscript{39} ibid 42
\textsuperscript{40} ibid 42
proposed treatment would be worthwhile one must first ascertain the patient’s present condition and consider whether and to what extent it would be improved by the proposed treatment.\textsuperscript{41} This exercise is often described as involving an assessment of the patient’s ‘quality of life’ now and after the treatment.\textsuperscript{42} Therefore, the ‘Quality of life’ theory makes a judgement on the quality of life itself, while ‘sanctity of life’ just passes a judgement on the worthwhileness of treatment despite the use of the term ‘quality of life’.\textsuperscript{43} Keown uses ‘quality of life’ to refer to an assessment of the patient’s condition as a preliminary to evaluating the worthwhileness of a proposed treatment and distinguishes this using a capitalisation of ‘Quality of life’ to refer to an assessment of the worthwhileness of the patient’s life.\textsuperscript{44}

Glover makes a similar argument to Keown’s ‘quality of life’ assessment by arguing convincingly that life has value, but not being desperately miserable can have even more value.\textsuperscript{45} Longer life is surely better than a short one, but only if it is a life of good quality and fulfilment.\textsuperscript{46} By destroying life, we are not destroying anything intrinsically valuable; killing only matters because it is the end of other things that matter in themselves, and make a ‘life worth living’.\textsuperscript{47} But it is important to clarify that Glover is rightly not suggesting that killing every person with a life that is not worthy would be justified.\textsuperscript{48} Rather, he is arguing that taking a worthy life is directly wrong.\textsuperscript{49} Thus, there are situations in which there are no options left for enjoying a good quality of life when one is experiencing unbearable suffering. In this sense, assisted death could be in our best interests when it will stop the suffering experienced. But even if death would not improve our condition it is reasonable to say that in some situations at least it would not render us worse off either. Ending life is not worse than an intolerable existence, unaccompanied by even the slightest possibility of having a good quality of life which is fulfilling. Thus, there is a differentiation between simply being alive in the biological sense and having a life worth living.

\begin{flushright}
\begin{footnotesize}
\textsuperscript{41} ibid 42
\textsuperscript{42} ibid 43
\textsuperscript{43} ibid 43
\textsuperscript{44} ibid 43
\textsuperscript{45} Glover (n 2) 45-46
\textsuperscript{46} ibid 55
\textsuperscript{47} ibid 55
\textsuperscript{48} ibid 55
\textsuperscript{49} ibid 51-52
\end{footnotesize}
\end{flushright}
But it is important to consider that if such an approach was adopted, it would be very hard to define precisely what makes life worthwhile.\textsuperscript{50} A worthwhile life has more to it than mere consciousness.\textsuperscript{51} If this approach was ever taken as the basis for a legalisation reform proposal on assisted death, discussing what things, such as intense physical or mental suffering, make life no longer worthwhile would be unavoidable. This would raise understandable objections of comparing being alive and being dead.\textsuperscript{52} Glover notes that this criticism is not entirely justified as one can have a preference for being alive over being dead, or for being conscious over being unconscious, without needing to make any ‘comparisons’ between these states.\textsuperscript{53} Thus, the assertion that a life of a certain sort is better than nothing, is ultimately only an expression of our preference.\textsuperscript{54}

Nonetheless, it seems that such criticisms have some validity. Greasley argues that assessing the worthwhileness of certain lives can cause untenable symbolic ramifications grounded in the symbolism of identifying which lives are worth living.\textsuperscript{55} What the law is saying by making such assessments is that although there is no obligation on us to die, it is reasonable that we may wish to do so in a greater degree than if we were healthy.\textsuperscript{56} Indirectly passing judgment on the worth of certain lives is indicating how we view those suffering and how they perceive themselves.\textsuperscript{57}

A concern about indirectly passing judgment on the worth of certain lives is also evident in the fact that the DPP’s guidelines for prosecuting cases of assisted suicide remove any mention of the victim’s medical condition to avoid discrimination.\textsuperscript{58} Nonetheless, although this argument is understandably concerning, it is not enough to indicate against a worthwhileness of life assessment. As explained in chapter 2,

\textsuperscript{50} ibid 51-52 \\
\textsuperscript{51} ibid 51-52 \\
\textsuperscript{52} ibid 51-52 \\
\textsuperscript{53} ibid 51-52 \\
\textsuperscript{54} ibid 51-52 \\
\textsuperscript{55} Kate Greasley, ‘R(Purdy) v DPP and the Case for Wilful Blindness’ (2010) 30(2) Oxford Journal of Legal Studies 301, 321 \\
\textsuperscript{56} ibid 321 \\
\textsuperscript{57} ibid 321 \\
\textsuperscript{58} Rob Heywood, ‘The DPP’s Prosecutorial Policy on Assisted Suicide’ (2010) 21(3) King’s Law Journal 425, 432
judgements on the worthwhileness of life are already made when deciding to withdraw life-sustaining treatment from incompetent patients and hastening death through palliative medication.\textsuperscript{59}

Consequently, it is evident from this discussion that ‘vitalism’ and the ‘sanctity of life’ position are extreme and should not be followed. Arguing through vitalism that taking life is always wrong is strict and unrealistic. There are many situations where it is considered acceptable to take life, such as in a war. Similarly, the ‘sanctity of life’ view is also flawed, as the omissions that are differentiated from intentional killing under this approach, often seem more like acts, since when treatment is removed it practically causes the patient’s death. Moreover, foreseeing death under the double effect doctrine could be morally wrong, even if it is not equally blameworthy to euthanasia. The most persuasive theory discussed is Keown’s ‘quality of life’ assessment which is similar to Glover’s argument that while life is valuable, it is more valuable not to be desperately miserable due to unbearable suffering. In this sense, assisted death could be allowed on the basis that it is in our best interests in some situations to stop the suffering experienced. This approach to potential legalisation will inevitably lead to a discussion of what it is that truly makes life worthwhile.

Thus, if we seek to ensure that assisted death is in our best interests, there are objective elements to take into consideration in assessing the quality of life which can be evidenced from medical examinations.\textsuperscript{60} However, the determination of the permissibility of assisted death cannot just be an objective determination of whether death is in our best interests.\textsuperscript{61} Such a position would raise significant concern that assisted death could eventually become mandatory, and we would allow involuntary euthanasia.\textsuperscript{62} It is worth noting that Williams argued that assisted death should be allowed when a dying person consents to it, and death is the only way to relieve their

\textsuperscript{59} Chapter 2.5 and 2.6
\textsuperscript{60} Emma Bullock, ‘Assisted Dying and the Proper Role of Patient Autonomy’ in Jukka Varelius and Michael Cholbi (eds), \textit{New Directions in the Ethics of Assisted Suicide and Euthanasia} (Cham, Springer, 2015) 12
\textsuperscript{61} ibid 12
\textsuperscript{62} ibid 12
suffering. The crucial distinction here is that the incredibly poor quality of life needs to be accompanied by a request for death to override the importance of life.

This position is widespread in jurisdictions with right to die legislation. In the Netherlands, physicians can perform euthanasia or assisted suicide provided, among other requirements, that there is a death request prompted by unbearable suffering with no prospect of improvement. In Belgium a physician can perform euthanasia and assisted suicide provided there is a death request and the requestor is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident. Also, in Canada medical assistance to die can be offered when there is a request prompted by a grievous and irremediable medical condition. Thus, it is important in addition to thinking about the quality of life when ending life through assisted death, to also think about consent to die.

3.3 Autonomy

Consent is the legal principle that expresses the right to autonomy. The appeal to patient autonomy in discussions of the right to die can be traced to the rise of the doctrine of informed consent. As noted in chapter 2, in law the principle of consent is used to differentiate between permissible and impermissible conduct. Hence, it has the power to determine the legality of one’s actions, even if that involves their ‘harm’. It allows people to govern themselves by their wants by being responsible and exercising significant control over their lives without legal interferences.

63 Williams (n 21) 277
64 Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding van 12 april 2001 [Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 12 April 2001] Stb 2001 194
65 Belgian Act on Euthanasia 2002 s 3
66 Canadian Criminal Code s 241
67 Bullock (n 60) 11
68 ibid 12
absence of consent is also used to identify criminal wrongdoing. The right to refuse medical treatment on the condition that we are making an informed, competent and fully voluntary decision.

One of the leading governing principles in medical ethics is respect for patient autonomy. As is evident from the above argument by Williams and the approach taken in foreign jurisdictions, much of the debate about the legalisation of assisted death has focused on the relevance and scope of this principle. The term autonomy has been generally associated with ideas as diverse as: ‘privacy, voluntariness, self-mastery, choosing freely, the freedom to choose, choosing one’s moral position, and accepting responsibility for one’s choices’. The concept has also been used with connotations of freedom, independence and self-determination. It is generally defined as the right to act and govern oneself following one’s own private beliefs, values, and choices without interference as long as one’s behaviour does not harm others. It permits people to exercise significant control and take responsibility for their lives and the kind of persons they become. The right to autonomy upholds that individuals should be able to make autonomous treatment decisions, notwithstanding that the reasons may be irrational.

A patient’s autonomy is identified with their ability to make choices that shape their life according to their conception of what a good life is. Bullock argued that a competent individual with access to information is the best judge of their interests and whether the benefits of their decisions outweigh the burdens for them. It is generally argued in this respect that we ought to respect patient self-determination because patients

---

72 Chapter 2.3
73 Bullock (n 60) 12
74 ibid 11
76 Bullock (n 60) 13
77 Tania Salem, ‘Physician Assisted Suicide Promoting Autonomy or Medicalizing Suicide?’ (1999) 29(3) The Hastings Center Report 30, 31
78 Dan W. Brock, Life and Death: Philosophical Essays in Biomedical Ethics (Cambridge, Cambridge University Press, 1993) 205-206
79 Re T (Adult: Refusal of Treatment) [1992] 4 All E.R. 649, 653
80 Bullock (n 60) 14
81 ibid 14
have special expertise regarding their well-being. As explained, a physician must comply with the patient’s refusal of treatment, as non-consensual touching may cause a civil action for damages and may constitute a criminal assault. But they are not under any obligation to assist when a patient wants to die.

There are many different arguments regarding the relevance of autonomy to assisted death. Supporters of the absolute importance of autonomy argue that a relaxation in the law of assisted death needs to occur to allow individuals to make their own choices about what to value and how to act. If an individual thinks that continuing life in suffering or while incapacitated is an indignity, inconsistent with their assessment of what makes life worth living, they should be allowed to die. Thus, following this view, the central basis for the moral permissibility of assisted dying is that it constitutes respect for individual autonomy. The argument from autonomy draws upon the claim that a person has a right to shape their own life through their choices and extends this right to include the right to choose the manner of their death.

Nonetheless, this approach of allowing individuals absolute autonomy over their decisions is somewhat extreme. Our ideas about ourselves are often rightly disregarded for the sake of our good, needs, happiness, interests and values. These are often referred to as paternalistic rules and are evident in medical decisions through the principle of best interests, which is occasionally used to overrule competent patients’ decisions when it is presumed that they do not understand that the treatment is to their benefit. This is also a guiding obligation of physicians under the principle of beneficence, which means that all medical practitioners have a moral duty to act according to what they believe is in the best interests of the patient.

---

82 ibid 14
83 Chapter 2.3.1
84 Keown (n 7) 50
85 ibid 50
86 Bullock (n 60) 12
87 ibid 12
89 Chapter 2.4.1
Our autonomy is limited by both ‘active’ and ‘passive’ paternalism, rules that require and others that forbid certain kinds of behaviour respectively. Some laws require motorists to wear seat belts while driving, motorcyclists to wear helmets, hunters to wear red caps or shirts, and sailors to wear life preservers. Some laws prohibit swimming at dangerous or unguarded beaches, the use of narcotic drugs, the private use of fireworks, or private consensual transactions deemed dangerous to one of the parties. The current prohibition of assisted death is an example of passive paternalism, as the state forbids citizens to carry out assisted death.

Paternalism can also be divided into ‘direct’ and ‘indirect’ forms. Direct paternalism refers to interfering with the freedom of persons to choose or act in ways that will cause harm to themselves. Indirect paternalism in contrast to direct paternalism involves a person whose welfare is supposed to be protected, but also it involves another party referred to as the assistant. Indirect paternalism is about measures that are not coercive to the persons that they are designed to benefit, but rather interfere with the assistant to prevent harm to those individuals. This form of paternalism is the one that is more relevant to this discussion, as, in assisted death cases, the assistor is prohibited from acting to fulfil the requestor’s wishes. Nonetheless, autonomy is often limited by paternalistic rules.

Some legal rules might be supported by other reasons besides paternalism, including to protect third parties from indirect harm, or the general public from harm, such as the prohibition of unlicensed driving. Similarly, assisted death besides protecting the requestor might be prohibited for other reasons in addition to paternalism, such as

92 ibid 33
93 ibid 33
96 ibid 149
97 ibid 151
98 ibid 151
protecting individuals from the burden of assisting or protecting the general public from assisted death becoming normal for certain groups of people. Regardless, it must be noted that there are a lot of examples where the state is abandoning paternalistic prohibitions such as the decriminalisation of suicide.\textsuperscript{100} This might be because the state recognises that the prohibitions of these practices are not for the good of the parties involved, or rather that they are prohibited for moral reasons such as religion.

We encounter paternalistic rules every day, such as seat-belt laws, warning labels on cigarette packs or requiring the wearing of helmets by motorcyclists. We accept these regulations and could even consider it unethical not to use these to protect people for the sake of health and safety concerns.\textsuperscript{101} Nonetheless, not every health and safety concern is a justifiable use of paternalism.\textsuperscript{102} This raises the question of whether disregarding autonomous wishes to assisted death is objectionable paternalism or not.

For those who believe in the absolute importance of autonomy, this value cannot be balanced against other factors. Respecting and valuing autonomy means excluding paternalistic interventions.\textsuperscript{103} However, absolute autonomy overlooks other important values, such as issues of obligations owed to others, the pursuit of community goals, notions of justice in healthcare decisions, and the importance of relationships in the lives of others.\textsuperscript{104} It is submitted that if you choose to live your life according to certain moral values, and since we live in a society that holds certain principles, these will involve some restrictions on our choices.

An important argument in judging whether a certain rule is objectionably paternalistic or not might be to assess whether it is very intrusive and whether it reaches far beyond its goal. Generally, health and safety rules that are not unreasonably intrusive are rightly considered more important than autonomous decisions and are thus generally

\textsuperscript{100} Gerald Dworkin, ‘Paternalism,’ in Richard A. Wasserstrom (ed), \textit{Morality and the Law} (Belmont, Wadsworth, 1971) 108
\textsuperscript{102} ibid 113
\textsuperscript{103} Glover (n 2) 74
considered an acceptable form of paternalism. The more intrusive a rule is, the less likely it is that we will regard it as good paternalism.\textsuperscript{105} While prohibiting some autonomous assisted death requests according to the circumstances is a justifiable form of paternalism to protect those individuals’ welfare, forbidding every autonomous wish for assisted death seems overly intrusive. There is validity in considering the exceptional permissibility of assisted death in some cases as sometimes, due to extreme suffering, death might be in our best interests to stop the intolerable life we are living. Thus, while an absolute prohibition on assisted death seems an extreme form of paternalism, this does not necessarily imply that all autonomous wishes should be accepted.

This leads to a different understanding of autonomy for assisted death. Often critics have suggested that not all autonomous decisions demand respect.\textsuperscript{106} The character of the choice must satisfy certain criteria to warrant respect.\textsuperscript{107} The most basic criterion is that a choice should be consistent with respect for the fundamental dignity both of the chooser and others.\textsuperscript{108} Keown convincingly argues that the capacity to choose brings with it the responsibility of making choices that promote, rather than undermine, human flourishing.\textsuperscript{109} Those making immoral choices have no right to be assisted in carrying them out.\textsuperscript{110}

There are certain situations where choosing death would be considered to promote and not undermine human flourishing. In this sense, it would not be immoral to kill another or oneself. This is because, in certain situations where someone is experiencing intolerable and indefinite suffering, there are no real options for human flourishing left open to them whatsoever.\textsuperscript{111} Thus, perhaps there is nothing to be gained in continuing life.\textsuperscript{112} Therefore, for some people, the lack of options and flourishing for their future might make death their best option – or at least, would not

\textsuperscript{105} Smith (n 101) 114
\textsuperscript{106} Keown (n 7) 51
\textsuperscript{107} ibid 51
\textsuperscript{108} ibid 51
\textsuperscript{109} ibid 52
\textsuperscript{110} ibid 53
\textsuperscript{111} Greasley (n 55) 316
\textsuperscript{112} ibid 317
render them worse off. Intentional killing even after an autonomous request and being in the requestor’s best interests would still be at least a pro tanto wrong as it still involves harm, but the value of life will be overridden.

The term pro tanto wrong is used to refer to conduct whose wrong-making features continue to bite in circumstances where the action is all-things-considered justified, and thus on the balance is not wrong. As Gardner noted it refers to conduct we have continuing reasons not to engage in; these reasons do not disappear by the existing justificatory reasons, but they may be ‘defeated’ by the reasons in favour of performing the act. We have many reasons not to kill an innocent person, but this is somewhat defeated by the combination of having a request to die, and that being in that person’s best interests. The wrongness of killing continues to bite, even with the combination of autonomy and best interests, however, on the balance, the killing is not as wrong as the act is all-things-considered justified.

Similarly to this argument, Bullock has convincingly argued for looking at autonomy as a side-constraint on action. This means that while our best interests to receive assisted death will be determined objectively, based on a quality of life assessment which can be based on medical examinations, whether this is permissible will also depend on whether we have autonomously consented to it. Even if it is determined objectively that it is in someone’s best interests to die, it is up to them to consent or refuse assisted death, protected under the doctrine of informed consent. The role of autonomy as a side-constraint is to permit or refuse the procedure, as whether or not assisted death could be in our best interests is not reducible to our autonomy.

---

113 Tim Burkhardt, ‘Epicureanism and the Wrongness of Killing’ (2020) 24(2) The Journal of Ethics 177, 179
114 Kate Greasley, ‘Sex, Reasons, Pro Tanto Wronging, and the Structure of Rape Liability’ (2020) 15(2) Criminal law and Philosophy 159, 161
116 Bullock (n 60) 11
117 ibid 12
117 ibid 21
118 ibid 22
119 ibid 22
Consequently, it is evident from this discussion that one of the leading principles for allowing assisted death is respecting autonomy. But it is submitted that accepting all assisted death requests is extreme and has been rejected. It is a justifiable form of paternalistic intervention to have limitations on decisions about assisted death to protect our best interests. Nonetheless, the current approach of rejecting every assisted death request seems an overly intrusive form of paternalism, as in some situations it might be in our best interests to die. Thus, autonomy should be looked at as a side-constraint on the action. While it might objectively be in our best interests to receive assisted death in some situations of intense suffering where there are no options for further flourishing in the future, whether this should be permissible will also depend on whether we have autonomously requested to die.

Thus, for future reform proposals on assisted death, autonomy should play an important role, but it should be accompanied by an analysis of whether death is in the requestor’s best interests. Best interests and autonomy will have equal and interdependent weight. Even if there is a self-regarding request to die, the killing would not be allowed as it is wrong to do this without that being in the requestor’s best interest. Similarly, killing others cannot be permissible, even if that would be in their best interests, without their earnest request to die. The view which is supported in this discussion is that the killing in such circumstances will be a justified wrong, but the request to die and being in their best interests will not make all concern for the killing go away. The killing is a pro tanto wrong even when it is justified because they have requested it and it is in their best interests to die. The request to die along with that being in their best interests is a justification for something that remains in a sense wrongful, rather than something that negates its wrongness entirely.

3.4 Dignity

The importance attributed to life and autonomy is often linked to the idea of human dignity. The exact meaning of dignity is unclear, which makes this largely vague and

---

120 Keown (n 28) 4
Generally, the word dignity is derived from the Latin, *dignitas*, meaning worthiness and nobility. It may be attributed to various things in life, or sometimes even actions for someone who acts in a dignified manner. Fukuyama notes that it is an individual concept regarding a property we are supposed to have by our ‘common humanity’ or merely by being humans. It is believed that there is a uniqueness of moral status in humans that the rest of the natural world does not have. This differentiation between humans and other beings is likely made because humans possess rationality, the ability to reason and to act upon reasons.

One interpretation of the notion of dignity is as an authority people possess as autonomous free and rational agents, which permits them to create reasons for themselves. According to Nussbaum, the possession of various capabilities is essential for a human being to have a worthy life with human dignity. Consequently, being human entitles us to certain forms of treatment, including being provided with the capabilities or with the conditions for having them. Having these capabilities is considered constitutive of what it is to have a dignified life. Such capabilities are exercised when we grant our consent before medical treatment, or being informed of our health condition. There is a difference between simply being biologically alive and a life that is dignified in virtue of autonomous choices. Thus, what has importance in life is being conferred value by the choices we make. Then, we have dignity only if we can choose autonomously. Respecting human dignity entails treating humans as persons capable of planning their future. According to this argument when an assisted death decision is made autonomously dignity leads to the acceptance of this decision as a way of recognising and reaffirming the worth of the agent as freely
choosing their death. However, respecting dignity does not mean accepting and respecting all decisions no matter what they might be. An autonomous choice can be selfish, stupid, self-contradictory, irrational, or immoral. If dignity just means respecting autonomy, then appealing to dignity does not add anything beyond the points already made in the debate on assisted death.

This discussion will focus on the second understanding of dignity, relating to being dignified in virtue of what happens to our bodies. Keown notes, human beings have inherent dignity that derives from their ‘radical capacities’. Some humans as infants may not possess the ability to exercise these capacities. He thus clarifies that radical capacities are different from abilities, as even though an infant has the radical capacity to speak, they do not possess yet the ability to do so. Therefore, the idea of inherent dignity holds that all humans possess dignity which cannot be lost in virtue of our inherent capacities even if due to age or disability we cannot exercise them.

The idea of dignity as an intrinsic quality that cannot be lost has been used by those opposing assisted death. They argue that whether a person is experiencing unbearable pain is unconnected to the idea of dignity. Our value does not depend on whether we experience pleasure or pain. Human beings do not have dignity because of what they are experiencing but because of who they are. The only reason that we care about what someone is experiencing is precisely due to our care about human beings. To have a bearable life and therefore a dignified life presupposes being alive. To flourish in life or fail to flourish requires having a life, as we cannot have a low or high quality of life without being alive. All humans must always be respected as ends in themselves and should never be used as means.

---

132 Glover (n 2) 74
133 Christopher Kaczor and Robert P. George, ‘Death with Dignity’ in Sebastian Muders (ed), Human Dignity and Assisted Death (New York, Oxford University Press, 2017) 74
134 ibid 74
135 Keown (n 28) 5
136 ibid 6
137 ibid 6
138 Kaczor and George (n 133) 78
139 ibid 78
140 ibid 71-72
141 ibid 71-72
142 ibid 77
beings does not depend on whether they are experiencing pain.\textsuperscript{143} Therefore, if dignity is attributed in the basic sense of thinking that all human beings have intrinsic dignity it cannot be minimised and assisted death is not a way to uphold dignity.\textsuperscript{144} Thus, it seems that dignity can be the secular foundation for the above-described ideas on the importance of life, of ‘vitalism’ and ‘sanctity of life’.

A different understanding of dignity relating to our body is that it is a value that can be impaired when a person is demoted from a fully functioning person to being under extreme suffering.\textsuperscript{145} A person who loses functioning capacities might feel that their dignity is also damaged, and they are degraded from a higher standing of a fully functioning person to a lower.\textsuperscript{146} They might have to endure the humiliation of not being able to take care of themselves, and needing help even for the most basic tasks like going to the toilet or taking a bath like an infant.\textsuperscript{147} This is often accompanied by feelings of shame, inferiority, or embarrassment.\textsuperscript{148} Tony Nicklinson, a stroke victim, was campaigning to be euthanised and argued that he was left with no privacy or dignity, as he was taken care of like a baby, by carers, and unlike babies, he was not going to grow out of it.\textsuperscript{149}

This interpretation of dignity as a quality that can be impaired has been convincingly used to justify requests for assisted death by individuals whose lives have become increasingly bad.\textsuperscript{150} When life falls below a certain quality threshold, assisted death would be beneficial as that person will stop being demoted and degraded.\textsuperscript{151} In this sense, the current prohibition of assisted death is damaging to our dignity, as severely ill people are left to endure a significantly low quality of life while being denied access

\textsuperscript{143} ibid 77
\textsuperscript{144} ibid 74
\textsuperscript{145} Leonard Sumner, ‘Dignity through Thick and Thin’ in Sebastian Muders (ed), \textit{Human Dignity and Assisted Death} (New York, Oxford University Press, 2017) 59
\textsuperscript{146} ibid 59
\textsuperscript{147} Jeff McMahan, ‘Human Dignity, Suicide, and Assisting Others to Die’ in Sebastian Muders (ed), \textit{Human Dignity and Assisted Death} (New York, Oxford University Press, 2017) 19
\textsuperscript{148} Sumner (n 145) 59
\textsuperscript{150} McMahan (n 147) 16
\textsuperscript{151} ibid 19
to assisted death. This perception of assisted death shielding human dignity has been used as a justification for legislation on assisted death in foreign jurisdictions.\(^{152}\) One of the most prominent organisations for assisted suicide in Switzerland is called ‘Dignitas’, and American laws regulating assisted suicide are called ‘Death with Dignity Acts’.\(^{153}\)

Taking the position that dignity might be impaired when a person is demoted from a fully functioning person to being severely ill under extreme suffering and leading an undignified life of not being able to take care of oneself, raises the question of whether dignity is a subjective notion rooted in our response to external situations or an objective one. Jeremy Waldron notes that this distinction is based on objectivity which relates to social aspects of a person’s standing in society and subjectivity which relates to feelings including hurt, shock and anger.\(^{154}\) He argues that our dignity relates to how things are for us in society, not with how things feel to us.\(^{155}\)

However, Sumner notes that the same set of circumstances might be experienced as humiliating by one person but not by another.\(^{156}\) People who have been used to being in charge of their care throughout their lives experience the loss of that independence, when being dependent on others for intimate functions such as bathing and excretion, as degrading.\(^{157}\) Being demoted below their level of respectability diminishes their self-esteem.\(^{158}\) Some others might experience this transition to dependence quite differently, perhaps as a sign of the love or commitment of those closest to them.\(^{159}\) Instead of feeling degraded and humiliated, they may feel accepted and loved by the efforts others are willing to make for them.\(^{160}\)

\(^{152}\) ibid 16
\(^{153}\) Ralf Stoecker, ‘Dignity and the Case in Favor of Assisted Suicide’ in Sebastian Muders (ed), Human Dignity and Assisted Death (New York, Oxford University Press, 2017) 31
\(^{154}\) Jeremy Waldron, The Harm in Hate Speech (Cambridge, Harvard University Press, 2012) 106
\(^{155}\) ibid 106
\(^{156}\) Sumner (n 145) 62
\(^{157}\) ibid 62
\(^{158}\) ibid 62
\(^{159}\) ibid 62
\(^{160}\) ibid 62
Both arguments regarding the objectivity and subjectivity of dignity seem persuasive to some degree. We can be undignified in a social sense, in virtue of how others in society view us. But we can also feel undignified based on how we view the circumstances we are in. Whether indignity relates to a sense of objectivity or subjectivity might depend on the person and the circumstances. Some might be happy to have others in charge, and others are content with their appearance and stoical about pain.\textsuperscript{161}

The fact that there might be different opinions and experiences does not substantially matter. Since a lot of people have a feeling of subjective indignity due to how their situation feels to them, we have sufficient reason to structure end-of-life care in a way that avoids such feelings of indignity as much as possible.\textsuperscript{162} A subjective understanding of dignity seems more personal. Assisted death is also a very personal decision relating to our death. But it is important to consider that if we were to base a potential reform on assisted death on an objective interpretation of dignity, there might be important dangers in eventually normalising and accepting involuntary euthanasia. Certain people might be forced to die because we do not view them as socially dignified anymore. Thus, relying on a subjective feeling of indignity for the potential legalisation of assisted death is important in avoiding such problems. Such concerns will be further analysed in this chapter’s discussion on slippery slope arguments for assisted death. What matters is providing people who feel their lives have become undignified with many options, including assisted death, for dealing with the dying process.\textsuperscript{163} It is important to ensure that by making this argument we do not conclude that people who do not want to die when experiencing intense suffering are undignified.

It is thus evident from this discussion that life and autonomy are often linked with the idea of being dignified in virtue of what happens to our bodies. But this is a quality that can be impaired and for this reason, we should allow assisted death requests for people whose lives have become increasingly bad leading to a sense of indignity. Whether this feeling is subjective or objective is debated, but since a lot of people have

\textsuperscript{161} ibid 64
\textsuperscript{162} ibid 64
\textsuperscript{163} ibid 64
a feeling of subjective indignity due to how their situation feels to them, we must structure end-of-life legislation accordingly to avoid such feelings when possible by allowing access to assisted death. Furthermore, it is noted that an objective interpretation of dignity for assisted death might have dangerous consequences in eventually normalising and accepting involuntary euthanasia.

3.5 The Morality of Suicide

It is important to consider why assisted suicide remains illegal in England and why past reform attempts were unsuccessful\(^\text{164}\) while suicide ceased to be a crime in 1961.\(^\text{165}\) Currently, there are no legal repercussions for committing or attempting to commit suicide. It will be useful to establish if there is anything morally wrong with suicide even if it is not illegal. This discussion is important because it also affects the morality of assisted suicide. When people are criminalised for aiding someone’s suicide, it is morally imperative to inquire into the ethical basis of these social attitudes.\(^\text{166}\) If it is concluded that suicide is wrong then this would logically imply that assisted suicide is also wrong. But if suicide is judged to be morally not wrong, then the same argument would apply to cases of assisted suicide.

It must be noted that the morality of suicide does not necessarily indicate whether it should be criminalised or not. Criminalising something does not always mean that it is wrong in a moral sense. Driving over the speed limit,\(^\text{167}\) or drinking while underage,\(^\text{168}\) is illegal, but not typically considered immoral. According to negative legal moralism, the fact that certain conduct is not morally wrongful prevents its criminalisation, but moral wrongfulness does not necessarily provide a positive reason for criminalisation.\(^\text{169}\) It merely removes a barrier to criminalisation.\(^\text{170}\) The wrongfulness of a type of conduct is merely an ‘enabling’ condition or reason.\(^\text{171}\) It opens the way


\(^{\text{165}}\) Suicide Act 1961 s 1

\(^{\text{166}}\) Williams (n 21) 224

\(^{\text{167}}\) Road Traffic Act 1988 s 1

\(^{\text{168}}\) Confiscation of Alcohol (Young Persons) Act 1997 s 1


\(^{\text{170}}\) ibid 71

\(^{\text{171}}\) ibid 55
for positive reasons in favour of criminalisation, such as that criminalising this type of
conduct will prevent harm.\textsuperscript{172} A lot of things might be immoral, such as breaking a
promise to a friend, or cheating on your partner, but this does not mean that they
should be illegal. Thus, even if suicide is morally wrong, this does not suggest that
there are sufficient reasons to make it and assisted suicide criminal.

The decriminalisation of suicide does not mean that the philosophical conflicts on
suicide have been entirely settled after such a long history of disapproval. The issue
of whether suicide is moral or not is a complex one. Religious condemnation of suicide
can be traced back to ancient times.\textsuperscript{173} Both the ancient Greeks and Romans depicted
suicide as wrong.\textsuperscript{174} Suicide was also forbidden by Judaism, and this view was later
adopted by the Christian Church, which influenced Islam.\textsuperscript{175} In the past, people in
England who were successful in killing themselves and could not be directly punished
by the legislation were subject to a degrading non-Christian burial without clergy,
mourners or prayers.\textsuperscript{176} Also, their family indirectly suffered as they were stripped of
their belongings which were handed to the Crown.\textsuperscript{177} William Blackstone argued that
the criminalisation of suicide in England was a right religious rule to forbid men from
destroying their life without the commission of God.\textsuperscript{178} This follows the reasoning that
since God has given us a life we ought to not commit suicide.\textsuperscript{179}

It is evident that in our history of debate about the morality of suicide, religious
arguments have been very influential. However, today we are progressively more able
to challenge and question theological traditions. We can acknowledge that religion
should not shape the law in today’s modern secular society, as religion is based on
faith rather than reason. We must not allow our legal ideology and morality to be
absorbed in theology. We must use logic, reason and evidence to design our legal
rules. This also implies, however, that we should not dismiss an idea simply because

\hspace*{1em}\textsuperscript{172} ibid 55
\hspace*{1em}\textsuperscript{173} Williams (n 21) 226
\hspace*{1em}\textsuperscript{174} ibid 226
\hspace*{1em}\textsuperscript{175} ibid 225
\hspace*{1em}\textsuperscript{176} Gerry Holt, ‘When suicide was illegal’ BBC News (3 August 2011)
\hspace*{1em}\textsuperscript{177} ibid
\hspace*{1em}\textsuperscript{178} William Blackstone, \textit{Commentaries on the Laws of England} (New York, Legal Classics Library,
1775)
\hspace*{1em}\textsuperscript{179} Williams (n 21) 238
it has theological roots. The origins of an idea do not imply anything about its merits. Although a lot about the morality of suicide comes from religion, this is rejected as a valid current consideration on its morality, and it will be disregarded for this discussion based on the assumption that is not a relevant consideration. Thus, the morality of suicide needs to be further considered, from a non-religious perspective.

Historically it was considered that human life belonged to the king or the state.\textsuperscript{180} Citizens were the objects of the King to enrich their master, and thus to kill themselves was a felony.\textsuperscript{181} One who killed oneself was guilty of an offence against the King who had an interest in the preservation of all his subjects.\textsuperscript{182} Williams noted that suicide’s criminalisation was developed by medieval judges to enrich the royal treasury and please the king.\textsuperscript{183} However, today the role of the monarch has substantially changed to a more ceremonial and formal one.\textsuperscript{184} Political power is now mostly exercised by the Parliament.\textsuperscript{185} Thus, the argument that suicide is an insult to the monarch or the state cannot translate to the modern era as it used to.

Williams notes that Thomas Aquinas also argued that suicide is wrong because it is contrary to human natural inclinations.\textsuperscript{186} Williams convincingly rejects this argument, by claiming that if suicide was contrary to human natural inclinations, it would simply not occur.\textsuperscript{187} We have many examples of people wanting to put an end to their lives, which shows that suicide is precisely a natural inclination. Even when it was penalised it never stopped.\textsuperscript{188} People who are determined to die are not likely to stop because of the fear of prosecution as if they succeed no one could punish them.\textsuperscript{189} Suicide’s criminalisation might only manage to make the offender try harder to succeed at the first attempt so they are not punished.\textsuperscript{190} Although today assisted suicide is illegal

\begin{thebibliography}{188}
\bibitem{180} Glover (n 2) 171
\bibitem{181} Williams (n 21) 245
\bibitem{182} Blackstone (n 178)
\bibitem{183} Williams (n 21) 248
\bibitem{184} Politics, ‘Monarchy’
https://www.politics.co.uk/reference/monarchy/ accessed 14 July 2021
\bibitem{185} ibid
\bibitem{186} Williams (n 21) 237
\bibitem{187} ibid 237
\bibitem{188} ibid 247
\bibitem{189} ibid 247
\bibitem{190} ibid 247
\end{thebibliography}
domestically, many Britons take the risk and travel to Switzerland to right-to-die organisations such as Dignitas to be assisted in suicide. Nonetheless, even if we were to accept that suicide is not natural behaviour that does not necessarily make it wrong. This seems like an argument which in essence relies on the illegitimate deduction of a must from an assumed is.

A related argument is that suicide is unnatural because it is against the most basic rule of evolution which is to survive and reproduce. But this does not necessarily imply that it is wrong. Many things are unnatural and are not considered immoral or illegal. An example of this might be contraception. Nonetheless, it is currently readily available through the NHS. Thus, Aquinas’s argument is not enough to indicate either that suicide is wrong or that it should be illegal. The criminalisation of suicide seems cruel. It seems unreasonable to morally condemn someone simply because they believe that their chances of finding happiness are so slender that they prefer to face pain and death to cease living.

Furthermore, Williams rejects the argument that suicide is immoral because we are depriving society of our presence and activity. This would only hold validity if we were living in a perfect society. In reality, however, people often kill themselves because of the very imperfect societies in which they are condemned to live, which prevent them from leading any form of creative life. When our circumstances are such that we cannot project into a future we hope for, it will be morally acceptable to take our own life. Considering all suicides as immoral because society is deprived of our activity is somewhat extreme. Thus, the fact that by suicide we are abandoning our duties to the state is not a valid reason to make it immoral.

---

193 Williams (n 21) 247
194 ibid 248
195 ibid 237
196 ibid 242
197 ibid 242
Nonetheless, regardless of whether suicide is or is not morally wrong, we often cannot blame people for choosing it. Instead of condemning suicidal individuals, it seems better to acknowledge that they might face mental health problems like depression, and thus they have this attitude of self-destruction. Glover notes regarding suicide that it is often linked to mental disturbance.\textsuperscript{198} This leads to another approach to the rightness of suicide, besides thinking of the autonomy and best interests views of saying that you are not taking this decision with a sufficient level of understanding. The decision of suicide was taken from an epistemic standpoint of suffering unbearably or having a life-changing injury and not thinking clearly of what the possibilities are for the future. This is more an argument on the validity of the decision of arguing that you are not able to process all the relevant information at the moment well enough to make a suicidal decision. This inability of processing information to make suicidal decisions can be also seen in the parliamentary debates regarding the Suicide Act of 1961.\textsuperscript{199} It was argued that individuals contemplating suicide need a great deal of help, medical attention, spiritual guidance and advice.\textsuperscript{200} Such measures are desirable since often news about a serious illness or a life-changing disability can cause severe depression and lead to suicide attempts.\textsuperscript{201} Impaired cognitive function is one of the characteristics of a depressive disorder.\textsuperscript{202} This involves a rigid tendency to see only one possible solution, such as suicide.\textsuperscript{203} It is thus important to acknowledge that the appropriate help should be given to those people. Nonetheless, this is not absolute and there needs to be some recognition that not every person thinking of suicide is mentally ill. Although it is right to consider potential mental problems when someone wants to die, it is essential not to presume that they are present.

\begin{itemize}
  \item \textsuperscript{198} Glover (n 2) 171
  \item \textsuperscript{199} ibid 171
  \item \textsuperscript{200} Mr Eric Fletcher HC Deb 28 July 1961 vol 645 cols 824-825
  \item \textsuperscript{201} Mental Capacity Act 2005 s 1(c)
  \item \textsuperscript{203} ibid 1614
\end{itemize}
Glover argued that when possible one must strive to save the maximum number of worthwhile lives.\textsuperscript{204} Thus, when someone with a worthy life wants to kill themselves, it is legitimate to reason with them and try to persuade them to rethink their decision.\textsuperscript{205} Where this is successful, it might prevent the loss of a worthwhile life.\textsuperscript{206} He also clarifies that this proposition is not an intrusion into autonomy, as reasoning does not mean prohibiting suicide.\textsuperscript{207} There needs to be caution since if this were to take the form of repeated interventions, it would be violating autonomy.\textsuperscript{208} Accordingly, for a capable person, an intervention should give them the chance to think again, but if they insist on their original idea of killing themselves, we should accept it in the light of respecting personal autonomy.\textsuperscript{209} This suggestion by Glover represents an acknowledgement that not every person contemplating death has mental issues. It is important to reason with someone who wants to commit suicide. However, if they insist, they should not be prevented as it might be a competent and well-thought out decision. Thus, they should be allowed to exercise their right to personal autonomy and commit suicide.

Consequently, upon considering the above arguments it is concluded that suicide is not morally wrong. Thus, assisted suicide is not morally wrong either. While historically religious arguments have been very influential in this debate, they are rejected as they are not currently valid considerations in modern secular society. We must use logic, reason and evidence to design our legal rules. From a non-theological viewpoint, the historical argument that suicide is an insult to the monarch or the state cannot translate to the modern era as it used to. It is also rejected that suicide is generally against our human inclinations and is unnatural, as if this was the case it would not occur. It seems unreasonable to morally condemn someone simply because they believe that their chances of finding happiness are so slender that they prefer to face pain and death to cease living. Finally, considering suicide as immoral because society is deprived of what we can offer through our activity seems also an extreme argument and not a valid reason to render it immoral.

\textsuperscript{204} Glover (n 2) 176
\textsuperscript{205} ibid 177
\textsuperscript{206} ibid 177
\textsuperscript{207} ibid 176
\textsuperscript{208} ibid 176
\textsuperscript{209} ibid 177
3.6 Compassion

Sometimes when some individuals see their loved ones suffer unbearably, they decide to perform either voluntary or involuntary euthanasia, or assist their loves ones’ suicide to relieve their suffering. For example, Frances Inglis was a mother who was convicted for murdering her son who was in a vegetative state due to serious head injuries.\textsuperscript{210} Inglis who wished to end her son’s suffering made two attempts to kill him by injecting him with heroin, succeeding the second time.\textsuperscript{211} Another example that happened the same year as Inglis is the case of Kay Gilderdale who was prosecuted for attempted murder for her role in her seriously ill daughter’s suicide.\textsuperscript{212} After suffering a severe form of ME which left her bedridden and unable to speak or feed herself for all of her adolescent and adult life, Lyn Gilderdale wanted to ensure her life would end before total degeneration robbed her of all dignity.\textsuperscript{213}

It is often said that people in these cases are led by strong compassionate feelings of not bearing to see their loved one in serious suffering.\textsuperscript{214} This discussion on compassion is relevant for this thesis as a person’s compassionate motives seem to make a significant difference to their culpability. A person who assists another’s death or suicide out of compassion seems significantly less culpable than a person who is acting out of other motives that we normally think about in homicide cases. Someone who kills for money and a mother who kills her child out of compassion because she cannot bear to see them in suffering should not be treated the same way. Those who kill for money despite the availability of reasonable alternatives for them, display a disregard for other persons, for the law, and for the social principles the law attempts to protect.\textsuperscript{215} On the other hand, an offender who kills out of compassion does not

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{210} \textit{R v Inglis} [2011] 1 W.L.R. 1110
  \item \textsuperscript{211} ibid
  \item \textsuperscript{213} ibid
  \item \textsuperscript{214} Amanda Clough, ‘Mercy Killing: Three’s A Crowd?’ (2015) 79(5) Journal of Criminal Law 358, 358
  \item \textsuperscript{215} ibid 314
\end{itemize}
\end{footnotesize}
necessarily exhibit such disregard. This will be further discussed in chapter 6 when the idea of a compassionate killing offence/defence will be constructed.

It is thus important to consider what compassion is. Feenan noted that it is one of the most politically charged emotions. Compassion has historically been an important topic of legal study, often reflected in the theoretical and conceptual analysis of the law. However, defining the exact meaning of compassion is hard as it has a contingent evolutionary and cultural history, making it open to different interpretations. Many scholars have debated the meaning of compassion, often using different or equivalent terms at different times. Today under the DPP’s guidelines, although compassion is taken into consideration in prosecution decisions, no exact definition is provided.

According to Keating and Bridgeman compassion is an altruistic emotion, which, unlike the heat of passion or anger, reflects well on the person who experiences it and acts upon it. Duff notes that compassion is naturally included in human relationships and is expressed through the disposition to be moved by and identify with others’ suffering, especially those close to us, like our loved ones. Lazarus treats compassion as ‘feeling personal distress at the suffering of another and wanting to ameliorate it’. One of the most famous accounts of compassion derives from Martha Nussbaum’s analysis of Aristotle’s examination of pity in Rhetoric. She identified the three components of compassion as a belief that the suffering is serious rather than trivial; a belief that this suffering was not caused primarily by the person’s culpable actions; and thirdly a belief that the pitier’s possibilities are similar to those of the sufferer.

---

216 Dermot Feenan, ‘Law and compassion’ (2017) 13(2) International journal of law in context 121, 122
217 ibid 122
218 ibid 122
219 Law Commission, Murder, Manslaughter and Infanticide (Law Com. No. 304, 2006) para 7.7
220 Chapter 2.2.2, Table 1
221 Feenan (n 216) 122
224 Richard S. Lazarus, Emotion and Adaptation (New York, Oxford University Press, 1991) 289
Compassion is closely linked to suffering. However, Nussbaum’s second criterion that the suffering was not caused primarily by the person’s culpable actions seems unconvincing. A person can feel compassion even if the suffering was caused primarily by the person’s culpable actions. A parent is not going to fail to feel compassion for their child who was left paralysed in a car accident due to their carelessness.226 Furthermore, Nussbaum’s third criterion, claiming that the pitier’s possibilities are similar to those of the sufferer, seems somewhat problematic. Firstly, it should be noted that the word ‘pitier’ does not seem appropriate in this context. This is because according to Brian Carr someone who feels pity instead of compassion is not experiencing the option of ‘feeling with’ the sufferer.227 Therefore it has a somewhat disapproving aspect of superiority similar to mercy.228 It involves the actor feeling superior to the sufferer and thus contains a sense of condescension, contrary to compassion’s feeling of shared humanity.229 Often, compassionate killing of a loved one to end their suffering is called ‘mercy killing’.230 But just as the word ‘pity’ is not appropriate, ‘mercy killing’ is also not the most suitable concept to use. Opposed to compassion, mercy has a sense of superiority and condescension, making ‘mercy killing’ not helpful language for this thesis.

Furthermore, the second problem with Nussbaum’s third requirement is that it suggests that compassion involves an appreciation of another’s suffering and not a sharing of it. Therefore, one does not need to believe that the afflicting condition could happen to oneself.231 One might have compassion for someone suffering napalm burns without believing that there is any possibility of oneself being in that condition.232 This means that compassion involves viewing the other person and their suffering in a sense of shared humanity, of regarding the other as a fellow human being.233 Thus, the other person’s suffering, and not necessarily their particular afflicting condition, is

---

226 Keating and Bridgeman (n 222) 715
227 Brian Carr, ‘Pity and Compassion as Social Virtues’(1999) 74(3) Philosophy 411, 429
228 Nussbaum (n 225) 29
229 Lawrence Blum, ‘Compassion’ in Robert B. Kruschwitz, Robert C. Roberts (eds), The Virtues: Contemporary Essays on Moral Character (Belmont, Wadsworth,1987) 230–231
229 Clough (n 214) 358
231 Carr (n 227) 421
232 ibid 422
233 ibid 424
seen as the kind of thing that could happen to anyone, including oneself insofar as one is a human being.\textsuperscript{234} Consequently, at the basis of compassion lies identification with the sufferer as a fellow human being, a recognition that similar misfortunes may also befall one, insofar as one is human.\textsuperscript{235} In this sense, compassion refers to the feeling of identification and sympathy towards someone who is in serious suffering, along with active regard for their good.

It is easy to accept that someone will feel compassion for someone close to them, such as a loved one. But it is harder to accept the same in a professional relationship.\textsuperscript{236} Loved ones often experience emotional pain along with the sufferer with whom they have a close bond.\textsuperscript{237} While there might be some cases of medical professionals who might experience compassion, usually the only bond that they have with the sufferer is that of a duty of care.\textsuperscript{238} This, in relation to the unique nature of their job in which they are often faced with death leads to the conclusion that the sufferer’s condition is usually unlikely to have the necessary emotional and psychological impact to cause them compassionate feelings.\textsuperscript{239} This is why compassionate killing and compassionately led assisted suicides are identified as those performed by loved ones and not medically trained individuals.

It must be noted that sometimes someone might experience compassion for a stranger merely as a fellow human being who is suffering. This is evident from the interpretation of Nussbaum’s final requirement that compassion involves a sense of identification with and sympathy for the sufferer. However, according to Del Mar, an assessment of compassion would necessarily involve knowledge, as it requires an understanding of what another person is experiencing and the situation in which they are experiencing it.\textsuperscript{240} Biggs noted that compassion provokes a subject-oriented approach that pays

\textsuperscript{234} ibid 424
\textsuperscript{235} Alexandra Mullock, ‘Overlooking the Criminally Compassionate: What are the implications of prosecutorial policy on encouraging or assisting suicide?’ (2010) 18(4) Medical Law Review 442, 453
\textsuperscript{236} Keating and Bridgeman (n 222) 717
\textsuperscript{238} ibid 106
\textsuperscript{239} ibid 106
\textsuperscript{240} Maksymilian Del Mar, ‘Imagining by Feeling: A Case for Compassion in Legal Reasoning’ (2017) 13(2) International Journal of Law in Context 143–157
heed not just to the person’s perceived suffering, but also to their attitude to suffering.\textsuperscript{241} Being able to evaluate the sufferer’s circumstances is the basic component of compassion, as they are salient to, and a subject of concern for, the observer.\textsuperscript{242} Such an understanding, being able to evaluate the circumstances in which the suffering is felt, is common in close relationships of love, care and affection. Loved ones are often familiar with the extent of pain the sufferer faces in their everyday life. They can assess whether the suffering could be alleviated to levels acceptable to the sufferer and whether there are future possibilities of flourishing.

Sometimes we might feel compassion for someone that we have never met, such as a homeless person. Nonetheless, there is something about the extent or the depth of this feeling. Compassion can be either appropriate or inappropriate according to the circumstances.\textsuperscript{243} It is not a proper expression of compassion for someone who watches children starving in a television program to travel to their country to take their life. The feeling that leads to the action of compassionate killing or compassionately led assisted suicide by a loved one is much deeper than that of strangers. Someone could indeed feel compassion for someone they never have met, but taking the step to assist a loved one to die is a proper expression of that compassion while aiding a stranger is not.

Consequently, it is acknowledged that compassionately motivated actors in assisted death cases seem to be differentiated in terms of culpability from other offenders in the law of homicide and this should be recognised in future legislative reform. Compassion was defined as the feeling of identification and sympathy towards someone who is in serious suffering, along with active regard for their good. We can feel compassion even for people we have never met. However, only assisting a loved one to die will be a proper expression of our compassion due to the knowledge, love and affection that it is due to our close relationship.

\textsuperscript{241} Hazel Biggs, ‘From dispassionate law to compassionate outcomes in health-care law, or not’ (2017) 13(2) International Journal of Law in Context 172, 176
\textsuperscript{242} Del Mar (n 240) 143–157
\textsuperscript{243} Duff (n 223) 210
3.7 Trust

Another concept that is particularly important for assisted death is that of trust. Trust is often defined as bonds between individuals and having confidence in your relationship.\textsuperscript{244} It is also linked to concepts such as fidelity, competency, integrity and familiarity.\textsuperscript{245} It is a key, multidimensional component of interpersonal relationships, financial interactions, organisations, social networks, and society more generally.\textsuperscript{246} It is a notion which underpins every relationship, including marriages, friendships or relationships with professionals.\textsuperscript{247} The focus here is in trust relationships between medical professionals and those who seek their advice or help in euthanasia or assisted suicide. As described in the previous chapter, many cases of euthanasia and assisted suicide are performed by physicians.\textsuperscript{248}

Foreign jurisdictions with right to die legislation only allow euthanasia or assisted suicide under the condition that it is performed by a trained physician.\textsuperscript{249} Under the Dutch Act 2001, physicians are allowed to perform euthanasia or assisted suicide provided they complied with a set of ‘due care’ criteria.\textsuperscript{250} Under the Belgian Act on Euthanasia 2002, a physician who performs euthanasia or assisted suicide does not commit a crime if they follow certain conditions.\textsuperscript{251} In Switzerland, almost all assisted suicides involve the self-administration of a lethal dose of barbiturates, prescribed by a requestor’s family physician or by a physician affiliated with a right-to-die organisation.\textsuperscript{252} In Oregon, physicians are permitted to prescribe lethal drugs to terminally ill adult residents of Oregon.\textsuperscript{253} Finally, Canada legalised physician-assisted dying, which includes both euthanasia and assisted suicide.\textsuperscript{254}

\textsuperscript{244} James Coleman, \textit{Foundations of Social Theory} (Cambridge, Harvard University Pres, 1994) 116
\textsuperscript{245} ibid 116
\textsuperscript{246} Adam S. Wilk and Jodyn E. Platt, ‘Measuring physicians’ trust: A scoping review with implications for public policy’ (2016) 165 Social Science and Medicine 75, 75
\textsuperscript{247} Peter Watkins, ‘Euthanasia – the erosion of trust?’ (2005) 5(2) Clinical medicine 93, 93
\textsuperscript{248} Chapter 2.2
\textsuperscript{249} ibid
\textsuperscript{250} Dutch Act (n 64)
\textsuperscript{251} Belgian Act on Euthanasia (n 65) s 3
\textsuperscript{253} Oregon Revised Statutes § 127.800
\textsuperscript{254} Carter v Canada (Attorney General), 2015 1 SCR 331
A strong trust bond between a physician and the patient is essential to the success of any medical consultations between them. Trust is what enables and encourages open and frank communication as well as treatment compliance. These are critical for managing the complex relationship and procedures that physicians and patients navigate. The physician is the expert in their field and the patient trusts the physician to do the right thing for them based on their knowledge. Their trust bond could be better explained by using the analogy of a fiduciary and a beneficiary. The physician is like a fiduciary and the patient is like a beneficiary who trusts the physician, who has the power to affect their interests and should act to their benefit. The physician is the one who has the power of knowledge in their relationship, and the patient trusts them to use this knowledge for their benefit. Therefore the person who is the beneficiary entrusts the fiduciary with a power that may affect their interests in the belief that it will be exercised only for their benefit.

It is evident from this analogy that this relationship is one-sided, as the beneficiary should entrust the fiduciary and not vice versa. Patients should trust their physicians to act for their welfare. This happens perhaps because in the past physicians enjoyed almost complete autonomy over their scope of practice and broad claim to expertise. It was thus expected implicitly that physicians were the dominant professionals, and would act in the best interests of their patients, manage ‘subordinated’ professionals fairly, and use health care and health care financing resources responsibly. Thus, it is not surprising that the patient was perceived as more passive in their relationship as the receiver of information and direction from the expert physician. Today things have changed, as physicians often share decision-making with patients and fellow care providers. Also, coordination and team-based care processes are encouraged. It is also important that physicians have been more
the subject of managerial authority, utilisation management protocols, and quality measurement regimes integrated into electronic health record systems and reporting tools.263

Particular legal or ethical rules are necessary to support and encourage this trust.264 The law is the facilitator of this trust relationship. This is evident under the Mental Capacity Act 2005 which states that an act or decision made for or on behalf of a person who lacks capacity must be based on their best interests.265 This ensures that a relationship of trust is maintained as the physician should act in a patient’s best interests. The Hippocratic Oath states ‘I will use treatments for the benefit of the ill in accordance with my ability and my judgment, but from what is to their harm and injustice I will keep them’.266 Similar commitments are evident through the notions of non-maleficence and beneficence, which the physician must consider together to produce a net benefit for their patients with minimal harm.267 Non-maleficence means that one has an obligation not to intentionally harm others, whilst beneficence means that one has a duty to act for the benefit of others.268 These commitments are evident in cases of withdrawn or withheld futile treatment from incompetent patients. According to these principles, if the only effect of maintaining life-sustaining treatment is to prolong a patient’s suffering, it is better to withdraw treatment as it would have the least harmful effects.269 This is why the relationship between physicians and patients’ has been often described as a healing relationship, since the physician restores the patient to health, or assists the patient in coping with illness, or disability.270

In the discussion about the legalisation of assisted death, there have been intense concerns regarding potential damage to the relationship between physicians and

263 ibid 75
265 Mental Capacity Act (n 201) s 1(5)
266 William Henry Samuel Jones, The Doctors Oath (Cambridge, Cambridge University Press, 1924)
267 Tom Beauchamp and James Childress, Principles of Biomedical Ethics (Cary, Oxford University Press 2001) 113
268 Raanan Gillon, ‘Medical ethics: four principles plus attention to scope’ (1994) 309(6948) British Medical Journal Publishing Group 184
269 Chapter 2.5
those requesting to die. It is believed by the opponents of legalisation of assisted death that a change in the law to allow physician-assisted dying would have profound implications for their role, responsibilities and their relationship. If a physician decides to discuss the possibility of assisted death, the patient might potentially feel abandoned and lose their trust in the physician. They might feel that their physician no longer feels the need to explore other treatments options with them and they would be better off dead. They might perceive this discussion for assisted death as an attitude of avoiding and not confronting issues of dependence and suffering around the time of death. However, similar problems of mistrust might be encountered by physicians who deny access to assisted death. Requestors might feel equally abandoned by the physician to a life of unbearable suffering without being offered any adequate alternative to relieve their pain because the physician fails to appreciate and understand the severity of their pain.

As is evident from the definitions of euthanasia and assisted suicide, they require a competent request for death. The physician is just complying with that request. Supporters of assisted death will argue that in such occasions where the physician is aiding the requestor to fulfil their wishes and prevent them from experiencing further suffering their trust relationship will be promoted rather than damaged. The legalisation of assisted death will prevent and control the experience of further pain and intense suffering rather than facilitate it. By providing assisted death, the physician fulfils the requestor’s wishes and maintains their trust.

Nonetheless, especially today when physicians no longer enjoy the most dominant role in medical relationships it is important to take into consideration concerns about potential harm in their relationship if assisted death was allowed. Certain safeguards

272 Ibid 115
273 Chapter 2.2
could be enforced to shield this trust bond. A potential way to minimise the possibility of harming the relationship of trust when a physician decides to discuss the option of assisted death is to ensure that this discussion comes as a part of continuous consultation and treatment. A physician, when under the impression that one of their patients is suffering unbearably, normally discusses their health condition, treatment options and any alternatives such as comfort care, hospice care, and pain-control options. Part of this consultation could be to provide information on the process of assisted death.

A physician who proposes assisted death, without first ensuring that all other options for a better quality of life have been considered, might seem unreliable and incapable of addressing our needs. Such a safeguard will better ensure that trust is maintained as physicians will seek to ensure that all other options are exhausted. Thus, assisted death should be an option of last resort, and not an alternative to other means of medicine, but a part of a continuum of medical treatment and palliative care. We will not feel abandoned at a time when we need care the most. Such measures have been implemented in jurisdictions with assisted death legislation. In the Netherlands, it is ensured that suitably qualified physicians are available to give expert advice on assisted death and to act as independent consulting physicians. In Canada to receive medical assistance in death, ‘you must be informed of available and appropriate means to relieve your suffering, including counselling services, mental health and disability support services, community services, and palliative care’.

Another safeguard that would be useful in future legislation on assisted death is to require the physician to have a close relationship with the requestor and to know their

---

277 Oregon Revised Statutes (n 253) § 127.815.
279 Baron et al (n 276) 1
280 ibid 1
medical history. As was noted by the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill 2004 such a physician would know a lot about the requestor, ‘not only from a medical standpoint but from a behavioural standpoint’. This will better ensure the relationship of trust as it will be more likely that the physician is acting according to the requestor’s best interests. They will know the requestor’s medical history and will be able to better assess whether their suffering is unbearable. This also addresses the concerns that physicians who do not know the requestor may act too quickly in discussing assisted death, without considering their personal needs and medical history.

Thus, it is evident from this discussion that trust is a very important concept for physician-performed assisted death. It is a valid concern that assisted death’s legalisation might create mistrust between physicians and patients who might feel abandoned. Hence, particular legal rules and safeguards are necessary to support and maintain the trust between physicians and those requesting to die in end-of-life decisions. A request to die is an important component in ensuring that assisted death fulfils the requestor’s wishes and maintains rather than undermines their relationship of trust. Also, it is important in maintaining this trust to ensure that the option of assisted death comes as part of continuous consultation and treatment and not an alternative to it. Physicians must ensure that all other options have been exhausted before proceeding to offer assisted death. Furthermore, it will be beneficial to strengthen their trust relationship when considering assisted death to require physicians to have a close relationship with the requestor and to know their medical history.

Nonetheless, it is important to distinguish that even with the enforcement of such safeguards, there will still be possibilities for breaking the relationship of trust between physicians and requestors when the latter are offered assisted death or denied access to it. This is something that we need to accept if assisted death is ever to be legalised.

---

283 Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL] Vol I (2004-05, HL86-1) 159
284 ibid 29
285 Timothy Quill, Death and Dignity; Making Choices and Taking Charge (New York, WW Norton, 1993) 162-63
Trust can be damaged by other end-of-life decisions that are currently allowed, such as withdrawal and withholding of life-sustaining treatment or hastening death through palliative medication. While in omissions cases the patient is unconscious, and thus there is no trust bond as such, it could be an example for conscious individuals who will lose trust thinking that faced with the same circumstances their physician would withdraw their treatment.

3.8 Slippery Slope concerns

Slippery slope arguments – that is, arguments about the risks of undesirable consequences that may occur if the law on assisted death were relaxed – have been much discussed in the relevant literature. Slippery slope arguments posit that accepting a certain desirable standard might lead to the subsequent acceptance of a standard that is ‘undesirable’. The slope is described as being ‘slippery’ because no matter where one decides to draw the line between the desirable and the undesirable consequences, it is impossible to hold it. One of the most common distinctions drawn among slippery slope arguments is between the empirical and logical perspectives. These are very different as one is an empirical prediction, while the other is an argument for a relevant similarity between two different cases.

Some critics of the slippery slope argument have claimed that using either the logical or the empirical perspective promotes ‘an air of self-defeat’. Sometimes it could be hard acknowledging bad from good arguments and we might end up accepting both without questioning. Fumagalli argues that we ‘are demonstrably bad’ in understanding the behaviour that we will or will not be able to abide by. Our ability

---

286 Chapter 2.5 and 2.6
287 Keown (n 7) 67
289 Frederick Schauer, ‘Slippery Slopes’ (1985) 99(2) Harvard law review 361, 378
290 Anneli Jefferson, ‘Slippery Slope Arguments’ 9(10) (2014) Philosophy compass 672, 672
291 ibid 672
292 Roberto Fumagalli, ‘Slipping on slippery slope arguments’ (2020) 34 (4) Public Health Ethics 412, 415
293 ibid 415
294 ibid 415
to differentiate between bad and good arguments largely depends on the circumstances and how obvious the links between two activities or the expected consequences are. Nonetheless, this does not mean that we should avoid using the slippery slope argument altogether. Jones argued that it is better to examine the connection between two different kinds of conduct in their own right.\textsuperscript{295} It is therefore worth assessing the validity of slippery slope arguments in the specific context of assisted death.

3.8.1 The ‘Logical’ argument and assisted death

The logical argument is concerned with the question of what the decision to take a certain step logically commits us to.\textsuperscript{296} Once a certain practice is accepted then we are committed to accepting other unacceptable practices since there are no good reasons against these once we have taken the all-important first step.\textsuperscript{297} The premises that underlie the acceptance of A logically entail the acceptance of B.\textsuperscript{298} The acceptance of A will lead to the acceptance of A1, as A1 is not significantly different from A. A1 will then lead to A2, A2 to A3, and eventually, the process will lead to the unacceptable B.\textsuperscript{299} This version of the argument does not say that there is no significant difference between A and B but instead argues that it is impossible to justify accepting A while also denying B.\textsuperscript{300}

According to the logical argument, if we allow one form of voluntary assisted dying, then we logically ought to allow non-voluntary cases where people are unable to consent.\textsuperscript{301} According to Keown any law permitting assisted death to those requesting it and experiencing intense suffering would be the first step onto a slippery slope, by raising logical dilemmas.\textsuperscript{302} A slide from voluntary active assisted death to non-voluntary assisted death is unavoidable, because the case for assisted death with

\begin{thebibliography}{9}
\bibitem{295} Jones (n 266) 386
\bibitem{296} Jefferson (n 290) 673
\bibitem{297} James Rachels, \textit{The End of Life: Euthanasia and Morality} (Oxford, Oxford University Press, 1986) 172-173
\bibitem{298} Jefferson (n 290) 673
\bibitem{299} Glover (n 2) 166
\bibitem{300} ibid 166
\bibitem{301} Keown (n 7) 77
\bibitem{302} ibid 77
\end{thebibliography}
those limitations is also, logically, a case for assisted death without them. Permitting assisted death for those experiencing intense suffering logically implies that these lives are worth less than others, and we are logically committed to permitting the ending of these lives even without a death request. Keown conceptualises the physician’s conduct as pivotal as he thinks their judgement is the real justification for voluntary assisted death and not the autonomous request or a combination of these.

However, Keown’s logical argument has not been widely accepted. Jones noted that it is the autonomous wish, and not the physician’s judgement, which is pivotal. Assisted death could not be extended to incompetent individuals as they do not have the mental capabilities to make such a request. Thus, autonomy provides a foothold that prevents a slide down the slope. Keown anticipated such objections and argued that if autonomy is the important element, then it is questionable how any person who autonomously asks to die could be denied that wish. Then we would logically accept all competent requests and intense suffering would not be a requirement.

Nonetheless, we tend to respect autonomy to decide as long as the patient can make an informed choice. We are often content to have physicians make decisions in incompetent people’s best interests, as in double effect cases. Thus, according to Keown’s argument if assisted death followed these rules of medical consent we could end up leaving physicians the power to decide whether death is right for us. Keown’s concerns relate particularly to euthanasia where the final act of killing is performed by someone else. Then we risk that physicians would judge certain lives to be not worth living regardless of consent. Regardless of which side of Keown’s logical argument we follow, either of downplaying autonomy to a rhetorical tool or increasing autonomy to an absolute right, assisted death will logically lead to the acceptance of practices that we would not endorse.

---

303 ibid 77
304 ibid 76
305 Jones (n 266) 399
306 Keown (n 7) 79
307 ibid 79
308 ibid 77
309 Chapter 2.4 and 2.6
However, as Smith rightly noted, this logical dilemma and the risk of slippage seem to arise only when unbearable suffering and autonomy are considered separately.310 When requiring both elements together no slippery slope is likely.311 Lillehammer also suggests that Keown’s argument confuses a necessary condition with a sufficient condition.312 A condition may be necessary but not sufficient because additional conditions must occur before the state of affairs comes to be.313 This thesis uses the argument that life can be overridden by a combination of an autonomous death request and that being in the requestor’s best interests due to intense suffering. Thus, both best interests and autonomy are individually necessary conditions for the permissibility of assisted death, but they must both be present if they are to be sufficient.314 Thus, there is no logical requirement that, by allowing assisting death, we should allow killings that are either not requested or not in a person’s best interests.

However, perhaps Keown is making a different argument, that autonomy and best interests are so different that they cannot exist together.315 There might indeed be occasionally some conflicts between these two notions, such as when there is an autonomous treatment decision but the physician disagrees.316 Nonetheless, this does not mean that these are incompatible.317 Personal choices and decisions must not necessarily be made by one person and one person alone.318 Many choices may require the agreement of another person to reach the desired state of affairs and each component may still involve an autonomous decision, such as a contractual relationship.319 Since physicians usually play a prominent role in assisted death they will have to make some judgement on the death request. Similar justifications may not be required in every case where a physician makes a judgement about an autonomous

311 ibid 232
313 ibid 548
314 ibid 548
315 Smith (n 310) 235
316 ibid 235
317 ibid 235
318 ibid 235
319 ibid 235
decision however, that is not to suggest that they are incompatible for assisted deaths.\(^{320}\)

Keown’s argument has been criticised for not following the definition of a slippery slope, even though he classifies it as such. There is some causal relationship present, as the argument seems to contain an assertion that voluntary assisted death and non-voluntary assisted death are not different. It is because they are the same that Keown suggests that they should be treated in the same manner. If they were different, this argument would lose its validity. Smith argued that Keown uses an argument of consistency and not a slippery slope argument.\(^{321}\) He alleges that voluntary assisted death and non-voluntary assisted death share a common criterion.\(^{322}\) This is either the physician’s judgement that life has no value or an autonomous request to die.\(^{323}\) It is the similarities between voluntary and non-voluntary assisted death on the relevant criterion that gives force to the argument, not a failure to abide by certain distinctions between them. Following this reason, all logical slippery slope arguments can turn easily into empirical ones. This seems somewhat to be part of Keown’s argument, as he claims that the autonomous request is merely a trigger to the physician’s judgement and thus an unimportant requirement that will be soon disposed of, which sounds more like an empirical prediction than a logical one.

How we characterise Keown’s argument is important because there is no reason to argue that we will fail to abide by the distinction between voluntary and non-voluntary assisted death if the argument essentially is that there is no relevant difference between them. But as Jones convincingly argues, since voluntary assisted death is acceptable, and non-voluntary assisted death is not, then there must be some relevant distinction between them.\(^{324}\) Thus, these seem to be different, and the argument that similar cases ought to be treated alike cannot be a justification for moving from the acceptable voluntary assisted death to the unacceptable non-voluntary assisted death.

\(^{320}\) ibid 235
\(^{321}\) ibid 229
\(^{322}\) ibid 229
\(^{323}\) ibid 229
\(^{324}\) Jones (n 266) 399
Thus, in this discussion, the logical slippery slope argument against allowing assisted death is rejected. It is true that if we follow Keown’s arguments of considering autonomy as merely a rhetorical tool or increasing autonomy to an absolute right, we are led to accept practices that we do not want to endorse. However, such risks exist only when unbearable suffering and autonomy are considered separately. The argument followed in this thesis for the legalisation of assisted death is that there must be both an autonomous death request and that being in the requestor’s best interests. Thus, there is no logical link to suggest that we will allow assisted deaths without their being requested or in our best interests. Furthermore, as has been noted, since voluntary assisted death is accepted and non-voluntary cases are not, they are essentially different and the logical argument that similar cases must be treated alike cannot justify a slippage from the former to the latter.

3.8.2 The ‘Empirical’ argument and assisted death

The empirical slippery slope argument warns that bad consequences will follow if a certain action is taken. It is an argument about what we will actually do and not about what we are logically committed to doing. The acceptance of A will in time lead to the acceptance of B. The slip is due to two important mechanisms. Firstly, due to a shift in our values, subsequent cases are treated similarly to a precedent but then also become precedents themselves, and over time, we move much further down the slippery slope than was initially intended. If we start finding voluntary assisted death acceptable, we will over time end up allowing non-voluntary cases too. Also, if we start killing people because of extreme suffering, we will eventually see no reason against killing them for other reasons too. The second mechanism causing an empirical slippery slope is that we will be unable to effectively draft, enforce and police any safeguards. Eventually, it will not matter how well regulated legislation on

---

325 Jefferson (n 290) 672
326 Rachels (n 297) 172-173
327 Keown (n 7) 72
328 Jefferson (n 290) 676
329 ibid 672
330 Rachels (n 297) 172-173
331 Keown (n 7) 72
assisted death might be, as we will resist any effective practical safeguards.\textsuperscript{332} Even if we try to use strict safeguards, ‘the goal will prove elusive if not impossible’,\textsuperscript{333} and assisted death would be extended to involuntary cases or individuals who are not in their best interests to die.\textsuperscript{334}

Both mechanisms depend on how accurate our predictions about the consequences of assisted death’s legalisation are. Although foreign jurisdictions with right to die legislation release annual reports with data on the cases they have had, an examination of these does not enable us to make a reliable prediction on the possibility of an empirical slippery slope if there were a relaxation of the law in England. There is no precise evidence to indicate whether there were cases of assisted death that violated the country’s criteria on an autonomous request and the requestor’s health condition. Under the Oregon Death with Dignity Act 2020 Data Summary, many interesting data are examined on participation in assisted death, the requestor’s characteristics, the number of attending physicians, and so on.\textsuperscript{335} But there is no evidence supporting an empirical slippery slope. It is mentioned that there were no referrals to the Oregon Medical Board for failure to comply with the legislation’s requirements in 2020.\textsuperscript{336} The previous year in Oregon only one physician was referred, but the reasons for this referral are not explained.\textsuperscript{337}

Similar vagueness in identifying an empirical slippery slope is evident from the evidence given in other jurisdictions. The Dutch Annual Report 2019 stated that the Regional Euthanasia Review Committee found four notified cases where the physician who performed euthanasia did not comply with all the due care criteria set out in the legislation.\textsuperscript{338} But this is less than 0.1\% of all notifications\textsuperscript{339} which seems a very small

\begin{itemize}
\item \textsuperscript{332} ibid 71
\item \textsuperscript{333} ibid 71
\item \textsuperscript{334} ibid 71
\item \textsuperscript{335} Public Health Division, ‘Oregon Death with Dignity Act 2020 Data Summary’ 7 https://www.oregon.gov/OHA/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx accessed 14 July 2021
\item \textsuperscript{336} ibid 7
\item \textsuperscript{337} ibid 7
\item \textsuperscript{339} ibid 19
\end{itemize}
percentage to indicate that following legalisation there was a shift in Dutch values or they were unable to follow the relevant guidelines leading to a slippery slope on assisted death. In the First Annual Report on Medical Assistance in Dying in Canada 2019, it is stated that in virtually all cases (99.1%) in which medical assistance in dying was provided, physicians reported that they had consulted directly with the requestor to determine the voluntariness of their request.\(^{340}\) Thus, the percentage of those that did not consult with the requestor was very small. More interestingly though, the Report stated that monitoring reports always come with limitations.\(^{341}\) A reason for this is that a written request was not required to be submitted to be assessed for assisted death.\(^{342}\) Thus, many cases of verbal requests that were assessed as ineligible were not captured in the Report.\(^{343}\) Such discussed limitations make this empirical evidence not entirely reliable, especially in decisively indicating an empirical slippery slope after the legalisation of assisted death.

Even if such statistical evidence were reliable, it would still make for an insufficient comparison to England.\(^{344}\) Often statistics do not tell us about other factors such as social feelings, the legal norms of the country, and cultural experiences.\(^{345}\) Thus, the inferences that are drawn from these statistics are often vague and largely speculative.\(^{346}\) England could experience different outcomes to other jurisdictions if we were to adopt similar legislation. Concerns about a change in attitudes that will lead to a slippery slope serve more to make us reflect on commonalities between the beginning and endpoint of the slope and social and psychological factors which make slippage more or less likely.\(^{347}\)


\(^{341}\) ibid para 2.4

\(^{342}\) ibid para 2.4

\(^{343}\) ibid para 2.4


\(^{345}\) ibid 205

\(^{346}\) Jefferson (n 290) 679

\(^{347}\) ibid 679
Due to the lack of reliable evidence for a potential slippery slope, we can try to look at the predictions of how slippage might occur and decide whether they look plausible. Predicting a change in our values for the worse which will lead to a slippery slope seems somewhat odd conceptually.\textsuperscript{348} This argument predicts that we will become unable to draw a moral distinction between cases that we currently see as clearly different.\textsuperscript{349} If we can see that voluntary assisted death is acceptable and involuntary assisted death is unacceptable, it is not plausible that we will lose this ability in the future.\textsuperscript{350} If we believe that assisted death is acceptable only when it is in our best interests to die, it is not plausible that in the future we will disregard this health requirement. Usually, we should be able to distinguish between likely and unlikely developments and the convincingness of slippery slope arguments is strongly dependent on how similar the starting point and the endpoint are perceived to be.\textsuperscript{351} There is no valid reason to assume a causal connection between legalising assisted death for voluntary requestors under extreme suffering beyond these criteria.\textsuperscript{352}

But even if there were a causal connection, there is no reason to believe that we would not be able to effectively guard potential legislation by using strict safeguards.\textsuperscript{353} Safeguards in the legislation on assisted death are used in many foreign jurisdictions. For example, under the Dutch Act, 2001 physicians can perform euthanasia and assisted suicide provided they comply with a set of ‘due care’ criteria.\textsuperscript{354} There is no valid reason to suppose that we will not manage to create and effectively enforce safeguards that shield against a slippery slope.

Keown noted that the burden is not on opponents of legalisation to prove a causal link between legalisation and abuse.\textsuperscript{355} Instead, the burden is on the proponents of legalisation to substantiate their claim that their proposals for assisted death can

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{348} ibid 676
\item \textsuperscript{349} ibid 676
\item \textsuperscript{350} ibid 676
\item \textsuperscript{351} ibid 676
\item \textsuperscript{353} Margaret Ottowski, ‘Getting the law right on Physician Assisted Suicide’ (2011) 3(1) Amsterdam Law Forum 127, 135
\item \textsuperscript{354} Dutch Act (n 64) s 2(1)
\item \textsuperscript{355} Keown (n 7) 81
\end{itemize}
\end{footnotesize}
effectively prevent mistakes, abuse, and slippage.\textsuperscript{356} But as explained, the evidence we have from foreign jurisdictions is not enough to indicate whether there is a slippery slope or not. Therefore discharging this burden will be hard. Arguing that any safeguards we could impose will be ineffective, we inevitably end up on a slippery slope ourselves, as we are essentially saying that we do not trust ourselves to follow the law. There is no reason to accept that we cannot trust ourselves to establish limits that can protect us. Nonetheless, even if such concerns about not effectively enforcing safeguards are valid, ‘grey area’ problems exist whenever we attempt to regulate anything and they are not enough to indicate against legalising assisted death.\textsuperscript{357}

Thus, the empirical slippery slope argument is also rejected. There are no reliable data from jurisdictions with assisted death legislation to reliably predict an empirical slippery slope upon relaxation of the law in England. But even if there were such data, England could experience different outcomes to other jurisdictions. Generally, predicting a change in our values for the worse which will lead to a slippery slope seems somewhat odd conceptually. There is no reason to believe that if assisted death is legalised, we would not be able to effectively create and follow strict safeguards to protect us against a potential slippery slope.

3.9 Conclusion

In conclusion, it is evident from this discussion of different arguments on the debate of the legalisation of assisted death that the current prohibition of euthanasia and assisted suicide is not ethically and normatively defensible. While life is a very important value and it is always at least a \textit{pro tanto} wrong to kill another, assisted death should be allowed when it is in our best interests to die because of the experience of intense suffering. Nonetheless, only taking into consideration such objective assessments of our best interests to determine the permissibility of assisted death risks making it mandatory for many individuals who do not experience a good quality of life. Thus, considering whether there are autonomous requests to die is also equally important in allowing assisted deaths. A combination of autonomy and best

\textsuperscript{356} ibid 81
\textsuperscript{357} Assisted Dying for the Terminally Ill Bill [HL], Volume III – Evidence (Individual Submissions) (2004-05, HL86-3) 52
interests has been widespread in informing foreign jurisdictions with assisted death legislation. While it might objectively be in our best interests to receive assisted death in some situations of intense suffering, whether this should be permissible will also depend on whether we have autonomously requested to die. Hence, the position which is used is that a request to die along with that being in our best interests is a justification for assisted death, but it does not negate its wrongness entirely, and thus assisted death remains a pro tanto wrong.

Often when our life becomes increasingly bad due to the experience of intense pain and suffering, we experience a sense of indignity, which can be either objective in virtue of how others view us in society or subjective based on how we view due to what we are experiencing. However, since many people have a subjective feeling of indignity due to the suffering they might find themselves in, we must structure our legislation in a way to give them options to avoid such feelings and thus allow them access to assisted death. The following chapters will therefore consider how English law can be reformed to offer access to assisted death when someone is under intense suffering and autonomously requests to die.

It is important to note that although there have been many reform attempts in the past to allow some form of assisted death in England, especially assisted suicide, they have been unsuccessful. This is particularly interesting, especially when contrasted with the decriminalisation of suicide in 1961. Although morality does not necessarily indicate whether something must be illegal, this chapter has concluded that while there are important arguments that suicide is immoral, they must be rejected. This is an indication that assisted suicide is also not immoral.

Often assisted deaths are performed by individuals who are motivated by compassion in seeing their loved ones suffer. This chapter has supported that compassionately motivated assisted deaths seem to be differentiated in terms of culpability from other offences in the law of homicide. However, even though we might occasionally feel compassion for strangers, it will not be a proper expression of our compassion to assist the death of someone with whom we do not have a relationship of knowledge, love and affection. Thus, there are important reasons to consider compassion in a future legislative reform of assisted death, but this should be limited to assisted deaths
performed by loved ones. There will be further discussion of how compassion can be taken into consideration in a potential legislative reform in chapter 6.

Some foreign jurisdictions limit their legislation to a form of physician-assisted death. Trust is a very important component of the relationship between physicians and those requesting to die. It is important to shield this trust in the potential legalisation of assisted death through appropriate safeguards and legal rules. These might include ensuring that there is a request to die, that physicians have a close relationship with the requestor of assisted death, that assisted death is part of continuous consultation and treatment, and ensuring that all other options of alternative treatments are exhausted before proceeding.

Generally, there have been persistent slippery slope concerns among those opposing any relaxation of the law on assisted death. However, this chapter rejects both the logical and the empirical arguments on this. Concerns that all autonomous requests to die will be accepted or that people will be inevitably killed despite their consent when they are under extreme suffering are valid only when best interests and autonomy are considered separately. Since the argument in this thesis is that these should have equal and interdependent weight, there is no logical link to suggest that there will be a slippery slope in the potential legalisation of assisted death. Moreover, predicting a change in our values for the worse is odd conceptually, as there is no reason to believe that if assisted death is legalised, we would not be able to create and follow strict safeguards to guard against a slippery slope.
Chapter 4: Applying Existing Defences for Assisted Death

4.1 Introduction

Since there is a good normative basis for more lenient treatment of assisted death cases, the rest of this thesis will examine how this can be achieved. In this chapter, it will be argued that defences are the right way of achieving a more lenient treatment for such cases. This is because although assisted death may be justified or excused in virtue of the existence of a death request along with that being in the requestor’s best interests, or that the actor was compassionately motivated, it nevertheless remains pro tanto wrong. Then this discussion will examine whether the existing defences diminished responsibility, necessity, or consent, or reformed versions of them, would be a good way of achieving this lenient treatment.

Diminished responsibility was chosen for discussion because in the past it has been occasionally used in euthanasia cases. Its suitability and potential problems arising from its application to euthanasia will be identified. Necessity has been chosen because its Dutch equivalent provided the foundation for effectively legalising euthanasia in the Netherlands. There have been attempts, albeit unsuccessful, to use this as a defence to euthanasia cases in England. Consent is discussed since a request to die is generally one of the most important elements of euthanasia as is evident from the discussion in chapter 3.

It will be argued that diminished responsibility should be rejected as a potential defence for euthanasia cases. Its 2009 reform made the defence stricter and more formalised, which makes it very hard to plead successfully in compassionate killing cases. While undeniably looking at compassionate killings with sympathy is desirable, facilitating these cases under diminished responsibility, through a sort of ‘benign conspiracy’, creates substantial problems of fair labelling. As will be explained, this defence is unable to capture the rational affectionate response of the defendant to
their loved one’s suffering and could create a dangerous social stigma for them as being mentally unwell.

Regarding necessity, although it is typically not extended to intentional killings, it will be argued that there is a valid discussion about its exceptional application to euthanasia, provided that there is a redefinition of the importance typically attributed to life. There will be some discussion comparing necessity with its Dutch equivalent of \textit{noodtoestand}. However, it will be noted that the two defences work in very different ways. Then, based on \textit{Quayle} it will be argued that it will be very hard in England to accept necessity as a defence for the alleviation of suffering. Also, it does not follow from its definition that there should be a request to die, thus it might be available in cases of non-voluntary and involuntary euthanasia. Hence, although necessity could, in theory, apply to euthanasia, it should not be accepted in practice.

The requirement for a combination of intense suffering and a request for death might be more easily accommodated within the criminal law defence of consent. Currently, consent can never be used as a defence to assisted death. Nonetheless, it will be argued that there are good reasons in the public interest to exceptionally allow consent as a defence to assisted deaths upon a redefinition of the importance typically attributed to life. It would be in the public interest to allow people under intense suffering to request to die. Furthermore, following the public interest notion the availability of consent will be limited to physician-performed assisted death.

It will be argued that consent seems in principle the most suitable of the existing defences to use for assisted death. However, many limitations would need to be placed on it to protect vulnerable individuals against abuse, which have not been developed yet in the case law relating to offences against the person. To apply consent, we must also ensure that the decision to die is competent, well informed and voluntary. However, since this defence was not designed to be used in this context it will be noted that there are some important problems to take into consideration. These include the lack of an appropriate competency test and the current reluctance to provide sufficient information on assisted death. Therefore, it will be argued that even if consent might theoretically be the most appropriate of the existing defences, it should also be rejected as such practical problems make it not an ideal defence to
assisted death. Since the examined defences will be rejected, this thesis will argue in favour of new defences in the following chapters.

4.2 Using existing criminal law defences for cases of assisted death

As is evident from the previous chapter, there is a good normative basis for a more lenient approach to cases of euthanasia and assisted suicide than the current prohibition we have in England. Inglis noted that such cases, especially of euthanasia, involve one of the most difficult sentencing decisions a court could face.\(^1\) Even if the killing was planned and premeditated, it involves a combination of complex features such as the vulnerability of the victim, a competent request, and often compassionate motives.\(^2\) Murder has a mandatory life sentence.\(^3\) Thus, we have defendants who we often believe deserve lenient treatment but who are convicted of the most serious offence and receive the most severe sentence.

4.2.1 The distinction between offences and defences

A potential way to offer a more lenient approach would be to apply one of the existing defences of diminished responsibility, necessity and consent to cases of euthanasia and assisted suicide. It is thus important to discuss the distinction between offences and defences, to explain why the application of these existing defences is the best way to approach facilitating a more lenient treatment of assisted death cases. This distinction will also be relevant in chapters 5 and 6 considering the construction of reform proposals for these cases.

The distinction between offences and defences has been widely researched but is still somewhat hard to pinpoint and explain.\(^4\) Different theories can lead to different

---

\(^1\) *R v Inglis* [2011] 1 W.L.R. 1110 para 61

\(^2\) ibid

\(^3\) Chapter 2.2.1

\(^4\) Luis Duarte d’Almeida, ‘*O Call Me Not to Justify the Wrong*: Criminal Answerability and the Offence/Defence Distinction’ (2012) 6 Criminal Law and Philosophy 227, 227
conclusions on what should count as an offence and a defence. Duff suggests that offences and defences mirror the distinction between criminal answerability and liability to criminal punishment.⁵ According to this theory, offence definitions should be those actions for which defendants can be called to answer in a criminal court for a wrong they committed on pain of conviction and condemnation if they do not offer an exculpatory answer.⁶ The word ‘wrong’ implies ‘conduct that we have, in the law’s eyes, reason not to engage in’, as there are ‘legally recognised reasons’ against it.⁷ Defences should be exculpatory answers that block the transition from responsibility to liability.⁸ ‘Responsibility’ stands for answerability for something, to some person or body, within a responsibility ascribing practice.⁹ Consequently, according to Duff the basic distinction between these is that offences reflect responsibility while defences relate to liability.¹⁰ For offences, people are held criminally responsible, but they can still avert liability by offering a suitable exculpatory answer as a defence.¹¹ Proof that the defendant committed an offence is proof that there is something for which they are criminally responsible and must answer in a criminal court; to deny responsibility is to deny that there is something that must be answered for in court.¹² In contrast, defences deny liability but admit responsibility.¹³

There are valid reasons to apply a defence to cases of assisted death as according to the discussion in chapter 3, they involve a wrong that is justified or excused, rather than no wrong at all. By applying a defence to cases of assisted death we recognise that although the act of killing is a pro tanto wrong, there are special reasons to engage in it. While life is a very important value and it is always at least a pro tanto wrong to kill another, assisted death should be allowed when it is in our best interests to die because of the experience of intense suffering, along with an autonomous request to die.¹⁴ Furthermore, in some cases loved ones who cannot bear to see someone close

---

⁶ ibid 18
⁷ ibid 18
⁸ ibid 18
⁹ ibid 23
¹⁰ ibid 18
¹¹ ibid 16
¹² ibid 21
¹³ ibid 21
¹⁴ Chapter 3.3
to them suffer proceed in assisted death with compassionate motives.\textsuperscript{15} These compassionately motivated assisted deaths are differentiated in terms of culpability from other offences in the law of homicide, but they are still wrong.\textsuperscript{16}

Thus, the offender should be able to offer an exculpatory answer in the form of a defence for the wrong or the \textit{pro tanto} wrong they committed, and thus block their transition from responsibility to liability. Offenders will be able to admit responsibility for their actions of assisted death, but deny liability for that wrong in light of the special circumstances present, either of the death request and that being in the requestor’s best interests, or the actor’s compassionate motives. Thus, those actors may be held criminally responsible and may be required to answer in court on pain of conviction, but they will be able to avert liability by offering an exculpatory answer either through diminished responsibility, necessity or consent.

Furthermore, Campbell argued that to distinguish between offences and defences, we must calculate reasons against doing something and reasons in favour.\textsuperscript{17} The defence of consent is used as an example which sometimes serves to justify the offence of assault occasioning actual bodily harm.\textsuperscript{18} In contrast, in the law of rape, absence of consent is an element of the offence, since the offence is not committed and hence does not need to be justified if the sexual intercourse is consented to.\textsuperscript{19} The difference according to Campbell lies in the fact that there is no general reason not to have sexual intercourse, while there is a general reason not to cause actual bodily harm.\textsuperscript{20} Actual bodily harm is an unwelcome turn of events even when consensual; sexual intercourse is not unwelcome, but becomes so if not consensual.

Gardner follows a similar approach by suggesting that when the law requires or prohibits a certain action by creating an offence, this is because one has a reason not

\begin{footnotes}
\item[15] ibid 3.6
\item[16] ibid 3.6
\item[18] ibid 79
\item[19] ibid 79
\item[20] ibid 79
\end{footnotes}
to act on any reason that militates in favour of committing the offence.\textsuperscript{21} The law is content when one acts on any reason in favour of conforming to the norm.\textsuperscript{22} Through defences, the law selectively allows for some reasons that some defendants may have had for non-conformity with the law’s norms.\textsuperscript{23} In this way, the law by granting a defence accept some otherwise excluded reasons and allows them to compare with the reasons for not offending.\textsuperscript{24}

Thus, it is valid to consider whether we can apply one of the existing defences to cases of assisted death since there are generally many reasons against engaging in assisted death. Life is a very important value and it is always at least in some sense wrong to kill another.\textsuperscript{25} Thus, assisted death is generally \textit{pro tanto} wrong even when consensual, in our best interests, or compassionately motivated. But it is valid through a defence to selectively allow some of these reasons to explain why the defendant did not conform to the prohibition on assisted death. Then we will be able to accept some of the currently excluded reasons of consent to die, death being in our best interests and compassionate motives which have been deemed as ethically and normatively important in chapter 3.

Nonetheless, it must be noted that ideas about what we can do and what we cannot might differ largely based on what values a society upholds.\textsuperscript{26} For example, in some cultures, sexual intercourse might be considered immoral under certain circumstances.\textsuperscript{27} Often our underlying value judgements are vague.\textsuperscript{28} In actual bodily harm cases, whether consent is aligned to the offence side represents a different view than if it were a defence.\textsuperscript{29} As an element of the offence, it implies that we consider the force that is consented to be no harm.\textsuperscript{30} Assigning it to the defence side implies

\begin{itemize}
  \item \textsuperscript{21} John Gardner, \textit{Offences and Defences: Selected Essays in the Philosophy of Criminal Law} (Oxford, Oxford University Press, 2007) 147
  \item ibid 147
  \item ibid 147
  \item ibid 147
  \item ibid 147
  \item ibid 147
  \item ibid 147
  \item ibid 147
  \item ibid 147
  \item ibid 84
  \item ibid 84
  \item ibid 84
  \item ibid 84
\end{itemize}
that all use of force is in law wrong but that such use is justified if there is consent.\textsuperscript{31} Similarly, for consent to sexual intercourse, consent as an element of the offence implies that we consider such conduct not to be wrongful if it is consensual. However, if consent is a defence, it implies that all sexual intercourse is wrong, except if there is consent where it can be justified.

It is therefore evident that each of these approaches marks a different conception of the wrong committed and largely depends on the interpretation of different societal values.\textsuperscript{32} Consequently, judging something as an offence or a defence largely depends on the environment we live in.\textsuperscript{33} Campbell uses the example of a household that operates a radio receiver without a radio license.\textsuperscript{34} It is questionable whether this should be analysed as an offence of ‘operating a radio’ with a defence of possessing a license or both elements being within the offence as that of ‘operating a radio without a license.’\textsuperscript{35} This depends upon whether the legislators believe that there are reasons against all instances of operating a radio, or whether there is a reason against operating a radio only if doing so without a license.\textsuperscript{36} In a society like ours, there is nothing wrong in the eyes of the law with operating a radio as such.\textsuperscript{37} The wrong is only in operating one without a license since that deprives the state of revenue.\textsuperscript{38} In contrast, though, for a fundamentalist state which actively discourages the use of western invented technology, there will always be a reason against operating a radio.\textsuperscript{39} Therefore the offence description would be that of operating a radio with a defence that one is doing so with a license.\textsuperscript{40}

Duff notes that if we believe that all human beings have a moral claim on us whatever they have done, we must justify their killing, as part of what we owe each other as fellow human beings.\textsuperscript{41} In this sense, we must justify ourselves to those that we have

\begin{itemize}
\item \textsuperscript{31} ibid 84
\item \textsuperscript{32} Duff (n 5) 211
\item \textsuperscript{33} Campbell (n 17) 80-81
\item \textsuperscript{34} ibid 80-81
\item \textsuperscript{35} ibid 80-81
\item \textsuperscript{36} ibid 80-81
\item \textsuperscript{37} ibid 80-81
\item \textsuperscript{38} ibid 80-81
\item \textsuperscript{39} ibid 80-81
\item \textsuperscript{40} ibid 80-81
\item \textsuperscript{41} Duff (n 5) 212
\end{itemize}
wronged.\textsuperscript{42} Duff uses the example of killing an outlaw to illustrate the distinction between offences and defences.\textsuperscript{43} Outlaws have renounced all the benefits of society and government, and are unprotected by any law; therefore, killing them would require no justification, as it would not be an action that criminal law should be concerned with.\textsuperscript{44} Outlaws and their interests have no claim on us and we do no wrong in killing them.\textsuperscript{45} We do not need to show that the killing was necessary to protect ourselves or to avert some greater evil since that would imply that there are reasons against our actions that would be outweighed or defeated.\textsuperscript{46} Therefore the killing of an outlaw would require no offence or defence. But unlike with an outlaw, in killing someone who still has moral claims on us, like attackers in self-defence, we ought to recognise their rights.\textsuperscript{47} For Duff self-defence is rightly classified as a defence as even the attackers have rights, and when we use serious violence against a person we commit a serious wrong with which criminal law is concerned.\textsuperscript{48} Therefore, we must be prepared to answer for our actions in a criminal court on pain of conviction if we cannot offer an exculpatory answer.\textsuperscript{49} In this way, we recognise the attacker’s rights through the need to justify our actions by offering a defence to avoid conviction.\textsuperscript{50}

Then, Duff uses the example of euthanasia to explain that the distinction between offences and defences matters.\textsuperscript{51} According to Duff, it is important whether we count the absence of a request as an element of the offence of murder or its existence as a defence against a charge of murder.\textsuperscript{52} Different answers to this will reflect substantially different understandings of the wrong that is basic to murder and of what we should answer for in a criminal court.\textsuperscript{53} Thus, whether we allow one of the existing defences to be applied in cases of assisted death reflects our conception of the wrong of killing and the moral standing of the person who is killed.\textsuperscript{54}

\textsuperscript{42} ibid 212
\textsuperscript{43} ibid 211
\textsuperscript{44} ibid 211
\textsuperscript{45} ibid 211
\textsuperscript{46} ibid 211
\textsuperscript{47} ibid 211
\textsuperscript{48} ibid 211
\textsuperscript{49} ibid 211
\textsuperscript{50} ibid 213
\textsuperscript{51} ibid 213
\textsuperscript{52} ibid 213
\textsuperscript{53} ibid 213
\textsuperscript{54} ibid 212
For someone like a classical liberal who believes autonomy is an absolute right, non-consent would be an element of the offence.\(^{55}\) This is because if autonomy is an absolute right, even more important than life; what is done at my request cannot wrong me and cannot be the business of the polity.\(^{56}\) A choice cannot be considered harmful unless it has implications for other people.\(^{57}\) Hence, for classical liberals, the basic wrong in murder is not killing another person, but killing without consent.\(^{58}\) Then the offence of murder would be killing without consent, and those committing this wrong could offer a defence like diminished responsibility or loss of control to avoid conviction.\(^{59}\)

But according to Duff if we follow the approach suggested in chapter 3 of perceiving autonomy in more perfectionist terms as being of value only insofar as it is a matter of being able to choose between genuinely valuable options, killing involves a presumptive wrong for which the agent must answer, regardless of what is carried out at an informed request.\(^{60}\) The fact that the grantor killed the requestor after this request to spare the intolerable suffering experienced is an exculpatory answer that should be offered the polity to avoid a conviction for committing that wrong.\(^{61}\) The request along with that being in the requestors’ best interests provide an exculpatory answer which can be offered to the polity as a defence to avoid or mitigate conviction.

Following the same argument, since it was pointed out in chapter 3 that compassionately motivated assisted deaths are still wrong even if they seem to be differentiated in terms of culpability from other offences in the law of homicide, it will make more sense to offer a defence to these cases. Thus, we should examine whether any of the available defences of diminished responsibility, necessity and consent might be applied. The wrong of assisted death will be acknowledged but a degree of exculpation will be offered in recognition of the unique circumstances. The actors will

\(^{55}\) ibid 214  
\(^{56}\) ibid 214  
\(^{57}\) ibid 214  
\(^{58}\) ibid 214  
\(^{59}\) ibid 214  
\(^{60}\) ibid 215  
\(^{61}\) ibid 215
have to admit responsibility for their actions but could offer an exculpatory answer in court through one of the existing defences.

However, it must be noted that in practice, if we allow one of the existing defences to be used in assisted death cases, there will be instances where they will not end in trial and the actors will not have to answer for the wrong they committed in court. One of the things the prosecution is expected to do is to anticipate the possible lines of defence in a case. If there is clear evidence that the actor is entitled to the defence, the case would not even go to prosecutors, but even if it does, they would likely choose not to proceed further with a prosecution.

Another thing that distinguishes offences from defences is the required evidential support. A party who has to prove something to establish or escape liability is said to have the burden of proof. The standard of proof is the degree of persuasion required before the burden of proof can be found to be discharged. There are generally two distinct burdens of proof, the ‘legal’ and the ‘evidential’ burden, which do not always lie on the same person. The legal burden might be defined as the burden of persuading the tribunal of fact, to the required standard of proof. The evidential burden is the obligation on a party to adduce or point to some evidence in support of their case.

In offences, the onus lies on the prosecution to prove beyond a reasonable doubt that the defendant committed the offence charged. This involves proving both actus reus and mens rea. This, however, does not ensure a conviction, since the defendant could still offer a defence. In all defences, the defendant bears at least an evidential

---

63 ibid
64 Duff (n 5) 207
66 ibid 75
67 ibid 75
68 ibid 75
69 *Sheldrake v DPP* [2005] 1 A.C. 264, 289
70 Campbell (n 17) 79
71 ibid 79
72 ibid 79
burden; an obligation to adduce or point to some evidence in support of that defence.\textsuperscript{73} This in a sense implies that they owe it to the court to admit their guilt or to offer an explanation of why they committed the offence which will exculpate them.\textsuperscript{74} This is why under the presumption of innocence it is required that citizens be presumed innocent until it is proved that they are criminally responsible for an offence.\textsuperscript{75} Then once criminal responsibility is proved, it is usually up to them to rebut the presumption that they are guilty by providing a suitably exculpatory answer that will block the transition from responsibility to liability.\textsuperscript{76}

Under diminished responsibility, the defendant bears the legal burden; of persuading the tribunal of fact, to the required standard of proof.\textsuperscript{77} The standard of proof is no higher than in a civil trial, which is on the balance of probabilities.\textsuperscript{78} Therefore the defendant must show that the defence is more probably true than not true.\textsuperscript{79} In the defence of necessity once the defendant discharges an evidential burden to raise sufficient evidence, then the legal burden falls upon the prosecution to prove beyond a reasonable doubt that the defendant was not acting in necessity.\textsuperscript{80} Similarly, in the defence of consent, the prosecution bears the legal burden of proving that the complainant did not consent to the infliction of force, while the defendant only bears an evidential burden.\textsuperscript{81}

Thus, the right question to ask to decide whether assisted death needs to be addressed through an offence or a defence is when it is proper to impose a legal burden on the defendant. Since assisted death is \textit{pro tanto} wrong, even when there is an autonomous request to die and this is in our best interests or is compassionately motivated, placing some burden on actors through offering them a defence is desirable. It would imply that they owe it to the court to answer for the wrong of the

\begin{itemize}
\item \textsuperscript{73} Duff (n 5) 207
\item \textsuperscript{74} ibid 207
\item \textsuperscript{75} ibid 207
\item \textsuperscript{76} ibid 207
\item \textsuperscript{77} Coroners and Justice Act 2009 s 52
\item \textsuperscript{78} \textit{R v Carr-Briant} [1943] KB 603
\item \textsuperscript{81} Nicola Monaghan, \textit{Law of Evidence} (Cambridge, Cambridge University Press, 2015) 39
\end{itemize}
planned and premeditated killing, but deny guilt in respect of that wrong. They have an explanation of why they acted which is either the request to die along with that being in the requestor’s best interests or their compassionate motives which can exculpate them partly or fully.

Consequently, there is a valid discussion to be had about the exceptional application of the existing defences of diminished responsibility, necessity and consent to cases of assisted death to achieve a more lenient approach. Assisted deaths are wrong or at least a pro tanto wrong, but through applying a defence we recognise there are some special reasons to act in that way. These include a combination of a death request along with that being in the requestor’s best interests or the actor’s compassionate motives. Through the available defences, we can selectively allow some of these reasons, which are normatively and ethically important as discussed in chapter 3, to explain why the actor did not conform to the prohibition on assisted death. The wrong of assisted death will be acknowledged but a degree of exculpation will be offered in recognition of the unique circumstances. Furthermore, placing some burden on the actor through a defence is desirable, since it will confirm that the actors owe it to the court to answer for their actions but deny guilt in respect of that wrong.

4.2.2 Justificatory and excusatory defences and their effect on criminal liability

Since this chapter will consider the potential application of existing defences to cases of assisted death, it is important to understand how these are generally divided between justificatory and excusatory types of defences, and what their effect on the defendant’s criminal liability is.82 This discussion is very important in understanding not only which of these defences should be used for assisted deaths, but also what kind of new defences might be constructed, which will be further explained in chapters 5 and 6.

---

82 Paul Robinson, ‘Competing Theories of Justification: Deeds vs Reasons’ in Andrew Simester and ATH Smith (eds), Harm and Culpability (Oxford, Clarendon Press, 1996) 45
Usually, justifications are considered to grant a universal privilege as neither the victim nor third parties are allowed to interfere with justified conduct, while whoever aids the justified agent is justified as well.\textsuperscript{83} By contrast, excuses are usually considered predicated on particular personal attributes or specific states of mind that arise from the circumstances; therefore they are personal and not universal.\textsuperscript{84} An excused person should not be aided, and anyone assaulted by them may be justified in defending themselves.\textsuperscript{85} According to Robinson, unlike justified conduct, excused conduct is to be avoided whenever possible, even when the excusing conditions exist.\textsuperscript{86}

There are numerous theories on the reasons that make a defence either a justification or an excuse.\textsuperscript{87} For example, the forfeiture theory of justifications works in a negative sense to deny that there is social harm in particular conduct.\textsuperscript{88} For example, following this theory, a defence like consent can be regarded as negating the wrongness of the harm. Another theory expressed by Robinson is that conduct ordinarily considered as an offence becomes justified when justifying circumstances exist and we are content to have it performed.\textsuperscript{89} He argues that even though the harm prohibited by the offence does occur, it is outweighed by the avoidance of greater harm or by the advancement of a greater good.\textsuperscript{90} Then we are content to have the otherwise criminal conduct performed, and there is no net societal harm.\textsuperscript{91} For example, according to Robinson, although the force in self-defence may injure the aggressor, this injury is outweighed by the societal value of the defensive force, in avoiding the threatened harm to the victim and in condemning and deterring unjustified aggression generally.\textsuperscript{92} A defence like necessity also seems naturally understood along the lines that Robinson suggests.

\textsuperscript{83} Shachar Eldar and Elkana Laist, ‘The misguided concept of partial justification’ (2014) 20(3) Legal Theory 157, 160
\textsuperscript{84} ibid 160
\textsuperscript{85} ibid 161
\textsuperscript{86} Robinson (n 82) 46
\textsuperscript{88} ibid 33
\textsuperscript{89} Robinson (n 82) 45
\textsuperscript{90} ibid 45
\textsuperscript{91} ibid 45
\textsuperscript{92} ibid 45
The harm which ordinarily is an offence is outweighed by the public interest in the avoidance of greater harm.

Furthermore, there is the theory of justifying an act because it is securing the defendant’s legal and moral rights.\(^93\) Under this theory, in self-defence, it is considered that the defendant is acting to promote their right which is under attack.\(^94\) In the same sense, the defence of consent can be understood as a justification defence as the defendant argues that the actions were consensual and promoted autonomy. However, this theory creates difficulties where there is a clash of rights between people, as it is questionable if each one of them is justified in attacking the other to promote their autonomy.

Justifications are distinguishable from the second type of exculpatory defences, which also include various conflicting theories regarding their exact definition. Robinson defines excuses as claims that although one committed an offence and that doing so might have been wrongful, one still ought not to be blamed as in the circumstances, one’s conduct was not culpable.\(^95\) Therefore, an excuse involves a plea that because of special conditions undercutting the actor’s ability to avoid performing the act they ought not to be blamed and punished for it.\(^96\) In criminal law, diminished responsibility is typically considered an excuse defence by which defendants argue that although they broke the law, they should not be held fully criminally liable due to their diminished mental abilities that impacted their actions.

Gardner provided a different, but less popular, idea of excuses, i.e. that we provide an excuse because the actor lived up to our expectations in the normative sense.\(^97\) This means assessing whether they manifested as much resilience, or loyalty, or thoroughness, or presence of mind as a person in their situation should have manifested.\(^98\) The character standards which are relevant to these and other excuses


\(^{94}\) ibid

\(^{95}\) Robinson (n 82) 45

\(^{96}\) ibid 46


\(^{98}\) ibid 579
are not the standards of our characters, nor even the standards of most people's characters, but rather the standards to which our characters should, minimally, conform, in the particular circumstances.\textsuperscript{99} Therefore, Gardner believes that the gist of an excuse is that one lived up to the standards of character demanded of him.\textsuperscript{100} In this sense, one's actions can be at the same time both admirable and wrongful, as we might recognise that certain things should not have been done, but cast the person who did them in a favourable light.\textsuperscript{101}

It must be noted that some commentators deny the usefulness of the distinction between justifications and excuses.\textsuperscript{102} Whether one is excused or justified, the result of the defence is the same as it makes no difference to responsibility. Also, the English courts have not placed great weight on this distinction, which might indicate that it lacks practical significance.\textsuperscript{103} The fact that there is much debate on whether such defences as duress are justifications or excuses, might indicate that the distinction is too vague to be useful.\textsuperscript{104} Some others argue that our society lacks agreed moral standards which can be used to assess the justifiability or not of particular actions.\textsuperscript{105}

However, Horder argues convincingly that it does matter whether a defence is a justification or an excuse.\textsuperscript{106} The former seek to offer guidance to defendants before they act while the latter assess the culpability of offenders once they have acted.\textsuperscript{107} Defences are inherently linked to moral judgement and the different rationales of justifications and excuses have an impact on how actors are morally judged.\textsuperscript{108} There is a difference between the moral assessment of an actor whose conduct was justified and the moral assessment of an actor who was excused.\textsuperscript{109} Krebs made an interesting

\begin{footnotesize}
\begin{enumerate}
\item ibid 579
\item ibid 579
\item ibid 579
\item Herring (93) 718
\item ibid 718
\item ibid 718
\item Law Commission, Murder, Manslaughter and Infanticide (Law Com. No. 304, 2006) part 7
\item ibid
\item Jeremy Horder, Excusing crime (Oxford, Oxford University Press, 2007) 26
\item ibid 26
\item Iris Haenen, ‘Justifying a Dichotomy in Defences. The Added Value of a Distinction between Justifications and Excuses in International Criminal Law’ (2016) 16(3) International Criminal Law Review 547, 552
\item Kent Greenawalt, ‘Distinguishing Justifications from Excuses’ (1986) 49(3) Law and Contemporary Problems 89, 89
\end{enumerate}
\end{footnotesize}
argument that the distinction between justifications and excuses contributes to fair labelling and has an important signal effect.¹¹⁰ A defendant found justified will be provided with a legal confirmation that the conduct was permissible, even right.¹¹¹ A successful excuse will convey to the defendant that the conduct was wrongful but is exonerated.¹¹² Even though the outcome of complete justifications and excuses is the same, the message and associated moral judgement conveyed to society are different. These competing theories of justification and excuse defences will be used in chapters 5 and 6 to explain how and which of them work with the reform proposals of this thesis.

Defences are also generally classified as either full (or complete) or partial.¹¹³ A full defence precludes liability altogether.¹¹⁴ Partial defences do not completely absolve the defendant of guilt: for example, in England, successfully pleading a partial defence for murder may reduce the conviction to manslaughter.¹¹⁵ Under the current law, it is widely accepted that excuses can be both partial and complete.¹¹⁶ Insanity is a famous example of an excusatory defence that exculpates completely.¹¹⁷ Diminished responsibility is an excusatory defence that only partially exculpates, by reducing the charge of murder to manslaughter.¹¹⁸

But this is not so straightforward for justification defences. According to Eldar and Laist, justifications are indivisible and by nature binary: conduct is both justified and permissible or it is not.¹¹⁹ Thus, there is no meaning to a partial justification.¹²⁰ One could simply say that within the calculus, some good consequences of the act were weighed against the bad ones before the balance was found to be unfavourable.¹²¹

¹¹¹ ibid (n 108) 553
¹¹² ibid 553
¹¹⁵ ibid 311
¹¹⁶ Keating and Bridgeman (n 113) 721
¹¹⁷ Robinson (n 82) 46
¹¹⁸ Coroners and Justice Act 2009 (n 77) s 52
¹¹⁹ Eldar and Laist (n 83) 161
¹²⁰ ibid 161
¹²¹ ibid 161
Therefore they believe that just as action can be either right or not, it can also be either permissible or impermissible, thus a partial justification should never exist.\footnote{ibid 161} Furthermore, some believe that there is no essential value in partial justifications, as they do not provide people with meaningful guidance as to which parts or aspects of their conduct were desirable and which were not.\footnote{ibid 161} In this argument, there is no meaning in a partial justification apart from saying that some good consequences of the act were weighed against the bad ones before the balance was found to be unfavourable.\footnote{ibid 162} As will be explained below, both consent and necessity are full justification defences that provide full removal of criminal liability.

However, some disagree with this approach and argue that partial justifications exist. Greenawalt believes that the term partial justification can be used to signify an act that was performed in a manner that rendered it less inappropriate than it would alternatively be or not as wrong as it might otherwise have been.\footnote{Greenawalt (n 109) 92} Berman convincingly argued that it is plausible to view ‘partially justified’ as indicating that an act is supported by some good reasons, but not enough to make the act overall justified.\footnote{Mitchell N. Berman, ‘Provocation as Partial Justification and Partial Excuse’ (2011) 52(4) William and Mary law review 55, 40} Consequently, it is submitted that partial justifications exist. In diminished responsibility, which is a partial excusatory defence, one is found not completely blameable because their culpability was diminished. The same line of argument could apply for partial justifications, as one might not have sufficient reasons for doing what they did, but have had some good reasons, more than the average offender.

4.3 Diminished Responsibility

A defence used in the past to achieve a more lenient treatment in this context is diminished responsibility.\footnote{Ben Livings, ‘Autonomy, Consent and the Criminalisation of Assisted Dying’ (2011) 11(4) Contemporary Issues in Law 302, 316} This defence was created in 1957 as a means for those who kill to not be convicted of murder if they were suffering from an abnormality of
mind which substantially impaired their mental responsibility. This is a partial excusatory defence, which if it is used successfully excuses the defendant's conduct and diminishes a charge of murder to manslaughter. Thus, the defendant's actions remain wrongful, but one's culpability, although not removed is reduced. Since this defence applies only to charges of murder, it will not be available to cases of assisted suicides.

According to section 52 of the Coroners and Justice Act 2009:

(1) A person ('D') who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which:
   (a) arose from a recognised medical condition,
   (b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A), and
   (c) provides an explanation for D's acts and omissions in doing or being a party to the killing.

(1A) Those things are:
   (a) to understand the nature of D's conduct;
   (b) to form a rational judgment;
   (c) to exercise self-control.

Ferguson argued that a jury can accept that the grief of watching a close relative endure extreme suffering may have tipped the balance of the accused's mind, hence diminishing their responsibility. The Law Commission commented that the cases most deserving of mitigation are killings in which long-term family carers have become progressively more depressed and mentally ill, usually because of the increasing burden of care as they become older. Depression constitutes a relevant 'abnormality of mental functioning'. Thus, severely depressed carers who kill will be

---

128 Homicide Act 1957 s 2
129 ibid s 52
130 Pamela R. Ferguson, ‘Causing Death or Allowing to Die? Developments in the Law’ (1997) 23(6) Journal of Medical Ethics 368, 369
131 ibid para 7.21
132 Law Commission (n 104) para 7.21
133 ibid para 7.21
covered by this defence when proving that there was an abnormality of mental functioning, arising from a recognised medical condition.\footnote{\textit{ibid} para 7.21}

In this way, the application of diminished responsibility is limited to cases of euthanasia performed by people who were close to the sufferer who had such a strong emotional reaction to the pain experienced. As explained in the previous chapter they often might decide to kill the sufferer out of compassionate motives. Diminished responsibility will be harder to accept as a defence for medical practitioners performing euthanasia. This is because usually the only bond that they have with their patient is that of a duty of care.\footnote{\textit{Suzanne Ost, ‘Euthanasia and the Defence of Necessity: Advocating a More Appropriate Legal Response’ in Charles A. Erin and Suzanne Ost (eds), \textit{The Criminal Justice System and Healthcare} (Oxford, Oxford University Press, 2007) 106}} The unique nature of their job in which they are often faced with death leads to the conclusion that the patient’s condition is unlikely to have the necessary emotional and psychological impact upon them which could satisfy the requirements for diminished responsibility.\footnote{\textit{ibid} 106} It must be noted that untrained individuals might, due to their inexperience, risk leaving the sufferer in a worse condition than before or causing them further pain during the procedure. Nevertheless, since, as noted in the previous chapter, there is something often differentiating loved ones who kill a person who is suffering motivated by compassion, it might be desirable for them to be offered a partial defence like diminished responsibility. The defendant should be partially excused because they are less blameworthy than the typical offender.\footnote{\textit{Husák (n 114) 321}}

Before the 2009 Act reform, this defence simply referred to an abnormality of the mind, rather than an abnormality of mental functioning caused by a recognised medical condition.\footnote{\textit{Homicide Act 1957 (n 128) s 2}} This made diminished responsibility significantly more flexible than the reformed plea. It was notorious for its easy accommodation of compassionate killers even with minimal evidence of mental abnormality. Such an example is the case of Robert Cook noted by Keating and Bridgeman.\footnote{\textit{Keating and Bridgeman (n 113) 706}} Cook killed his ill and depressed wife, and pleaded guilty to manslaughter on the grounds of diminished

\begin{footnotes}
\item[\footnote{134}]{\textit{ibid} para 7.21}
\item[\footnote{136}]{\textit{ibid} 106}
\item[\footnote{137}]{\textit{Husák (n 114) 321}}
\item[\footnote{138}]{\textit{Homicide Act 1957 (n 128) s 2}}
\item[\footnote{139}]{\textit{Keating and Bridgeman (n 113) 706}}
\end{footnotes}
responsible.\textsuperscript{140} His wife Vanessa had taken an overdose, and Robert kept his promise to not call emergency services until he was sure she was dead.\textsuperscript{141} She tried to kill herself on three previous occasions and wrote notes expressing her wish to die.\textsuperscript{142} He stated that he had acted out of love and affection following his wife’s wishes.\textsuperscript{143} Even if there was no evidence of mental abnormality, the court was willing to accept his defence with a certain degree of elasticity to facilitate their sympathy for him.\textsuperscript{144} As Keating and Bridgeman note, it is interesting that in the reports there is not any information on Robert’s Cook’s mental health although the judge received reports from psychiatrists and psychologists before sentencing.\textsuperscript{145}

4.3.1 Problems with diminished responsibility’s application to euthanasia cases

The new reformed diminished responsibility defence has moved towards a more medical and psychiatric definition, as it requires the abnormality of mental functioning to arise from a medical condition.\textsuperscript{146} This is harder to prove than the 1957 Act requirements, which allowed the defence to be used in cases such as Cook’s. Additionally, the current test becomes even more standardised by requiring the defendant’s mental abnormality to have substantially impaired their ability to understand the nature of their conduct, form a rational judgment or exercise self-control. These new requirements formalise the idea that the defence should be grounded in various physical, psychiatric or psychological diagnoses.\textsuperscript{147} It seems to preclude more ambiguous forms of expert evidence, requiring a more scientific approach to the defence.\textsuperscript{148}

\textsuperscript{140} ibid 706
\textsuperscript{141} ibid 706
\textsuperscript{142} ibid 706
\textsuperscript{143} ibid 706
\textsuperscript{144} ibid 706
\textsuperscript{145} ibid 706
\textsuperscript{146} John Child and David Ormerod, \textit{Smith and Hogan’s Essentials of Criminal Law} (Oxford, Oxford University Press, 2015) 177
This new medicalised plea will be an important problem in applying diminished responsibility to euthanasia. It will be increasingly more challenging for these cases to be accommodated even if they were long term-carers who experienced extensive suffering. Cases such as Robert Cook who cannot prove that he had a recognised medical condition at the time of the crime are extremely unlikely to successfully use this defence today. According to Ost, the desire to treat offenders in such cases with sympathy can be fulfilled today only if a medical explanation for the defendant’s behaviour can be found. This is not an easy task, even in cases of long term carers who understandably might experience anxiety, despondency, despair, futility and helplessness from seeing their loved ones suffer. While these are signs of plenty of mental illnesses, they are also frequently experienced by ordinary people in the course of their normal life, especially when dealing with such a complex situation as taking care of a loved one in suffering. This requirement is unlikely to be applied in the majority of euthanasia cases and thus may exclude diminished responsibility as a successful plea.

This medicalisation of diminished responsibility which makes it more limited in its application is evident in post-2009 cases. In the case of Bunch in 2013, the defendant murdered the victim in front of her husband by stabbing her after the relationship between the two ended. The defendant claimed that he was a heavy drinker and did not remember the killing and therefore that he was entitled to a defence of diminished responsibility. However, he produced no evidence that he had alcohol dependency syndrome. A consultant psychiatrist testified that the defendant was not physically dependant on alcohol, had not been suffering from a mental disorder and there was no mental abnormality. Thus, the defence of diminished responsibility was rejected.

151 Oliver Quick and Celia Wells, 'Partial Reform of Partial Defences: Developments in England and Wales' (2012) 45(3) Australian and New Zealand Journal of Criminology 337, 347
152 R v Bunch [2013] EWCA Crim 2498 para 11
153 ibid para 11
154 ibid para 11
155 ibid para 11
156 ibid para 11
But even if we ignore this problem of proving a recognised medical condition, and consider that perhaps a sympathetic expert would be happy to make a false diagnosis to save the defendant from life imprisonment,¹⁵⁷ there are more problems with showing that the defendant had a substantial impairment in their ability to exercise the capacities described in section 1(a) of the relevant Act. Arguably, it is difficult to show in cases of euthanasia that the defendant had a substantial impairment in understanding the nature of their conduct. This is restricted to cases where the defendant was substantially unaware of the circumstances, consequences or wrongfulness of their actions.¹⁵⁸ In many euthanasia cases, the defendant, while undeniably in a complex emotional state, is perfectly capable of understanding what they are doing.¹⁵⁹ They act in the full knowledge that they will kill the sufferer, to save them from their pain.¹⁶⁰ Thus, it is unlikely that they will be able to satisfy this first capacity of the substantial impairment test.

The second listed capacity is the defendant being impaired in their ability to form a rational judgement.¹⁶¹ According to the Law Commission, this part of the test can be satisfied for euthanasia cases.¹⁶² A seriously depressed man caring for many years for a seriously ill loved one, might have found it progressively more difficult to stop her repeated requests to die, dominating his thoughts to the exclusion of all else.¹⁶³ Hence, his ability to think rationally might have been seriously impaired until he gave her what she wanted by killing her.¹⁶⁴ This interpretation seems to be focused on the lack of rationality leading up to the killing.¹⁶⁵ Although this might happen in some cases, where the defendant was experiencing a medical condition such as depression, as noted above, this is unlikely to be the case in the majority of cases. The defendants although

¹⁵⁷ Gibson (n 148) 194
¹⁵⁸ Rudi Fortson, ‘The Modern Partial Defence of Diminished Responsibility’ in Alan Reed and Michael Bohlander (eds), Loss of Control and Diminished Responsibility: Domestic, Comparative and International Perspectives (Ashgate, Farnham, 2011) 32-34
¹⁵⁹ Keating and Bridgeman (n 113) 698
¹⁶⁰ ibid 698
¹⁶¹ Coroners and Justice Act 2009 (n 77) s 52
¹⁶² Law Commission (n 104) para 5.121
¹⁶³ ibid para 5.121
¹⁶⁴ ibid para 5.121
¹⁶⁵ Gibson (n 148) 194
understandably sad because of their loved one’s condition, usually make an entirely rational judgement to help them die.\textsuperscript{166}

An illustration of this is the Frances Inglis case, whose son was in a vegetative state and Frances, convinced that he would not want to live like that, injected him with a lethal dose of heroin.\textsuperscript{167} She stated that she refused to plead diminished responsibility since she wanted her actions to be understood as an act of love, rather than one of mental abnormality.\textsuperscript{168} This case shows not only that diminished responsibility fails to catch killings that were fully rational, but it also ‘pathologises’ such rational decisions, which might be in some way demeaning for the defendant. It seems that this requirement for a recognised medical condition, proving that the defendant lacked rational judgement will wholly rely on finding a sympathetic expert who will be willing to testify for this even if is not true.\textsuperscript{169}

Furthermore, the third capacity of the substantive impairment test of being able to exercise self-control seems inapplicable to situations of euthanasia. In the Supreme Court case of \textit{R v Golds},\textsuperscript{170} it was held that the impairment of the defendants’ abilities must be more than merely minimal or trivial.\textsuperscript{171} For example, it should be ‘significant or appreciable’.\textsuperscript{172} Given that euthanasia usually is a response to extensive pain and potential repeated requests to die, defendants tend to plan and think of their actions advance before committing the crime. Thus, it will be very hard to prove that they could not exercise self-control, especially to a significant degree.

Even if we disregard the apparent inapplicability of these requirements, and believe that both the jury and the medical experts will be always sympathetic and able to accept a diminished responsibility plea, this will be theoretically inappropriate. It means that the application of this defence will depend on a sort of ‘benign conspiracy’, where although its requirements will not be met other factors such as the defendant’s

\begin{flushleft}
\textsuperscript{166} ibid 194  \\
\textsuperscript{167} Inglis (n 1) para 32  \\
\textsuperscript{168} ibid paras 41 and 42  \\
\textsuperscript{169} Gibson (n 148) 194  \\
\textsuperscript{170} R v Golds [2016] UKSC 61  \\
\textsuperscript{171} ibid  \\
\textsuperscript{172} ibid
\end{flushleft}
compassionate motives will be taken into consideration.\textsuperscript{173} As Baroness Mallalieu noted during debates that preceded the passing of the Coroners and Justice Act 2009, to watch the judge, the prosecutor and the defence trying to find a way to achieve the right result is not the way justice should be administered.\textsuperscript{174} The application of diminished responsibility for euthanasia will create further confusion and vagueness in an already complicated area of the law. The new defence was drafted in such a strict medicalised way, to be used and excuse those with a recognised medical condition.\textsuperscript{175} Using it as a defence of convenience to protect all those who do not deserve a conviction and sentence for murder is incompatible with the aim of its reform.\textsuperscript{176} Using this defence for euthanasia goes against not only the letter of the law but also the underlying rationale for the defence. Therefore, although undeniably, looking upon euthanasia with sympathy is desirable, facilitating those defendants under this diminished responsibility plea will create large inconsistencies between what the law says and what it does.

This leads to an important problem in accepting diminished responsibility for euthanasia as it would create issues of fair labelling. Fair labelling is a complicated term. It could mean the communication of information that does not create a false or misleading impression of the nature or magnitude of the offender's wrongdoing or encourage an inaccurate conclusion to be drawn.\textsuperscript{177} Its basic concern is to see that widely felt distinctions between different kinds of offences and degrees of wrongdoing are recognised and signalled by the law.\textsuperscript{178} Offences must be subdivided and labelled to represent fairly the nature and magnitude of the law-breaking.\textsuperscript{179} It might also be important in communicating something of value to the offender.\textsuperscript{180} The law should make clear 'what sort of criminal each offender is' and should communicate this to the

\begin{itemize}
\item \textsuperscript{173} Livings (n 127) 313
\item \textsuperscript{174} House of Lords, Debate 30, vol 99, col 157, June 2009
\item \textsuperscript{175} Gibson (n 148) 196
\item \textsuperscript{176} ibid 196
\item \textsuperscript{177} James Chalmers and Fiona Leverick, ‘Fair Labelling in Criminal Law’ (2008) 71(2) The Modern Law Review 217, 228
\item \textsuperscript{178} ibid 228
\item \textsuperscript{179} ibid 219
\item \textsuperscript{180} ibid 229
\end{itemize}
defendants so that they can know exactly what they have done wrong and why they are being punished.\textsuperscript{181}

But labelling implications for defences are not as straightforward as with offences. There is much debate and questioning whether fair labelling is relevant in this context.\textsuperscript{182} Part of the function of the law is to communicate with wrongdoers so they understand the allegations against them, respond, and, more importantly, know what they can lawfully do.\textsuperscript{183} As Gardner suggested, it may also be relevant in terms of the individual's self-respect.\textsuperscript{184} Gibson noted in regards to partial defences to murder that the fulfilment of fair labelling is dependent on how accurately the defendant's circumstances are represented, especially the name of the defence.\textsuperscript{185} Some have argued that while this might be true for partial defences, it is irrelevant to full defences, as the actor who pleads this successfully is guilty of no crime, so there is nothing to be labelled for.\textsuperscript{186}

It is thus evident that fair labelling might be important to defences but for different reasons to why it is important for offences.\textsuperscript{187} Previous acquittals are not generally made known to sentencers or employers.\textsuperscript{188} But at least some criminal trials that result in acquittals are reported by the media, which means that the public is receiving a message about the person thus acquitted.\textsuperscript{189} It may be that it is only fair to an individual that the nature of their defence is communicated, as this may influence how they are regarded by the public.\textsuperscript{190} The verdict may spell out the defence. For example, in the context of insanity the defendant may receive the special verdict 'not guilty because of insanity'.\textsuperscript{191}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{181} \textit{ibid} 228
\item \textsuperscript{182} \textit{ibid} 244
\item \textsuperscript{183} Christopher Clarkson, 'Necessary Action: a New Defence' (2004) 13 Criminal Law Review 81, 94
\item \textsuperscript{184} Gardner (n 97) 590
\item \textsuperscript{185} Gibson (n 148) 197
\item \textsuperscript{186} Chalmers and Leverick (n 177) 244
\item \textsuperscript{187} \textit{ibid} 245
\item \textsuperscript{188} \textit{ibid} 245
\item \textsuperscript{189} \textit{ibid} 245
\item \textsuperscript{190} \textit{ibid} 245
\item \textsuperscript{191} \textit{Hill v Baxter} [1958] 1 Q.B. 277, 286
\end{itemize}
\end{footnotesize}
For this discussion on diminished responsibility, it must be noted that partial defences present an unusual case. They are defences, but they also influence the offence’s label. For example, we often talk about manslaughter on the grounds of diminished responsibility. Therefore, fair labelling is a concern for partial defences such as for cases of euthanasia that use diminished responsibility. Fair labelling is not just about achieving the appropriate manslaughter conviction, but also about identifying the correct partial defence which should be the one that most accurately captures the features of euthanasia to attain the appropriate conviction. Therefore, applying diminished responsibility to euthanasia could be problematic in terms of fair labelling. This defence is unable to take account of the rational affectionate response of the defendant to their loved one’s suffering. Allowing this defence for euthanasia would make drawing a line and distinguishing in terms of fair labelling between them and other cases, such as spousal killings, very difficult.

Chalmers and Leverick also suggest that in regards to justification defences the rules of conduct are communicated and not simply an adjudication which Clarkson argues is irrelevant to fair labelling. Citizens are entitled to rely on rules of conduct in deciding how to act. The defendant may have a legitimate preference in having their conduct declared to be acceptable rather than, say, unacceptable but excused, and if this is correct then the principle of fair labelling has some application to at least justification defences. However, a similar interpretation could apply for excuses as the defendants might have a legitimate interest in explaining to the public that although their conduct was unacceptable they cannot be blamed for their behaviour.

It is interesting to note that Gardner mentions that diminished responsibility could not be an example of a true excuse, but just an example of a denial of responsibility. This is important for this discussion because if you are pleading diminished responsibility...
responsibility, you are arguing that you were not fully responsible because you were not fully rational and thus you should have a defence.\textsuperscript{200} Provocation and diminished responsibility if pleaded successfully had the effect of substituting a manslaughter conviction for a murder conviction.\textsuperscript{201} Although, provocation has now been abolished and replaced with the defence of loss of control since Gardner was writing, nonetheless, this comparison remains relevant for this discussion.\textsuperscript{202} Since provocation was tightly circumscribed, defendants could sometimes rely on the more loosely drawn diminished responsibility instead.\textsuperscript{203} A victim of a long domestic violence relationship that was not able to affect the assessment of how gravely she had been provoked by her violent partner when she killed him could rely on ‘battered woman syndrome’ and use diminished responsibility for her actions.\textsuperscript{204} Practically both defences led to the same conclusion which would be a manslaughter conviction. But they had very different theoretical conclusions.\textsuperscript{205}

The whole gist of diminished responsibility is that it depends on the unreasonableness of the defendant's reactions.\textsuperscript{206} According to Gardner, any self-respecting defendant would rather be able to give an intelligible account of themselves in rational terms.\textsuperscript{207} They would rather be judged by the proper standards of character for the life they lead and not by some standard manipulated to take account of some claimed weakness they have.\textsuperscript{208} In this sense, the woman who was abused would rather have a provocation defence that properly takes into account the circumstances she was subjected to and her reaction to them by the proper standards of character, than relying on a diminished responsibility plea and conceding that those standards of character do not apply to her in the first place.\textsuperscript{209} Similarly, a person who decided to offend because they could not bear to see their loved ones suffer could justifiably prefer to be labelled in a more appropriate way that will conform to their compassionate motives and standards of character.

\begin{thebibliography}{99}
\bibitem{200} ibid 591
\bibitem{201} ibid 591
\bibitem{202} Coroners and Justice Act 2009 (n 77) s 54
\bibitem{203} Gardner (n 97) 591
\bibitem{204} ibid 591
\bibitem{205} ibid 591
\bibitem{206} ibid 591
\bibitem{207} ibid 592
\bibitem{208} ibid 592
\bibitem{209} ibid 592
\end{thebibliography}
Applying diminished responsibility to euthanasia cases could also create a dangerous social stigma for many defendants as being mentally unwell. What we are concerned with here is mostly the moral character of the label, and not how it is understood by the public. When someone is found guilty of manslaughter on the ground of diminished responsibility, we are essentially saying that there is something genuinely normatively different about that person. Due to its medicalised nature, this defence carries a syndromising stigma for the defendants invoking it and could lead even to their hospitalisation.\textsuperscript{210} There is the danger of encouraging heightened speculation, misleading impressions and false assumptions about their mental state which might not be accurate.\textsuperscript{211} Using this defence will necessarily pathologise those defendants while failing to capture their often compassionate motives.\textsuperscript{212}

It is evident from this discussion that diminished responsibility should be rejected as a potential defence for euthanasia cases. Diminished responsibility used to be notorious for its easy accommodation of individuals who compassionately killed a loved one. However, its 2009 Act reform resulted in it becoming increasingly harder to be pled successfully in such cases. The reformed plea is much more strictly grounded in requirements for medical diagnosis, which is unlikely to be satisfied for most compassionate killers. While those defendants are undeniably in a complex emotional state, they are usually capable of understanding their actions and usually make an entirely rational judgement to help their loved ones die. Given that compassionate killings are a response to extensive pain and potentially repeated death requests, defendants tend to plan their actions, thus is hard to prove that they could not exercise self-control, especially to a significant degree. While undeniably looking at compassionate killings with sympathy is desirable, facilitating those defendants under diminished responsibility through a sort of ‘benign conspiracy’, creates substantial problems of fair labelling. This defence is unable to appreciate the rational affectionate response of the defendant to their loved one’s suffering and thus could create a dangerous social stigma for them as being mentally unwell. A person who offends

\textsuperscript{210} Gibson (n 148) 178
\textsuperscript{211} ibid 178
\textsuperscript{212} Andrew Ashworth and Barry Mitchell, ‘Introduction’ in Andrew Ashworth and Barry Mitchell (eds), \textit{Rethinking English Homicide Law} (Oxford, Oxford University Press, 2000) 12
because they could not bear to see their loved ones suffer could justifiably prefer to be labelled in a more appropriate way that will conform to their compassionate motives and standards of character.

4.4 Necessity

Another defence that is important to examine is necessity. This defence is available to defendants charged with any criminal offence.\textsuperscript{213} It is generally classified as a justificatory full defence,\textsuperscript{214} which means that it transforms an act that would otherwise be criminal into a legal one. It is used to refer to a choice between competing values, where the ordinary rule has to be departed from to avert some greater evil.\textsuperscript{215} This means that necessity is used in criminal law if the defendant is arguing that it was necessary for them to commit a crime. It thus dismisses the law's applicability to unique factual circumstances.\textsuperscript{216} Textbook necessity cases are the destruction of property to prevent the spread of fire, violating the speed laws to rush a spouse to a hospital, disposing of valuable cargo to save a floundering vessel, and dispensing a drug without the requisite prescription to alleviate grave distress in an emergency.\textsuperscript{217}

One of the most important cases is \textit{Dudley and Stephens}, which ruled that necessity is not applicable as a defence in cases of murder.\textsuperscript{218} In this case, a group of shipwrecked sailors killed and ate a cabin boy to save themselves from starvation.\textsuperscript{219} It was proposed that lots should be cast on who to put to death to save the rest.\textsuperscript{220} But afterwards, they thought it better to kill the cabin boy.\textsuperscript{221} They were found guilty of murder, despite the extreme circumstances of desperation and starvation they were

\begin{footnotesize}
\begin{itemize}
\item[213] Glanville Williams, ‘Defence of Necessity’ (1953) 6 Current Legal Problems, 216, 224
\item[214] Keating and Bridgeman (n 113) 708
\item[215] Penney Lewis, ‘The failure of the defence of necessity as a mechanism of legal change on assisted dying in the common law world’ in Dennis J. Baker and Jeremy Horder (eds), \textit{The Sanctity of Life and the Criminal Law: The Legacy of Glanville Williams} (New York, Cambridge University Press, 2013) 286-287
\item[217] ibid 698
\item[218] \textit{R v Dudley and Stephens} (1884) 14 Q.B.D. 273
\item[219] ibid
\item[220] ibid
\item[221] ibid
\end{itemize}
\end{footnotesize}
experiencing at the time of the crime. It was noted that the evil they inflicted by killing the cabin boy was greater than the evil they avoided which was to die. Also, their act was perceived as immoral since they sacrificed someone’s life merely for their interest. This case is particularly important for this discussion. Necessity would be theoretically applicable to the case of assisted suicide, but following Dudley and Stephens, it will not apply to any cases of intentional termination of life such as euthanasia.

However, the successful application of necessity in the case of Re A for an intentional killing has given rise to arguments that it can be exceptionally extended to such cases. In Re A the court was faced with parental opposition to the separation of conjoined twins. Without the operation, it was predicted that they would die of congestive heart failure. The crucial question was whether it could be lawful to separate them while knowing that only the stronger twin would survive while the weaker one would be killed as she was dependent on her sister to live. Legally this separation fulfilled both the actus reus and the mens rea of murder since the physicians knowingly and actively would cause the weaker twin’s death. But it was ruled that the physicians were not criminally liable as the defence of necessity was applicable. This case also established the leading test for the use of necessity, which requires that: a) the accused intended to avoid inevitable and irreparable evil, b) he did no more than was reasonably necessary, and c) the evil inflicted was not disproportionate to the evil avoided.

This case represents the most famous exception to the rule that necessity cannot be used as a defence for intentional killing. The operation was considered the lesser of two evils since both twins would inevitably die unless the separation was performed.

---

222 ibid 287
223 Lewis (n 215) 287
224 ibid 288
225 Ost (n 135) 111-112
227 ibid 162
228 ibid 155
229 ibid 237
230 ibid 237
231 ibid 240
232 Keating and Bridgeman (n 113) 709
Ward LJ stated that given the conflict between the duties towards each twin there was no other way of dealing with it than by choosing the lesser of the two evils and so following the least detrimental alternative.\textsuperscript{233} He balanced the benefits of the operation to separate the twins and held that this fell in favour of Jodie, as Mary would die either with or without operation.\textsuperscript{234} He observed that the physicians owed a duty to defend Jodie from the threat of fatal harm which arose from the physical burden imposed by Mary.\textsuperscript{235} Therefore in \textit{Re A}, contrary to \textit{Dudley and Stephens} the physicians chose to preserve life as without the operation neither of the twins would survive.

Furthermore, Ward LJ compared the conjoined twins’ case with the lawful killing of a 6-year-old boy who was indiscriminately shooting playmates in the schoolyard.\textsuperscript{236} ‘In law killing that 6-year-old boy in self-defence of others would be fully justified and the killing not unlawful’.\textsuperscript{237} What makes the separation of the conjoined twins in \textit{Re A} lawful is that the separation in effect is an act of self-defence.\textsuperscript{238} The physicians were coming to Jodie’s defence by performing the separation and thus removing the fatal threat presented by Mary.\textsuperscript{239} Accordingly, such ‘a plea of quasi-self-defence’ modified to meet the quite exceptional circumstances nature inflicted on the twins made the physicians’ intervention lawful.\textsuperscript{240}

### 4.4.1 Exceptional application of necessity to euthanasia

Even if currently necessity is not extended to intentional killings there is a valid discussion to be made for its exceptional application to some killing cases as in \textit{Re A}. Williams was one of the most prominent academics who insisted that necessity could be applied to euthanasia.\textsuperscript{241} He believed that it is likely a humane judge would accept that the value of human life is submerged by the strong necessity to relieve pain.

---

\textsuperscript{233} \textit{Re A} (n 226) 204 –205  
\textsuperscript{234} ibid  
\textsuperscript{235} ibid  
\textsuperscript{236} ibid 204  
\textsuperscript{237} ibid 204  
\textsuperscript{238} ibid 148  
\textsuperscript{239} ibid 148  
\textsuperscript{240} ibid 204  
\textsuperscript{241} Lewis (n 215) 284
especially when someone is terminally ill and insists on dying.\textsuperscript{242} To support this he used the 1938 case of \textit{R v Bourne}, where a 14-year-old girl was raped by five soldiers and became pregnant as a result.\textsuperscript{243} An eminent gynaecologist performed an abortion on her and was charged with the offence of conducting an illegal abortion.\textsuperscript{244} Eventually, he was acquitted, and the jury was directed that the unborn child may be destroyed to preserve the yet more precious life of the mother.\textsuperscript{245}

To better establish whether necessity could be extended to euthanasia, it is important to compare such cases to the circumstances in \textit{Re A} and \textit{Dudley and Stephens}. These cases are exceptional and dependent on their facts. The first thing which seems to differentiate euthanasia from the shipwrecked sailors is that the defendant does not decide who should die. In \textit{Dudley and Stephens}, the problem was that they did not draw lots on who should die.\textsuperscript{246} This points to a sense of morality in the case in the sense that the wrong was not killing and eating per se, but choosing who they would kill. In euthanasia, death is often dictated by the bad quality of life and often the repeated death requests.\textsuperscript{247} This is different from what the sailors did in \textit{Dudley and Stephens}, as they specifically chose the cabin boy to save themselves.\textsuperscript{248} Euthanasia seems more similar to \textit{Re A}, where the physicians did not choose which of the twins would die. The decision was simply made by the poor health of one of the twins.\textsuperscript{249}

However, simply not having selfish motives and not choosing who should die, are not adequate to establish the use of necessity for euthanasia. It is essential to consider whether the test for the use of this defence as set out in \textit{Re A} can apply in this context. The first requirement specified, that the accused should intend to avoid inevitable and irreparable evil, can be interpreted as relevant to some cases of euthanasia. If someone is experiencing unbearable pain and a significantly low quality of life, killing them could be considered as acting to avoid the inevitable and irreparable evil of

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{242} \textit{ibid} 284
\item \textsuperscript{243} \textit{R v Bourne} [1938] 3 All E.R. 615
\item \textsuperscript{244} \textit{ibid}
\item \textsuperscript{245} \textit{ibid}
\item \textsuperscript{246} \textit{R v Dudley and Stephens} (n 218)
\item \textsuperscript{247} Lewis (n 215) 282
\item \textsuperscript{248} \textit{ibid} 282
\item \textsuperscript{249} \textit{ibid} 282
\end{itemize}
\end{footnotesize}
extending their suffering.\textsuperscript{250} This might seem a somewhat extreme interpretation, but one should understand the amount of suffering entailed in certain illnesses.\textsuperscript{251} Also, they may have to endure the humiliation of not being able to take care of themselves and needing help even for the most basic tasks like going to the toilet or taking a bath.\textsuperscript{252} As explained in chapter 3, often when our life becomes increasingly bad due to the experience of intense pain and suffering, we experience a sense of indignity, which can be either objective in virtue of how others view us in society or subjective based on how we view due to what we are experiencing.\textsuperscript{253} Losing their functioning capacities might substantially impair their dignity and sense of security, as they might feel degraded from a higher standing of a fully functioning person to a lower, of being taken care like an infant.\textsuperscript{254}

Opponents of the application of necessity to euthanasia might reply that death is an extreme solution, as their intense pain could be alleviated through therapeutic options or appropriate hospice and palliative care.\textsuperscript{255} This is true, but not absolute for every case. There are a lot of situations where the suffering experienced is so intense that it cannot be eliminated.\textsuperscript{256} This limits the potential use of necessity to ensure that euthanasia is performed only when pain cannot be relieved by other means. Only then could death be perceived to comply with this requirement and being necessary to avoid the irreparable evil of further suffering and fear.

The second requirement of the necessity test, that it can be used when the accused has done no more than the reasonably necessary, is also relevant for some cases of euthanasia. Its application will depend on the defendant’s knowledge of the sufferer’s exact medical condition.\textsuperscript{257} If the defendant knows or believes that the sufferer might stop experiencing such intense pain, then it could not be accepted that they have done
only what is reasonably necessary. If they believed that their pain could have been alleviated the reasonable thing to do would have been to offer them palliative or hospice care, and not to kill them.

The final condition of Re A, requiring that the evil inflicted be proportionate to the evil avoided, might be the hardest to satisfy for euthanasia. This is because it would necessarily entail thinking of intentional termination of life as a lesser evil than living under unbearable suffering. Nonetheless, currently, life is typically considered an overriding value, which cannot be overruled by any other factor. It is sometimes presumed that the conjoined twins’ case overruled the importance which is normally attributed to life for the sake of the stronger twin’s interests, but this is not accurate. The Court of Appeal declared the separation to be lawful, even though Mary, who was the weakest twin, would be killed. Without the operation, both twins would eventually die within a few months. Jodie who was the stronger twin had a normal life expectancy once separated from her sister; while Mary had no chance of surviving independently and by her very existence posed a threat to Jodie’s life. Therefore, the court’s decision to perform the separation was to promote life. Death was not preferred over life, as the operation was the only way of keeping at least one of the twins alive and one death was considered a lesser evil than two deaths. Thus, the application of necessity for euthanasia does not follow from this case.

The legal unwillingness to regard termination of life as a lesser evil than unbearable suffering is evident in the case of Nicklinson. Tony Nicklinson suffered a severe stroke and became paralysed from the neck down. He wished to end his life but was unable to commit suicide without assistance. Thus, he sought a court declaration that the common law defence of necessity would be available to anyone who assisted him to die. The High Court ruled against this, and he died shortly after refusing nutrition,
fluids and medical treatment. Then his wife continued his petition to the Court of Appeal and Paul Lamb was added to the case. Lamb was a 57-year-old man who in 1990 was involved in a car accident in which he sustained multiple injuries leaving him paralysed. Lamb required constant care and experienced a significant amount of pain every day and had done ever since the accident, with the consequence that he was constantly on morphine and his condition was irreversible. He felt that he was trapped in his body and that he could not enjoy or endure a life that was so monotonous and painful and lacking in autonomy, thus he wished that a doctor should end his life. The Court rejected the argument in Nicklinson for the applicability of necessity in cases of euthanasia and ruled that all rights including autonomy and dignity have to yield to the importance of life. Five years later, Paul Lamb lost a High Court bid to challenge the law on assisted suicide, with two judges telling him his case was ‘unarguable’ and should not proceed to a full hearing. Eventually, he died naturally in 2021.

However, in the case of Re J, it was stated that in ‘exceptional circumstances’ the strong presumption in favour of life could be rebutted; affirming that someone could be allowed to die based on their best interests. However, as it is noted in this case, ‘the problem is to define those circumstances’. As was explained in chapter 3, sometimes it might be in our best interests to die when we are experiencing intense suffering and a life of very low quality. Or at least death would not render us worse off. Thus, in the future, a looser interpretation of the lesser evil doctrine might be possible. Under this interpretation, necessity will justify the ending of the life as preferable to enduring unbearable pain which cannot be otherwise relieved. Hence, the defendant will be acting in the sufferer’s best interests in a similar way that the

---

265 ibid
266 ibid
267 ibid
268 ibid
269 ibid para 14
270 ibid
272 ibid
273 Re J (A Minor) (Wardship: Medical Treatment) [1990] 3 All E.R. 930
274 ibid
275 Chapter 3.3
physicians in *Re A* operated for the stronger twin’s welfare. Such an interpretation will also distinguish euthanasia from *Dudley and Stephens*, as the sufferer’s best interests would not be ignored in the same way that the shipwrecked sailors ignored the interests of the cabin boy to save themselves.

It must be noted that this interpretation for the exceptional application of necessity is considerably medicalised. For this reason, this defence’s potential application is likely to be limited to physician-performed euthanasia. Physicians, due to their medical experience, will be able to fulfil the requirements of necessity as explained above. Without appropriate medical training, the defendant will not be able to appreciate if the suffering was inevitable or whether it could be alleviated through medication or some form of alternative treatment. Although often our loved ones, due to their close relationship, will be able to appreciate if the suffering is so extreme to prevent us from having a good quality of life, they lack the expertise of knowing whether it can be effectively relieved or not.

Thus, it has been argued that even if necessity is not typically extended to intentional killings, there is a valid argument to be made for its exceptional application to euthanasia. Provided that someone is experiencing unbearable pain and significantly low quality of life, in these circumstances, killing them could be considered as acting to avoid the inevitable and irreparable evil of extending their suffering, when this cannot be alleviated through other means. This is a very medicalised approach and will imply that the application of necessity is likely to be limited to physician-performed euthanasia.

### 4.4.2 Comparison with the Netherlands

Both euthanasia and assisted suicide were technically illegal in the Netherlands until the enactment of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 (‘Dutch Act’), which came into force on 1 April 2002.\(^{276}\) This made the Netherlands the first country in the world to legalise both euthanasia and

\(^{276}\) *Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding van 12 april 2001 [Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 12 April 2001] Stb 2001 194*
assisted suicide. Nonetheless, this Act only formally acknowledged what was already done informally, before the enactment of the Act. Dutch public prosecutors had declined to prosecute physicians who assisted deaths, provided they complied with the ‘due care’ criteria laid down by the Dutch Supreme Court in the 1984 case of Schoonheim. According to the *noodtoestand* defence which is generally considered to be available in situations of necessity these ‘due care’ criteria allowed physicians to perform assisted death. *Noodtoestand* refers to the situation of the patient’s dire distress, wherein an ethical dilemma and conflict of interests arise, resulting in a decision by the physician to break the law in the interest of what is considered a higher good.

More specifically, this defence was only available to physicians who were under a ‘psychological compulsion’ to commit the offence of euthanasia or were in an emergency, where there was a conflict of duties. Thus, they decided to break the law to promote a higher good. The emergency they are experiencing is that the patient is under extreme pain with no way of alleviating it, while their duty of preserving life conflicts with their duty to relieve the patient’s suffering and fulfil their wishes to die. In the case of Alkmaar, a physician-administered a series of lethal injections to an elderly patient who was seriously ill with no prospects of improvement. It was decided that he had faced a conflict of duties between the duty to preserve life and the duty to alleviate suffering due to the emergency situation. Hence, he used *noodtoestand* and was acquitted of the offence of taking the life of another, at their express and earnest request under Article 293 of the Dutch Criminal Code.

---

278 *Hoge Raad (Strafkamer) [Supreme Court (Criminal Division)] 27 November 1984 reported in Nederlandse Jurisprudentie 1985*
279 *ibid*
281 *Alkmaar Case Nederlandse Jurisprudentie 1985 No.106, Supreme Court 27 Nov 1984*
282 *Ost (n 135) 109*
283 *Alkmaar Case Nederlandse Jurisprudentie (n 281)*
284 *ibid*
285 *ibid*
286 *ibid*
Although *noodtoestand* is said to be available in situations of necessity, it has many important differences from the English defence of necessity. *Noodtoestand* is based on the conflict of duties which makes it limited to physicians. Physicists’ duties typically involve the obligation to respect the patient’s right to bodily integrity and the duty to provide medical treatment that preserves the patient’s life or health. Thus, *noodtoestand* is different from necessity as the Dutch definition of the conflict of duties is not present in the English definition. The decision as to whether or not assistance with dying can be justified is primarily a medical decision in the Netherlands. The conflict of duties will come in favour of euthanasia when a physician feels compelled to comply with a request for death, rested on the premise that no other course of action would satisfactorily relieve suffering. In England, a physician’s conflicting duties are relevant only when a patient cannot authorise their actions through consent. Then, a physician can justifiably administer treatment under necessity, which is in the patient’s best interests to receive. Therefore, necessity could not be applied in England in the same way that *noodtoestand* is in the Netherlands.

### 4.4.3 Problems with the application of necessity

Even though necessity is very different from *noodtoestand*, as noted above, upon a potential redefinition of the importance which is typically attributed to life there is a valid argument to be made for its exceptional application to euthanasia. Following the test established in *Re A*, the defence might apply when the person killed was under extreme suffering with no other means to relieve it. According to Williams, one might consider the termination of life to be a lesser evil than unbearable suffering only if ‘no span of useful life is left’ to the sufferer. However, accepting in practice necessity as a defence for euthanasia to alleviate suffering would be very hard. In *R v Quayle*, five appellants appealed against convictions for the cultivation, production and

---

287 Ost (n 135) 109  
290 *Re F (mental patient: sterilisation)* [1990] 2 A.C. 1  
291 ibid  
292 Lewis (n 215) 275
possession of cannabis and cannabis resin. They sought to plead medical necessity, on the basis that cannabis prevented them from suffering severe pain. It was ruled that where there is only a general assertion that the offending was to prevent or alleviate pain, it is difficult to identify any factors to measure whether the motivation was such as to override the defendant’s will or force him to act as he did. Thus, the plea of necessity was rejected.

It must be noted that Quayle seems to be strongly policy-based as it was noted that there were strong public policy grounds for not treating necessity as covering the conduct of the cases involving the alleged medicinal use of cannabis. It was submitted that an accused who was seeking to avoid their pain was unable to show that the allegedly causative feature of the commission of the offence was an extraneous circumstance, while those who were seeking to avoid pain for others could not reasonably be said to have a responsibility towards those for whose benefit they claimed to be acting. Thus, according to the Attorney-General, the defence of necessity did not embrace the avoidance of serious pain, and should not be extended to do so. Meeting Re A’s third requirement for euthanasia, that the evil inflicted was not disproportionate to the evil avoided, would be difficult. Even though the alleviation of pain can justify considerable levels of physical intrusions, such as surgery, the courts are reluctant to accept that it can justify the intentional destruction of life.

An important issue that might preclude the appropriate application of necessity to euthanasia is that under its interpretation there is no requirement of a voluntary request for death. The lesser evil analysis might justify ending a person’s life to alleviate their suffering regardless of their power to consent. In Nicklinson, there was an argument that necessity should be available for euthanasia cases because there is a duty owed by physicians to the claimant based on his rights of autonomy.

---

293 R v Quayle [2005] 1 W.L.R. 3642
294 ibid
295 ibid
297 Quayle (n 293)
298 ibid
300 Michalowski (n 288) 363
self-determination, dignity and private life. However, it has been argued convincingly by scholars that the duties that correspond to the principle of autonomy are all negative duties, of a non-interfering nature. None of them requires the provision of positive help. This leads to an important issue regarding the protection of vulnerable individuals, which is that necessity does not include an assessment of a voluntary request for death.

The same problem exists upon considering Lord Justice Ward’s view in Re A that the separation of the conjoined twins was justified by a quasi-self-defence as physicians were coming to Jodie’s defence by removing the fatal threat posed by Mary and that made the intervention by the physicians lawful. This argument cannot be applied in the same way for euthanasia, as there is no third person from which the physician needs to save another. The physician acts to save them from intense suffering. Nonetheless, even if the comparison of self-defence was applicable in euthanasia cases as it was in Re A, this defence is not designed to be applied in this context, and a request to die is not entailed in its interpretation. Therefore, if necessity is applied in this context following Re A, it will be available not only in cases of voluntary euthanasia that involve a request to die but also in non-voluntary euthanasia; to those non-competent to request it, and involuntary euthanasia; performed against the expressed wishes of the sufferer.

For example, in the 1995 Dutch cases of Prins and Kadijk, two critically ill and severely disabled infants were killed using noodtoestand. The Prins case involved a three-day-old baby with spina bifida, whilst the case of Kadijk involved a 24-day-old baby with trisomy 13. As the infants in both cases had a limited life expectancy with

---

301 R (Nicklinson) v Ministry of Justice (n 262) para 26
302 John Griffiths, Alex Bood, Heleen Weyers, Euthanasia and Law in the Netherlands (Amsterdam, Amsterdam University Press, 1998) 171
303 ibid 171
304 Re A (n 226) 204
305 Chapter 2.2.1
307 Rechtbank Alkmaar (Prins) [District Court of Alkmaar] 26 April 1995 reported in Nederlandse Jurisprudentie 1995 nr 602
308 Rechtbank Groningen (Kadijk) [District Court of Groningen] 13 November 1995 reported in Nederlandse Jurisprudentie 1996 nr35
suffering that could not be alleviated, at the explicit request of their parents, the infants’ physicians ended their lives with lethal medication. In neither of these cases were the physicians found guilty of murder. Instead, in both cases, the courts accepted the defence of necessity and found the physicians to have acted according to sound medical opinion and within the norms of medical ethics.

This is particularly problematic since a request to die is an indication that the killing was not abusive. The grantor of their request was simply complying with their wishes and by killing them they were not deprived of something they valued and in a sense, they are not wronged. Vulnerable individuals will be in danger of being killed against their will simply because their health is degrading. Since necessity is a full defence providing full removal of criminal liability, it is questionable whether it should be available to cases of involuntary and non-voluntary euthanasia. As we saw in the previous chapter, a request to die along with that being in the requestor’s best interests, render killing only a pro tanto wrong and life could justifiably be ended. Since a request to die cannot be guaranteed under necessity, we would not be entirely content to have the act of ending life performed and there will be societal harm.

Thus, even though it is evident that the use of necessity for euthanasia cases could be a theoretical possibility, provided there is a redefinition of the importance attributed to life, there are important issues to consider. According to recent case law, it is somewhat hard to accept this defence in practice for alleviating intense suffering. Furthermore, it is particularly problematic that a consent requirement cannot be guaranteed under this defence’s interpretation, meaning that it would be available to euthanasia cases irrespective of a request to die. Given that this is a full defence that provides full removal of criminal liability, it is questionable whether its application in this context is appropriate. Consequently, although necessity could, in theory, apply to euthanasia, it should not be accepted in practice. Such concerns about a combination of intense suffering and a request for death might be more easily accommodated within the criminal law defence of consent.

309 Griffiths, Bood and Weyers (n 302) 350-351
310 ibid 350-351
311 ibid 350-351
4.5 Consent

As previously explained, consent is generally a very important notion which legally expresses the idea of autonomy; the right to act and govern oneself according to our beliefs, values, and choices without interference, as long as our behaviour does not harm others.\textsuperscript{312} Thus, consent is used to distinguish morally permissible from morally impermissible conduct.\textsuperscript{313} It is a concept that is important across various legal contexts such as assaults, medical law and sexual offences. In medical law, informed consent is used to authorise medical treatment,\textsuperscript{314} as non-consensual touching of the patient might found an action for damages or assault.\textsuperscript{315} In sexual offences, an element of the offence of rape is the absence of consent and reasonable belief in consent.\textsuperscript{316}

For this discussion, we are interested in how consent is used as a defence in criminal law for assaults, to prevent state interventions in situations in which the harm in question is self-regarding and autonomously consented to.\textsuperscript{317} It is usually presumed to be wrong for someone to harm another under criminal law.\textsuperscript{318} Nonetheless, under the defence of consent, this behaviour can be justified, on the basis that the other person competently and voluntarily consented to the harm inflicted.\textsuperscript{319} Then the otherwise criminal act becomes legal and the defendant is not criminalised.\textsuperscript{320} Thus, in a sense, this defence protects our right to autonomy by allowing us to make choices even if they involve our harm.\textsuperscript{321}

\textsuperscript{312} Chapter 3.3
\textsuperscript{314} Chapter 2.3.1
\textsuperscript{315} John K. Mason and Graeme T. Laurie, \textit{Law and Medical Ethics} (Oxford, Oxford University Press, 2016) 68
\textsuperscript{316} Sexual Offences Act 2003 s 1
\textsuperscript{319} ibid 98
\textsuperscript{320} ibid 98
\textsuperscript{321} ibid 98
However, this expression of autonomy through the defence of consent is not always absolute.\textsuperscript{322} There are certain situations where it is illegal for someone to harm another, even if they have agreed to it.\textsuperscript{323} According to the leading case of \textit{Brown}, consent cannot generally be used as a defence for actual bodily harm or more serious injury.\textsuperscript{324} In this case, the defendants were a group of men engaging in sadomasochistic acts against each other for sexual gratification.\textsuperscript{325} This was discovered by an unrelated police investigation,\textsuperscript{326} and they were eventually convicted for inflicting bodily injury, with or without weapons and for assault occasioning bodily harm.\textsuperscript{327} They tried to use the defence of consent as their behaviour was consensual, but the court ruled that this defence was inapplicable under the circumstances of the case.\textsuperscript{328} It was held to be against the public interest that injuries should be allowed to be inflicted on others without good reason.\textsuperscript{329} Here, the defendants’ activities ‘were unpredictably dangerous and degrading to body and mind and were developed with increasing barbarity and taught to persons whose consents were dubious or worthless.’\textsuperscript{330}

Following \textit{Brown}, consent can never be used as a defence to euthanasia or assisted suicide cases.\textsuperscript{331} As Lord Mustill argued in \textit{Bland}, there is no satisfactory reason to suggest that it makes a legal difference if the patient consents to end their life.\textsuperscript{332} The interest of the state in preserving life overrides the interest of the patient’s autonomy.\textsuperscript{333} The House of Lords Select Committee on Medical Ethics observed in 1994 that ‘the issue of assisted death is one in which the interest of the individual cannot be separated from the interest of society as a whole.’\textsuperscript{334} Especially, active intentional killings are currently regarded as always violating the public interest.

\begin{itemize}
\item \textsuperscript{322} ibid 98
\item \textsuperscript{323} ibid 98
\item \textsuperscript{324} \textit{R v Brown} [1994] 1 A.C. 212
\item \textsuperscript{325} ibid 238
\item \textsuperscript{326} ibid 238
\item \textsuperscript{327} ibid 238
\item \textsuperscript{328} ibid 238
\item \textsuperscript{329} ibid 238
\item \textsuperscript{330} ibid 238
\item \textsuperscript{331} Baker (n 318) 111
\item \textsuperscript{332} \textit{Airedale NHS Trust v Bland} [1993] A.C. 789, 892–893
\item \textsuperscript{333} ibid 892–293
\item \textsuperscript{334} Report of the Select Committee on Medical Ethics (1993-94, HL21-1) (HMSO 1994) 48
\end{itemize}
Brown essentially limits the exercise of autonomy for actual bodily harm for the sake of public interest and human dignity. However, a few exceptions to this rule have been recognised, where consent can be used as a defence in this context when there is a good reason in the public interest. These exceptional categories include sporting activities, dangerous exhibitions and bravado, rough and undisciplined horseplay, surgeries, tattooing, body piercing, religious flagellations or any consensual acts in the course of which one individual is infected with a medical condition. Further exceptional categories can be created if the activity in question is beneficial to society.

It is questionable what are the exact reasons in the public interest that differentiate these from sadomasochism or assisted deaths. Some of the reasons provided for sports being in the public interest are that they are culturally rooted, popular, promote fitness, are regulated by governing bodies and have safety rules with medical assistance on hand. But while these are valid, certain sports are inherently dangerous, like boxing, which cannot be exercised without a high possibility of physical harm. A boxer may suffer serious injuries, such as chronic brain damage as a result of their involvement in this sport. If the sadomasochistic activities in Brown were considered dangerous and degrading, the same could be argued for sports such as boxing that involve a considerable level of risk.

Another category whose legality for public interest reasons can be questioned is rough and undisciplined horseplay. In Jones, the defendant was playing with other children and was throwing the victim in the air, who eventually fell and was seriously injured. The Court of Appeal ruled that the victim had consented to rough horseplay or at least

---

335 Simon Cooper and Mark James, ‘Entertainment – the Painful Process of Rethinking Consent’ (2012) 3 Criminal Law Review 188, 190
336 Herring (93) 372
337 ibid 373
338 ibid 192
339 ibid 373
340 ibid 193
337 Cooper and James (n 335) 192
342 ibid 193
the defendant had this impression.345 The whole escapade was a joke and the children had no intention of causing the victim any serious harm, though they had foreseen that they might get the odd bruise, as boys do in playground roughness.346 Thus, they could use the defence of consent against the charges of assault.347 It was considered that if rough horseplay were criminalised, all around the country there would be numerous offences taking place, as it is a common activity.348 It is a typical part of childhood and it would be unrealistic to punish it.349

Nonetheless, while this is true and we cannot criminalise all rough horseplay, some cases have taken this exception too far to justify behaviours that are beyond the scope of typical childish play and could be characterised as degrading and dangerous. In Aitken, the appellants were RAF officers, and during a celebration on completing their training, they set fire to three officers wearing their fire-resistant clothing, and the third officer sustained serious burns.350 Nonetheless, it was ruled by the Court of Appeal that no offence had been committed.351 Also, in Richardson and Irwin, the court regarded as rough horseplay a group of students who were throwing the victim off a 12 foot high balcony after drinking at the student union.352 It is questionable how such behaviours could be regarded as rough horseplay, which is beneficial in the public’s welfare.

Not all reasons of ‘public policy’ seem to be convincing reasons in favour of the public interest. This raises the question of whether the policy reasons against allowing this defence for assisted deaths, are persuasive. Kleinig notes that the preservation of shared morality and not the public’s protection is the true reason for prohibiting consent to euthanasia.353 A grantor of a wish to die is no menace to others.354 But there are certain standards of behaviour or moral principles that society requires to be

---

345 ibid
346 ibid
347 ibid
348 ibid
349 ibid
350 R v Aitken and Others [1992] 1 W.L.R. 1006
351 ibid
352 Richardson and Irwin [1999] 1 Cr. App. R. 392
353 John Kleinig, ‘Consent as a Defence in Criminal Law’ (1979) 65(3) Archives for Philosophy of Law and Social Philosophy 329, 333
354 ibid 333
observed, such as the importance which is typically attributed to human life.\textsuperscript{355} The breach of such principles is considered an offence not merely against the person who is injured but against society as a whole.\textsuperscript{356} Therefore, it is worth examining whether there are good reasons in the public interest for the exceptional application of the defence of consent to cases of assisted death.

4.5.1 Exceptional application of consent for assisted death

Regardless of whether one agrees with the outcome in \textit{Brown} or not, it is the leading authority dictating that consent cannot be used as a defence to actual bodily harm, as it is against the public interest. However, \textit{Brown} represents a very different example of consensual harm when contrasted to assisted deaths. In \textit{Brown}, the defendants were engaging in sadomasochistic practices for their sexual gratification, which the court regarded as not a good reason, in the public interest, to allow the defence of consent. But this is quite distinct from the facts in assisted death cases, where the defendant kills or aids the requestor to die out of respect for their wishes, and to save them from further suffering.

It is argued that for assisted death, there is a good reason in the public interest and it is beneficial to a person’s dignity to allow consent as a defence to harm. When life has dropped beyond a certain quality threshold, and the person concerned wants to end it, it could be in the public interest to allow them to die. Assisted death will not be degrading, and it could be in the public interest to save those individuals from their misery. Taking the approach advocated in chapter 3 will necessarily involve a redefinition of the importance given to life as an absolute value. No person should be forced to endure the indignities involved in dying against their will, and consent should be allowed as a defence. Therefore, it could be considered in the public interest to allow consent as a defence for people under extreme suffering who are experiencing a very bad quality of life and want to be killed or to be assisted in killing themselves.\textsuperscript{357}

\textsuperscript{355} ibid 333
\textsuperscript{356} ibid 333
\textsuperscript{357} Campaign for Dignity in Dying, ‘Assisted Dying’ (Dignity in Dying) https://www.dignityindying.org.uk/assisted-dying/ accessed 12 August 2021
It must be noted that suffering should not be limited to the physical element, but could also include mental suffering.\textsuperscript{358} Often, psychological suffering might be equally painful to physical deterioration and might make someone's life extremely miserable. An example in the Netherlands is the case of Chabot, where a psychiatrist complied with a woman's repeated requests for assistance in committing suicide, after terrible grief and unhappiness following the death of her children had left her irretrievably determined to end her life.\textsuperscript{359} The Court accepted that there may be circumstances in which noodtoestand could apply in the absence of unbearable physical suffering, provided that there was serious psychological suffering that could not be alleviated through other means.\textsuperscript{360}

Treating mental illness is complex and usually does not result in a 'cure,' per se.\textsuperscript{361} Rather it aims to make us feel better, get better, and eventually no longer need treatment.\textsuperscript{362} But even then, professionals are reluctant to state that there was a complete cure of the condition.\textsuperscript{363} This reluctance comes from the belief that mental illness is far more recurring than many physical diseases.\textsuperscript{364} Thus, many mental illnesses might be equally tormenting to physical suffering. Even if a person continues to live physically, they may not have any options of living a good life in the future.

Some might argue that even in situations of increased suffering, dignity can be maintained through adequate palliative care.\textsuperscript{365} Palliative care is thought to often relieve much of the pain experienced.\textsuperscript{366} Hence, there is no need for assisted death as a means to stop the patient's suffering.\textsuperscript{367} As explained earlier in this chapter, although this is true in some cases, is not always. Often there is such an increasing decline and intense suffering that even with skilled end of life care, our physical

\begin{flushleft}
\footnotesize
\textsuperscript{358} Lewis (n 215) 276
\textsuperscript{359} Office of Public Prosecutions v Chabot, Nederlandse Jurisprudentie 1994 No 656, Supreme Court
\textsuperscript{360} ibid
\textsuperscript{361} John M. Grohol, ‘How Do You Cure Mental Illness?’ (Psych Central, 8 July 2018) https://psychcentral.com/blog/how-do-you-cure-mental-illness/ accessed 3 October 2021
\textsuperscript{362} ibid
\textsuperscript{363} ibid
\textsuperscript{364} ibid
\textsuperscript{365} Annette E. Clark, ‘Autonomy and Death’ (1997) 71(1) Tulane law review 45, 103
\textsuperscript{366} ibid 103
\textsuperscript{367} ibid 103
\end{flushleft}
integrity and functional ability is so minimised that our life is beyond what we might perceive as dignified.\textsuperscript{368} Nevertheless, in the potential application of the defence of consent to assisted death cases, it is important to ensure that all available options of maintaining dignity have been exhausted, and it is appropriate for patients to experience adequate hospice or palliative care before being assisted in dying.

Similar safeguards for palliative care can be seen in jurisdictions with some form of assisted dying legislation. In Belgium where both assisted suicide\textsuperscript{369} and euthanasia are allowed under certain conditions,\textsuperscript{370} the physician is required to discuss the death request, health and life expectancy, and possible therapeutic and palliative treatment available with the requestor.\textsuperscript{371} These discussions must be spread out over a reasonable time, to allow the physician to be certain of the persistence of the requestor’s suffering and the enduring character of the request.\textsuperscript{372} While the Belgian Act on Euthanasia does not include a mandatory requirement for a requestor to receive palliative care, according to the Belgian Palliative Care Act, which was passed at the same time, every requestor approaching the end-of-life should be able to benefit from palliative care.\textsuperscript{373} A few months after the Belgian Act was passed, the Belgian Medical Disciplinary Board issued a set of guidelines endorsing the Belgian Act, and emphasising that palliative care must be exhausted as an option before resorting to euthanasia.\textsuperscript{374} As a result, every Belgian hospital has a palliative care team, and palliative home care is available nationally.\textsuperscript{375}

\begin{thebibliography}{9}
\bibitem{HA} David Harris, Benjamin Richard, Pankaj Khanna, ‘Assisted Dying: The Ongoing Debate’ (2006) 82(970) Postgraduate Medical Journal 479, 479
\bibitem{BE} Belgian Act on Euthanasia s 2
\bibitem{BI} ibid s 3
\bibitem{BS} ibid s 2(2)
\bibitem{JL} Jan L. Bernheim and Arsène Mullie, ‘Euthanasia and Palliative Care in Belgium: Legitimate Concerns and Unsubstantiated Grievances’ (2010) 13(7) Journal of Palliative Medicine 798
\end{thebibliography}
Canada was the first common law country to allow medical assistance in dying, including both cases of euthanasia and assisted suicide under certain conditions. Among these conditions it is specified that to be eligible for medical assistance in dying in Canada, the requestor must give informed consent to receive such medical assistance after having been informed of the means that are available to relieve their suffering, including palliative care. Requiring in a potential application of the consent defence to assisted deaths that the requestor must first experience adequate hospice or palliative care is a much stricter requirement than those followed in foreign jurisdictions. Nonetheless, in this way, we can ensure that assisted death is truly an option of last resort, and not an alternative to other means of medicine, but a part of a continuum of medical treatment.

Furthermore, upon a close examination of the Brown ruling, another limitation is placed on the kinds of assisted death that should be justified under the defence of consent. In this case, the defendants’ activity was characterised as barbaric. They were nailing their prepuces and scrota to a board, inserting hot wax into their urethras, burning their penises with candles, and incising their scrota with scalpels, which caused the exudation of blood and put them at risk of contracting septicaemia and HIV. In Wilson, the defendant’s absence of aggressiveness was one of the reasons for allowing his wife’s consent to having her husband brand his initials onto her buttocks. If it were judged to be in the public interest to allow assisted death, it would be important that it is performed in a dignified manner, which might involve the assistor handing or administering lethal medication to the requestor.

This point is related to another important issue regarding the application of consent to assisted deaths. Since the boundaries of this defence are explicitly based on public interest judgements, its application will be limited to those cases of euthanasia and assisted suicide which are performed by medically-trained individuals such as physicians. As noted above, untrained individuals, with no medical experience, might

---

376 Canadian Criminal Code s 241.1
377 ibid s 241.2 (1)
379 R v Brown (n 324) 246
381 Michalowski (n 288) 351
cause botched euthanasia and assisted suicide attempts, and eventually could leave the requestor in a worse condition than before or cause them further pain and agony during the procedure. It is thus in the public interest to limit the availability of this defence to physicians who due to their medical experience can practise assisted death as an act of responsible benevolence.

Therefore, it is evident that consent is a suitable defence in principle to apply to cases of assisted death. It could be considered in the public interest to allow consent as a defence for people under extreme suffering who are experiencing a very low quality of life and want to be killed or to be assisted in being killed following the argument proposed in chapter 3. It is important to ensure, if consent is applied in these cases, that all available options including hospice and palliative care have been exhausted. Also, we must ensure that assisted death is performed in a dignified manner which involves the assistor handing or administering lethal medication to the requestor. Furthermore, since the boundaries of this defence are based on public interest judgements, its application should be limited to those cases of assisted death that are performed by medical practitioners.

4.5.2 Ensuring competence, information and voluntariness

While it is evident that consent is a suitable defence in principle to use for cases of assisted death, there are some limitations that need to be placed on it to ensure the protection of vulnerable individuals. Not every decision is worthy of the same amount of respect, as people differ in intellectual ability, experiences or emotional reactions, which might preclude the objective processing of medical information. Therefore, not every death decision for those suffering unbearably should be endorsed. To offer adequate protection to vulnerable people when applying the defence of consent to assisted deaths, it is important to place limitations to ensure consent is competent, informed and voluntary. However, such limitations have not been developed at all in the existing law of consent dealing with offences against the person. Thus, we need

---

382 Peter Marzuk, 'The right kind of paternalism' (1985) 313(23) The New England journal of medicine 1474, 1476
to extend the application of this defence, and the most sensible option is to create further specific safeguards for assisted death cases.

Competence is what makes our choices truly autonomous, as not all people enjoy the same ability to decide freely without interference, which might preclude the objective taking of decisions. As explained in chapter 2, only a capable individual can make decisions about their future, while choices by mentally fragile individuals are not given legal validity. But the fact that someone is under extreme suffering, either physical or mental, does not suggest that they are incompetent. As is evident from Re B, a person under intense mental suffering or physical deterioration is still mentally competent and has the same right to personal autonomy as any other capable person. Although it is true that in some cases of intense physical or mental suffering the requestor might be incompetent, competence is task-specific and should be judged on a case-by-case basis. We can be competent to request to die, even if at the same time we are incompetent to make other choices. Competence both for those suffering mentally and for those suffering physically will be judged on a case-by-case basis. For those cases where the requestor was not competent the defence of consent should not be available.

In medical law, the test for determining capacity has been addressed in Re C and then placed on a statutory footing by the Mental Capacity Act of 2005, which has been outlined in chapter 2. Assisted deaths are largely a medical decision as the wish to die is initiated by the deterioration of health. Thus, if the defence of consent was accepted for assisted death, the most likely test to use would be the medical test of competence as described in the Mental Capacity Act 2005. This is supported by the fact that under the DPP’s guidelines on cases of assisted suicide, it is mentioned as a factor in favour of prosecution that the victim did not have the capacity, as defined by

383 Chapter 2.3 and 2.4
384 Re B (Adult: Refusal of medical treatment) [2002] 2 All E.R. 449
385 Kasper Raus, and Sigrid Sterckx, ‘Euthanasia for Mental Suffering’ in Michael Cholbi and Jukka Varelius (eds), New Directions in the Ethics of Assisted Suicide and Euthanasia (Cham, Springer, 2015) 86
386 Re C [1994] 1 All E.R. 819
387 Mental Capacity Act of 2005
the Mental Capacity Act 2005, to reach an informed decision to commit suicide.\textsuperscript{388} However, since this test was not designed for assisted death there are some important issues with its application, which need to be addressed. These were explained in chapter 2.

The first problem which was explained in chapter 2 arises from the first requirement of the test, stipulating that a person is unable to decide if they cannot understand the information with which they are provided. The way and the degree to which an individual understands this information is influenced by the nature and the amount of information they receive.\textsuperscript{389} This is problematic in assisted death cases as the requestor might be easily manipulated by the provider of the information by being provided with confusing or misleading information. In this way, the provider of the information might have more control over the person’s future than themselves, as they are the judge of the amount and the kind of information they give and lead people to request assisted death to gain something from their passing.\textsuperscript{390}

Another problem that was referenced in chapter 2 is that the test of competence does not require in-advance psychological or psychiatric assessment for determining capacity.\textsuperscript{391} This is particularly important for assisted death decisions as often we might have a strong emotional reaction to the suffering we are experiencing, which will limit our capacity and may cause an intention to end our life. Impaired cognitive function is one of the characteristics of a depressive disorder.\textsuperscript{392} This involves a rigid tendency to see only one possible solution, such as suicide.\textsuperscript{393} It is thus important to acknowledge that the appropriate help should be given to people suffering from depression. Although such conditions do not necessarily mean that we are incompetent, sometimes they can substantially impair our decision-making capacity. The fact that under this test of competence, they can remain undetected, and assisted

\textsuperscript{388} Director of Public Prosecutions, ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (Crown Prosecution Service, February 2010) para 43(2) http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html accessed 11 June 2021
\textsuperscript{389} Chapter 2.3.1
\textsuperscript{390} ibid 2.3.1
\textsuperscript{391} ibid 2.3.1
\textsuperscript{392} ibid 3.5
\textsuperscript{393} ibid
death can be justified represents an important problem in using the defence of consent.

Besides competence, another important factor that can negate consent and needs to be considered is whether the requestor’s decision to die was well-informed. The importance of this can be seen from the fact that the DPP’s guidance on prosecuting assisted suicides mentions as a factor in favour of prosecution that the victim had not reached a voluntary, clear, settled and informed decision to commit suicide. As explained in chapter 2, medical law provides that to be able to make an informed decision regarding our future, we must be given all of the information in terms of what the treatment involves. Implicit within this duty to provide sufficient information is the obligation to provide accurate information. If in medical law for a simple surgery or medical treatment a patient is required to be given all the relevant information, then we should require the same when seeking to justify assisted deaths, which involve a far more important decision.

But to ensure that the requestor can make such an informed decision for assisted deaths, it is essential to make relevant information more accessible. Currently, we can see an unwillingness to inform the public about such practices, probably in an attempt to keep the numbers of assisted deaths low. The DPP states as a factor in favour of prosecution that the suspect ‘was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication’. Furthermore, it is stated as a factor in favour of prosecution that the suspect ‘was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer (whether for payment or not), or as a person in authority, such as a prison officer, and the victim was in his or her care’. Such provisions make it extremely difficult to obtain any meaningful information on assisted death. It seems that currently, the only way that the requestor can access relevant information is through private research.

394 ibid 2.2.2, Table 1
395 ibid 2.3.1
396 ibid
397 ibid 2.2.2, Table 1
398 ibid
If the defence of consent becomes available in assisted death cases, it is important to allow physicians to provide relevant information to those interested. In this way, we can better assure that they are making an informed decision. This has been also followed in jurisdictions with assisted death legislation. Under the Death with Dignity Act in Oregon, assisted suicides are allowed by physicians provided, among other conditions that they inform the requestor of all feasible alternatives, such as comfort care, hospice care, and pain-control options. Furthermore, in the Netherlands under specified conditions of performing euthanasia and assisted suicide in the Dutch Act, it is mentioned that a physician must inform the requestor of their condition and further prognosis and discuss the situation with the requestor and come to a joint conclusion that there is no other reasonable solution. They must also consult an independent physician who must examine the requestor and confirm in writing that the attending physician has satisfied the ‘due care’ criteria. The physician should be independent, to reduce the possibility of manipulating the procedure and misinforming the requestor. Having such requirements when applying consent to assisted deaths would be very important in ensuring an informed decision to die is made by the requestor. But it will also require a substantial change in policy in making professional information on assisted death much more accessible to the wider public.

The final thing to consider when assessing consent as a defence for assisted deaths is whether the decision to die was voluntary. As explained in chapter 2, the absence of consent can be implied when the victim has been subject to violence. The DPP’s policy follows a similar provision, mentioning as a factor in favour of prosecution that the suspect pressured the victim to commit suicide. It also states that prosecution is more likely to be required if the suspect had a history of violence or abuse against the victim. Additionally, a factor in favour of prosecution is that the suspect was motivated by the prospect of gaining something from the death of the victim. In such situations, it is possible that in the prospect of gaining they might have pressured the

---

399 Oregon Revised Statutes § 127.815
400 Dutch Act (n 276) sub-s 2(1)
401 ibid sub-s 2(1)
402 Chapter 2.3.1
403 ibid 2.2.2, Table 1
404 ibid
405 ibid
victim into requesting assisted suicide. But it is important to clarify that simply gaining something in the form of inheritance might be common in such cases. It does not necessarily suggest that the decision to die was coerced.

Glover suggests that, to avoid coercion, the decision to die should be deliberated over a fairly long period.\textsuperscript{406} This has been also implemented in jurisdictions with assisted death legislation. For example, Belgium requires that the request for euthanasia and assisted suicide needs to be voluntary, well-considered and repeated, and not the result of any external pressure.\textsuperscript{407} In Switzerland where many assisted suicides of British citizens are performed\textsuperscript{408} one of the most famous right-to-die organisations called Dignitas, requires that the requestor is making a voluntary and considered choice by making repeated initiatives before proceeding.\textsuperscript{409} Furthermore, in Oregon, a requirement imposed for assisted suicides, is that there should be two oral requests and one in writing.\textsuperscript{410} There should be two ‘cooling-off’ periods before a prescription is issued, a 15-day lapse between the requestor’s initial oral request and the writing of a prescription, and a 48-hour lapse between the requestor’s written request and the writing of the prescription.\textsuperscript{411} These ‘cooling-off’ periods ensure that the requestor’s request is voluntary, informed and well-considered. To ensure that the requestor’s desire for death remains unchanged, and is not the result of pressure, the Act requires that immediately before a prescription is written, the attending physician verifies that the requestor is making an informed decision.\textsuperscript{412} However, imposing such a limitation when applying the defence of consent to cases of assisted death does not directly address the issue of potential coercion, and it might be difficult to rely on estimations made at different times and moods.\textsuperscript{413} Nonetheless, such safeguards will at least better allow us to acquire an impression of the requestor’s actual desire to die.\textsuperscript{414}

\textsuperscript{407} Belgian Act on Euthanasia (n 370) s 3
\textsuperscript{408} Margaret Branthwaite and David Jeffrey, ‘Should patients be able to choose physician-assisted suicide at the end of their lives?’ (2006) 7(7) Lancet Oncology 602
\textsuperscript{410} Oregon Revised Statutes (n 399) §127.840
\textsuperscript{411} ibid § 127.850
\textsuperscript{412} ibid § 127.830
\textsuperscript{413} Glover (n 406) 174
\textsuperscript{414} ibid 185
This analysis of the defence of consent shows that while this is a suitable defence in principle to use for assisted deaths, many important limitations would need to be placed on it to protect vulnerable individuals against abuse. These have not been developed in the existing law dealing with different offences against the person. Thus, if consent is used for assisted death, we need to extend its application by creating new specific safeguards. Firstly, it must be ensured that the assisted death decision is competent. The most probable test of competence to use is the one defined under the Mental Capacity Act 2005. However, since this test was not designed for assisted deaths, it presents some important problems. These include that the provider of the information might have too much control over the requestor's decision and that it does not include a psychological or psychiatric assessment. Secondly, the assisted death decision needs to be well-informed. However, there is currently an unwillingness to provide any meaningful information on assisted death, as is evident from the DPP's guidelines on assisted suicide. Thirdly, the assisted death request must be made voluntarily, as often individuals might be pressured in their decision by someone who has something to gain from their passing. A potential way to address such concerns is to allow for the decision to be deliberated over a fairly long period of time. As these problems suggest, even with an incremental expansion of the existing consent defence, it is unlikely that it would do the required work when applied in assisted death cases. Thus, it would be better to create a dedicated new defence to deal with these cases. Consent being the most suitable in principle of the examined defences can potentially provide a useful reference point for creating a consent-type defence specifically for physician-assisted death, which will be considered in the next chapter.

4.6 Conclusion

In conclusion, this chapter examined whether we can achieve a more lenient treatment of assisted death cases through the existing defences of diminished responsibility, necessity and consent. In the first part of this chapter issues such as the differentiation between offences and defences were explained as well as the meaning of excuse and justification defences. It was argued that through applying one of the existing defences the wrong of the assisted death will be acknowledged but a degree of exculpation will be offered in recognition of the unique circumstances.
The examination of diminished responsibility was important since before its 2009 reform it was used many times in euthanasia cases. However, after examining the current reformed plea, it was evident that it would be very hard to apply this defence to euthanasia cases as it currently stands. But even if a sympathetic judge and jury were ready to accept this plea, there would be considerable problems of fair labelling, due to its medicalised and stigmatising nature. Due to the problems presented, diminished responsibility was deemed an inappropriate defence to use in euthanasia cases.

Necessity is a defence that is generally inapplicable to killing cases. But it has been supported that there is an argument to be made for its exceptional application to euthanasia upon a redefinition of the importance typically attributed to life. We should accept that our life can lose its value when we are under intense suffering that cannot be alleviated. Then necessity can justify the intentional ending of life as being preferable to enduring unbearable pain which cannot be otherwise relieved. Nonetheless, after examining Quayle it was evident that it will be hard for the courts to accept necessity as a plea for crimes committed to alleviate intense pain. But even if a necessity plea was accepted, there are other important issues to consider. A request to die cannot be guaranteed under this defence’s interpretation. Thus, it would be available in cases of non-voluntary and involuntary euthanasia. Given that this is a full defence that provides full removal of criminal liability, it was questioned whether its application in this context is appropriate. Therefore, although necessity is potentially an applicable defence to euthanasia cases, it should be rejected.

Consent is generally not used as a defence in assisted death cases. Nevertheless, there are good reasons in the public interest to exceptionally allow consent as a defence to assisted deaths upon a redefinition of the importance typically attributed to life. It would be in the public interest to allow people under intense suffering to request to be killed or assisted in suicide. The public interest notion limits this defence’s availability to physician-performed assisted death. Since this is not a defence specifically designed to be used for assisted deaths some important limitations need to be taken into consideration, which have not been used before in the law of offences against the person. Consent can be negated in cases of incompetence, misinformation.
and coercion. The competency test as defined under the Mental Capacity Act will present important issues when applied in this context. Also, there is a reluctance to provide meaningful information on assisted death to facilitate an informed decision. It was thus argued that an incremental expansion of the existing consent defence is unlikely to do the required work when applied in assisted death cases, and it should also be rejected.

This inability of our legal system to provide an appropriate defence for euthanasia and assisted suicide raises the issue of reforming our criminal law to find a better and more specific way to accommodate these cases. Thus, we will be able to incorporate the theoretical leniency that some of these cases deserve into law, while also having an appropriate fair labelling mechanism. As explained, physician-performed assisted death is very different from euthanasia performed by untrained individuals such as loved ones who are often motivated by compassion. As noted, consent being the most suitable defence in principle for physician-assisted death can provide a useful reference point for creating a more specific consent-type defence in the future. This will be considered in chapter 5. Also, as was noted in the discussion of diminished responsibility, a person who decided to offend because they could not bear to see their loved one suffer should be labelled in a more appropriate way that will take into consideration their compassionate motives and reflect their standards of character. Potential reform proposals to facilitate such compassionate killing cases will be discussed in chapter 6.
Chapter 5: Physician-assisted death defence

5.1 Introduction

This chapter will examine how the current law in England can be reformed to facilitate a more sympathetic approach towards physician-assisted death cases. Firstly, it will be argued that substantive law reform is preferable to the current policy of prosecutorial discretion as a way of dealing with assisted suicide cases. It is generally a much-debated question whether the post-*Purdy* publication of the policy is a positive development or not. Arguments both in favour of and against the formalisation of the policy will be explained. It will be supported that the policy brings some ease to assisted suicide requestors who might be concerned about the prosecution of their loved ones after their deaths and makes the overall situation much clearer. Arguments about a potential slippery slope will be analysed and rejected.

Nonetheless, since a substantive law reform is better than prosecutorial discretion, this chapter will proceed in considering what the best approach for English criminal law is. It will be supported that since physician-assisted death is a *pro tanto* wrong and there are special reasons to offend, we should recognise this through applying a relevant defence. Through creating a specific defence of physician-assisted death, we will selectively allow these reasons which are normatively and ethically important to explain why the physician did not conform to the prohibition of assisted death.

Then it will be examined whether this defence should be a justification or an excuse, which are the two main types of exculpatory defences. It will be argued that if life can be overridden by a combination of death being in our best interests due to intense suffering and a death request, then it would make more sense as justification since these are justifying circumstances. Furthermore, it will be argued that this defence should provide full removal of criminal liability, as there is essentially no value in punishing physician-assisted death due to the special circumstances in these cases.
Then it will be analysed what the required safeguards should be to shield vulnerable requestors in assessing the two main elements of this defence, the requests for assisted death and the requestor’s medical condition. Examples from other jurisdictions and past reform Bills will be used as reference points to inform these propositions. Mainly this discussion will focus on ensuring that there is a competent, informed and voluntary decision to die, and that death is in the requestor’s best interests in light of their medical condition.

Finally, this chapter will examine the appropriate allocation of the burden and standard of proof for this defence to ensure that it is successful only in cases that fulfil the described safeguards. To know how to allocate the burden of proof, we need to have an idea of the reasons that are relevant to that. But it is not the purpose of this discussion to solve the issue of when, if at all, a legal burden should be reversed and provide guidance on this. Rather, this thesis aims to assess based on the perspective of the current law on reverse burdens whether the legal burden for the physician-assisted death defence is better placed on the prosecution or the accused. It will be argued that the physician-assisted death defence should uphold the presumption of innocence and impose the legal burden on the prosecution.

5.2 The desirability of the DPP’s guidelines on assisted suicide

The Suicide Act 1961 makes clear that no criminal offence is committed by a person taking their own life or attempting to do so.\(^1\) However, under section 2 of the Act, a person commits an offence if they do an act capable of encouraging or assisting the suicide or attempted suicide of another person, and the act was intended to encourage or assist suicide or a suicide attempt.\(^2\) No proceedings shall be instituted for this offence under this section except by or with the consent of the Director of Public Prosecutions.\(^3\) In 2010 the DPP published the prosecuting policy on assisted suicide

---

\(^1\) Suicide Act 1961 s 1  
\(^2\) ibid s 2  
\(^3\) ibid s 2(4)
which included 22 public interest factors in favour of and against prosecution which were outlined in chapter 2.⁴

Norrie argued that the publication of the DPP’s policy is a fine way to balance the conflicting social, moral and political debates by achieving a pragmatic compromise.⁵ This reflects a moral impasse that can satisfy everyone.⁶ In this way, the formalisation of the policy has achieved a positive clarification of an extremely complex area of law regarding prosecutions, while theoretically, it does not make any official change to the law. Pro-life supporters can be content that the law has not changed, and legally assisted death remains punishable. But at the same time, supporters of assisted death can argue that the policy has progressed, and in practice, prosecutions for assisted suicide are rarely brought.⁷ Nonetheless, this argument is not convincing. While there is validity in what Norrie is arguing and the current approach might shield against tensions between those in favour of and against assisted suicide, it is not the purpose of the law to satisfy everyone. It is preferable to have a clear position for such complex matters through an official substantive law reform rather than through prosecutorial discretion for the sake of not disappointing certain groups of people.

Furthermore, a substantive law reform is preferable to the current prosecutorial policy, since this policy can be easily changed if the DPP changes. Although it must be noted that in the general code there are similar prosecutorial guidelines for different offences,⁸ as Keown rightly noted, a policy like this places too much burden on a single law officer which could be overwhelming.⁹ This could cause great uncertainty and disarray which is very problematic for such important matters as assisted suicide. It

---

⁴ Chapter 2.2.2, Table 1
⁶ ibid 134
would be better if such important regulatory decisions came from those elected, rather than merely an unelected law officer. In a truly democratic society, it should not fall to the DPP to resolve controversial moral dilemmas, but to Parliament.

The question of whether this formalisation of prosecutorial discretion is a positive development has been also much debated. Purdy’s main argument was that without the guidelines it was not clear whether the suspect would be prosecuted or not, but as Greasley notes this might be somewhat overstated. Before the clarification of the policy, there were no known prosecutions for cases of assisted suicide. In this sense, the publication of the DPP guidelines does no more than simply state the obvious factors that were already used before Purdy.

Nonetheless, even in the absence of prosecutions, the uncertainty that comes with a non-official policy could be causing too great distress to individuals who are already in a distressing scenario. This could make the last days of the most vulnerable full of agony and stress, regardless of whether they know that the chances of prosecution are minimal. It was clear to Ms Purdy that her husband’s prosecution if he assisted her to die was extremely unlikely. But still, Ms Purdy was agonising over the fate of her husband after her passing and tried to remove even the slightest residual risk posed by the formal mandate to prosecute. Therefore the post-Purdy publication of the policy succeeds in bringing some ease to the requestors of assisted suicide in this regard. The fact that this is now an official policy, from which it is more difficult for prosecutors to depart, makes the situation clearer.

Keown was concerned about a slippery slope from the publication of the guidelines which would lead eventually to the complete decriminalisation of assisted suicide. As he states, once something is de facto allowed, then the argument for its de jure

---

10 R (Purdy) v DPP [2009] UKHL 45
11 Kate Greasley, ‘R(Purdy) v DPP and the Case for Wilful Blindness’ (2010) 30(2) Oxford Journal of Legal Studies 301, 326
13 Purdy (n 1210)
14 ibid
15 Keown (n 9) 306
legalisation becomes even stronger.\textsuperscript{16} The policy has created an expectation that where someone acts following the policy, they will not be prosecuted. As Greasley notes, it is irrelevant that the clarification does not modify the offence itself, so long as the public perception is that it has been modified.\textsuperscript{17} In a debate in the House of Commons, the Solicitor-General noted that 'there is growing confusion between the guidelines which are the DPP's statement on when it is and is not thought appropriate to prosecute and the factors that he will consider, and the substantive view that is set out in section 2 of the Suicide Act'.\textsuperscript{18} Thus, the slippery slope is envisaged in two different ways by Greasley and Keown regarding the DPP's policy on cases of assisted suicide. Keown is concerned that DPP's policy on assisted suicide will lead eventually to its legalisation. Greasley is concerned that a formal policy of non-prosecution in some assisted suicide cases will lead the public to believe that assisting suicide is legal altogether.

Greasley also noted that an official policy of non-prosecution is believed to undermine the formal prohibition on assisted suicide in a way that even an identical non-official policy does not.\textsuperscript{19} Thus, the pre-\textit{Purdy} situation referred to as ‘wilful blindness’ of formally prohibiting assisted suicide, but readily disregarding and never prosecuting known instances of law-breaking, was better.\textsuperscript{20} Accordingly, notwithstanding that the general action is illegal under the current law if a legitimate expectation of non-prosecution has been created, then this constitutes an effective amendment of the offence.\textsuperscript{21}

Admittedly, the DPP’s published guidelines have further opened the line of discussion for the legalisation of assisted suicide. As noted in chapter 3, the slippery slope argument essentially says that we do not trust ourselves to understand the law and effectively implement the guidelines in deciding which cases should be prosecuted.\textsuperscript{22} There is generally no reason to indicate that we would not be able to follow the current guidelines. However, even if the publication of the guidelines leads to legalisation,
perhaps societal values have shifted in such a way that this will not be a negative development. Thus, even if there is a slip down the slope through the legalisation of assisted suicide, this is not a slippery slope in the strong sense since what is lying at the end of the slope is not something we should worry about.

Consequently, it has been argued that substantive law reform, is better than the current policy on prosecutorial discretion on assisted suicides. It is better to have a clear position in the substantive law, especially for such important matters, than to deal with them through discretion. It is better if such important decisions came from Parliament, rather than merely an unelected law officer. This will provide more clarity and certainty as substantive law is harder to change than prosecutorial policy. Nonetheless, it was argued that the publication of prosecutorial policy post-\textit{Purdy} was a more desirable step than the situation pre-\textit{Purdy} where there was no guidance on what cases the DPP chose to prosecute. The argument that the formalisation of the policy will lead to a slippery slope was rejected and it was noted that the previous non-official policy created much uncertainty and distress. Since a substantive law reform is better than the current approach of dealing with assisted suicide cases through prosecutorial discretion, it is important to consider what the best reform option might be for the English criminal law on this issue.

5.3 Creating a new defence

As has been observed in this thesis, even though our legal system criminalises euthanasia and assisted suicide, the grantors of a wish to die in these cases are often viewed with sympathy.\textsuperscript{23} Assisted deaths performed by trained individuals like physicians raise very different issues than those performed by untrained individuals like loved ones.\textsuperscript{24} An untrained person due to their inexperience risks leaving the requestor of assisted death in a worse condition than before.\textsuperscript{25} Such an example is the case of Dr William Stanton, a terminally ill geologist who agreed with his wife who did not want to be left behind after her husband’s death to each pull helium-filled bags

\begin{footnotes}
\item[23] Chapter 4.3
\item[24] ibid
\item[25] ibid
\end{footnotes}
over their heads while they lay in bed, and thus die.\textsuperscript{26} However, while his wife suffocated, Dr Stanton lived because his bag was so small he was unable to fasten it below the chin to cut off the air supply.\textsuperscript{27} Eventually, he died of cancer before the Crown decided whether to proceed or not.\textsuperscript{28}

Nonetheless, currently, there is no appropriate way of identifying and labelling physician-assisted death cases under English criminal law.\textsuperscript{29} Eventually, someone who is prosecuted is forced to explain their actions within a set of legal rules into which very few of them fit. This raises the issue of creating a specific legal mechanism that will accommodate the complexity of these cases. As was explained in the previous chapter when examining the application of the defence of consent for assisted deaths, even if this was not deemed to be appropriate for use in this context, it could provide a useful reference point in considering alternative ways of dealing with physician-assisted death.\textsuperscript{30} The aim is to achieve a more lenient approach to those physicians who commit euthanasia or assisted suicide, after a competent request prompted by the experience of intolerable suffering. Creating a specific legal mechanism to deal with physician-assisted death will also provide for a more appropriate fair labelling mechanism that will more accurately capture the features of the act.\textsuperscript{31} Jurisdictions with right to die legislation limit this to cases performed by physicians.\textsuperscript{32}

In addition, many past reform Bills on this issue introduced in England and Wales have limited their scope to some form of assisted death performed by physicians. The Assisted Dying for the Terminally Ill Bill 2004 aimed to enable competent adults suffering unbearably as a result of a terminal illness to receive euthanasia or assistance in suicide.\textsuperscript{33} The Assisted Dying for the Terminally Ill Bill 2005 would have allowed physicians to assist a capable adult who was suffering unbearably as a result

\textsuperscript{27} ibid
\textsuperscript{28} ibid
\textsuperscript{29} Chapter 4.1
\textsuperscript{30} ibid
\textsuperscript{31} Glenys Williams, ‘Necessity: Duress of Circumstances or Moral Involuntariness?’ (2014) 43(1) Common Law World Review 1, 26
\textsuperscript{32} Chapter 3.7
\textsuperscript{33} Assisted Dying for the Terminally Ill Bill 2004
of a terminal illness to die by prescribing medication.\textsuperscript{34} Under the Assisted Dying Bill, 2014-15 competent adults who were terminally ill would be prescribed medication by the attending physician to enable them to end their own life.\textsuperscript{35} Finally, the Assisted Dying Bill, introduced by MP Rob Marris in 2015\textsuperscript{36}, the Assisted Dying Bill 2016 introduced by Lord Hayward\textsuperscript{37} and the most recent Assisted Dying Bill 2019-21 all intended to give competent adults who are terminally ill to have the choice to be provided with medically supervised assistance to end their own life.\textsuperscript{38}

The Select Committee Report on the Assisted Dying for the Terminally Ill Bill 2004 noted that it was wrong that the Bill was trying to legalise both assisted suicide and euthanasia as these two issues were thought to be very different.\textsuperscript{39} The Select Committee focused on two jurisdictions with very different assisted death laws Oregon, where only physician-assisted suicide is legal, and the Netherlands, where both physician-assisted suicide and euthanasia by physicians are legal.\textsuperscript{40} These showed very different annual rates of assisted deaths. Whilst less than one in 700 deaths in Oregon was attributable to assisted death, that figure was more than one in 40 in the Netherlands.\textsuperscript{41} Of those deaths in the Netherlands, less than 10% were from assisted suicide, while over 90% were the result of euthanasia.\textsuperscript{42} Such figures led the Committee to the conclusion that the inclusion of euthanasia in the law on assisted death had led to a significantly higher rate of assisted deaths.\textsuperscript{43} The Select Committee was also of the view that since for assisted suicide it is the requestor who performs the final act of killing themselves, this makes them think more carefully before taking action to give effect to their wishes.\textsuperscript{44} Nonetheless, as was pointed out in the discussion of a potential slippery slope in the context of assisted death, figures such as these from foreign jurisdictions have important limitations and cannot be adequately relied upon.\textsuperscript{45} Other countries that have similar legislation allowing both assisted

\textsuperscript{34} Assisted Dying for the Terminally Ill Bill 2005
\textsuperscript{35} Assisted Dying Bill 2014-15
\textsuperscript{36} Assisted Dying Bill 2015
\textsuperscript{37} Assisted Dying Bill 2016
\textsuperscript{38} Assisted Dying Bill 2019-21
\textsuperscript{39} Select Committee Report 2004 House of Lords Vols I, II and III para 243
\textsuperscript{40} ibid para 243
\textsuperscript{41} ibid para 243
\textsuperscript{42} ibid para 243
\textsuperscript{43} ibid para 244
\textsuperscript{44} ibid para 244
\textsuperscript{45} Chapter 3.8.2
suicides and euthanasia might not experience the same increase as in the Netherlands. But even if they do and this leads to a significantly higher rate of assisted deaths, this is not necessarily bad.

As explained in the previous chapter, physician-assisted death is a pro tanto wrong, but we can recognise through applying a relevant defence that there are some special reasons to act in this way. These are the request to die along with it being in the requestor's best interests to act in that way. Thus, through creating a specific defence for physician-assisted death, we can selectively allow these reasons which are normatively and ethically important to explain why the physician did not conform to the prohibition of assisted death. The wrong of assisting in the requestor's death will be recognised, but a degree of exculpation will be offered in recognition of the death request, and the requestor's best interests. A defence that places at least an evidential burden on the grantor of this wish will imply that they owe it to the court to answer for their actions but can deny guilt for the pro tanto wrong.

5.4 Justification defence

As explained in chapter 4 there are two main types of exculpatory defences; these are justifications and excuses. There are generally many theories on the reasons that make a defence either a justification or an excuse which were explained in the previous chapter. Usually, justifications are considered to grant a universal privilege as neither the victim nor third parties are allowed to interfere with justified conduct, while whoever aids the justified agent is justified as well. By contrast, excuses are usually considered predicated on particular personal attributes or specific states of mind that arise from the circumstances; therefore they are personal and not universal.

It is important to discuss how the physician-assisted death defence should be characterised, as the distinction between justifications and excuses is useful, at least on a theoretical level. Classifying a defence of assisted death as either justification or an excuse represents a hard question to answer. The Law Commission in its

---

46 ibid 4.2.2
47 ibid
48 ibid
consideration of creating a ‘mercy killing’ defence, ultimately declined to proceed in its recommendation, because it was hard to separate the issues of excuses from issues of justification, and wider consultation was needed.  

Duff notes that if we assume that killing another is always impermissible, then the potential defence for these cases would be an excuse. This would recognise that euthanasia was an undesirable act that should be avoided whenever possible but there were exceptional circumstances. However, as already noted this is only one approach to the importance of life. If one accepts the argument that ending life is not always impermissible and can be overridden by a combination of a request to die along with that being in the requestor’s best interests, then this defence would make more sense as a justification rather than an excuse.

Following Robinson’s definition of justifications considered in the previous chapter, the physician-assisted death defence would make more sense as a justification. This is because there are justifying circumstances such as the requestor’s expressed wish to die, along with the significant suffering they are experiencing, making death potentially in their best interests. This interpretation of physician-assisted death as a justification entails accepting the argument made in chapter 3 that personal autonomy should have limits according to our best interests. Even if a decision to be killed is self-regarding and valid, it should not be justified as it is wrong for you to choose this in the absence of certain circumstances making it in your best interests. Consequently, autonomy and best interests carry equal and interdependent weight, which means that not every autonomous decision to be killed should be accepted if the condition of being in your best interests is not satisfied. Also, one could not be justified in killing another individual based on an assessment of their best interests without their consent.

49 Law Commission, Murder, Manslaughter and Infanticide (Law Com. No. 304, 2006) part 7
51 Paul Robinson, ‘Competing Theories of Justification: Deeds vs Reasons’ in Andrew Simester and ATH Smith (eds), Harm and Culpability (Oxford, Clarendon Press, 1996) 45
53 Chapter 3.3
Another justificatory condition in this defence is the grantor’s medical training, as physicians have the required training to appropriately perform assisted death without causing further pain or leaving the requestor in a worse condition than before. Medical training is the point differentiating this defence from other kinds of assisted death carried out by untrained individuals.\(^\text{54}\) Although there might be people who are not physicians, when assisting someone to die they have these justificatory traits of a request to die and that being in the requestor’s best interests, their actions will not be justified because of the danger to the requestor due to their lack of medical training. Thus, they should not have access to this defence, even though there might be a death request and the requestor is under intense suffering. It must be held, that to better shield requestors under this defence, and truly take advantage of the grantors’ medical training it would be better to require them to remain with the requestor through the assisted death procedure. This will ensure that there will be professional medical assistance available in the event of any complications.

This is a requirement that is also evident in jurisdictions with assisted death legislation. In the Netherlands, physicians must exercise due medical care and attention in terminating the requestor’s life or assisting in their suicide.\(^\text{55}\) A physician must either stay with the requestor continuously or be immediately available until they die.\(^\text{56}\) This helps to ensure that the lethal medication used remains under the control of the physician until the requestor’s death and thus avoids any possible misuse or abuse.\(^\text{57}\) In Switzerland, the right to die organisation Dignitas requires that trained volunteers mix the lethal medication, and remain with the requestor whilst the latter ingest the drug.\(^\text{58}\) They also manage any complications that arise during the procedure.\(^\text{59}\) Complications such as difficulties in swallowing and the inability to ingest lethal

\(^{54}\) ibid 4.5.1

\(^{55}\) Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding van 12 april 2001 [Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 12 April 2001] Stb 2001 194 sub-s 2(1)

\(^{56}\) John Griffiths, A Bood and H Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam, Amsterdam University Press, 1998) 106


\(^{59}\) ibid 296
substances are not uncommon. However, Bosshard expressed concerns that since these volunteers are not medically trained, they are not adequately prepared to deal with situations where the requestor remains in a coma for a lengthy period or vomits the medication.

Consequently, although some commentators deny the usefulness of the distinction between justification and excuses, it has been supported that the distinction is important. Thus, it is useful for this chapter considering the construction of a physician-assisted death defence to examine whether this should be a justification or an excuse. Having a death request, along with that being in the requestor’s best interests and the grantor of that wish being a physician with medical training, makes physician-assisted deaths justified, and we are potentially content to have them performed. All these factors must be present to claim this defence.

5.5 Full defence

Besides establishing the justificatory nature of this defence, it is essential to consider whether it will be of a complete or partial character. As explained in the previous chapter, defences are generally classified in regards to the criminal liability they impose as full, which is also referred as complete, or as partial. Duff argues that the law should recognise that deliberately killing an innocent person with their request is wrong, but is something that one could reasonably be tempted to commit. Also, according to the Law Commission, when someone intentionally kills, then a defence should only be partial and reduce the first degree to second-degree murder.

Creating physician-assisted death as a partial defence shows that while the grantor is a rational agent fully responsible for their actions and the wrong they committed, they must be held to account for violating such an important principle as life. The act of

---

61 ibid 107
62 Chapter 4.2.2
63 Duff (n 50) 212
64 Law Commission (n 49) para 5.83
65 Duff (n 50) 208
killing an innocent person is wrong and the grantors of requests to die should be prepared to answer for their actions in court as they deserve to be at least partially punished.

Nonetheless, even though killing an innocent person is normally wrong, the physician-assisted death defence is an exceptional situation. The requestor in assisted death cases is indeed innocent in the usual sense as they are not engaged in an unlawful attack that could justify the use of force, or in comparison to the victim of a provoked killing, who has done a wrong that provoked the killing.66 Nonetheless, they might not be as innocent in the sense that they persistently requested to die and tried hard to make this happen, rendering in a way themselves somewhat complicit in their death.67

However, even without accepting this argument, physician-assisted deaths represent an exceptional case compared to other crimes in the law of homicide. Under certain circumstances, even the intentional killing of an innocent person is not wrong, or at least not as wrong, and there is no essential value in their punishment. The crucial elements differentiating physician-assisted deaths are a combination of the requestor’s medical condition making death in their best interests, their competent request to die, and the grantor’s medical experience limiting the possibilities of botched attempts. Furthermore, homicides more commonly occur in the course of a quarrel or loss of temper or revenge and the defendant may be prompted to kill by anger, loss of control or fear.68 A grantor who kills in the best interests of someone who requested to die is unlikely to be an aggressive person who represents a danger to the public by repeatedly killing people.

Physician-assisted death cannot follow Greenawalt’s argument explained in chapter 4 regarding partial justifications of splitting the conduct into two phases, the first phase being completely justified and the second phase being forbidden.69 Assisted death cannot be so easily divided into two phases. When an agent retaliates with reasonable

66 ibid 212
67 ibid 212
and proportionate force to an assault, but after subduing the assailant, continues to pound him.\textsuperscript{70} Because the first phase of the conduct is completely justified, the conduct in its entirety, including the second and forbidden phase, can be described as partially justified.\textsuperscript{71} In contrast, the grantor in physician-assisted death would be a fully rational individual with active regard to the requestor's wishes and best interests in the entirety of their conduct. Therefore, they cannot be described as partially justified, as there is no wrongful and unwarranted phase of their actions.

Moreover, Berman's argument also explained in the previous chapter, that a partial justification can exist when an act is supported by some good reasons but not enough,\textsuperscript{72} does not apply to physician-assisted death. The basic reason against these behaviours is the importance typically attributed to human life. However, as explained above this can be overruled by a combination of the requestor's best interests along with their right to autonomy, making physician-assisted death right, or at least not as wrongful. These along with the fact that the proposed physician-assisted death defence has limited danger for leaving the requestor in a worse condition than before provides sufficient reasons for the conduct, and make it overall justified. Accordingly, the physician-assisted death defence should be of full justificatory character providing full removal of criminal liability.

\section{5.6 Safeguards of the defence}

It must be acknowledged that providing a full justificatory defence to assisted death might cause issues of medical paternalism. Individuals might be forced into assisted death for what is perceived to be in their best interests against their will. Also, it might cause issues of abuse towards vulnerable individuals who will be pressured into an assisted death request when someone has something to gain, such as in the form of an inheritance from their passing. These are especially concerning for euthanasia cases where requestors are not the ones in control of the final act of terminating their

\begin{thebibliography}{9}
\bibitem{70} ibid 92-93
\bibitem{71} ibid 92-93
\bibitem{72} Mitchell N. Berman, ‘Provocation as Partial Justification and Partial Excuse’ (2011) 52(4) William and Mary law review 55, 40
\end{thebibliography}
life as in assisted suicide. In assisted suicide, the responsibility for the ultimate act rests with the requestor, and thus the possibility for abuse is minimised.

According to the House of Lords’ Select Committee on the Assisted Dying for the Terminally Ill Bill 2004, a blurring of the line between voluntary and involuntary assisted dying is more likely to occur by legalising voluntary euthanasia than by legalising assisted suicide.\(^73\) According to the campaigning organisation Dignity in Death, dying people should have support to take the final act that brings about their peaceful death, but they should always control the final act.\(^74\) They consider this to be an important protection to ensure that an assisted death is completely voluntary.\(^75\)

Nonetheless, while these are valid concerns, it seems unfair to provide a defence only for assisted suicides and not to euthanasia cases simply because the requestor needs more active help. As was noted in chapter 3, slippery slope concerns from voluntary to non-voluntary assisted death arise mostly when suffering and autonomy are considered separately.\(^76\) But for this defence, they have equal and interdependent weight and will be required together. Accepting these concerns of a slip to non-voluntary or involuntary euthanasia would mean acknowledging that we are bad in creating effective safeguards to guard against abuse and abide by them. Creating a physician-assisted death defence will necessarily entail accepting the danger of abuse in some cases. But there is essentially no valid reason to believe that we would not be able to create and enforce effective safeguards. We can ensure that the request to die was competent, informed and voluntary, and in the requestor’s best interests, through enforcing strict and effective safeguards.

### 5.6.1 Requests for assisted death

As previously noted the request for assisted death is closely linked to the legal notion of consent which is used across various legal fields, such as sexual offences, medical

---

\(^{73}\) Select Committee Report 2004 (n 39) para 245

\(^{74}\) Campaign for Dignity in Dying, ‘Our Position’ (Dignity in Dying)

https://www.dignityindying.org.uk/assisted-dying/our-position/ accessed 9 September 2021

\(^{75}\) ibid

\(^{76}\) Chapter 3.8
law and the law of assaults. Consent is generally used to express autonomy and differentiate between legally permissible conduct and legally impermissible. It is a form of guarantee that the killing was not abusive or paternalistic and that the requestor wanted to die. The grantor of the wish to die simply complied with their wishes and by killing them, they did not deprive them of something they valued. Without a requirement of a request to die in this defence, vulnerable people will be in danger of being killed against their will, which would morally equate assisted deaths to murders. Thus, an essential safeguard for access in this proposed defence should be that the grantor acted only after a request to die. To ensure that a request has been made, it is better to require that is in writing and thus clearly prove that they unequivocally communicated their decision to the requestor.

This has been also required in foreign jurisdictions. In Belgium, to ensure voluntariness the requestor’s repeated wishes for euthanasia should be a written request. In Oregon one safeguard which is enforced to get access to assisted suicide is that there should be two oral requests and one in writing. Furthermore, in Canada, one of the legislation’s requirements is that the request for medical assistance in dying was made in writing, signed and dated by the requestor or another person and then signed and dated by a medical practitioner who informed them of their medical condition. Two independent witnesses must also sign and date the request. They could be any adult who understands the nature of the request for medical assistance in dying. The only exceptions are when they would benefit financially or materially from the requestor’s passing, are an owner or working at a health care facility in which the requestor is treated, or are involved in providing health care services or personal care to him.

77 ibid 4.5
78 ibid 3.3
79 Director of Public Prosecutions, ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 12)
80 Belgian Act on Euthanasia s 4
81 Oregon Revised Statutes § 127.840
82 Canadian Criminal Code s 241.2(3)
83 ibid s 241.2(3)
84 ibid s 241.2(5)
85 ibid s 241.2(5)
This was also a requirement in many past reform Bills in England and Wales. For example under the Assisted Dying for the Terminally Ill Bill 2004, the requestor had to make a written declaration which should have been witnessed by two individuals, one of whom was a solicitor holding a current practising certificate.\textsuperscript{86} Also, in the recent Assisted Dying Bill 2019-21, which is currently in its second reading in the House of Lords, it is specified that requestors of assisted suicide should make a written application to the High Court of their voluntary, clear, settled and informed wish to end their life in the presence of an independent witness.\textsuperscript{87}

Having the request signed by an independent witness might be also a good requirement for the physician-assisted death defence. It will better ensure that the request is indeed voluntary and not coerced. Nonetheless, while this is a well-intended requirement it has produced some unexpected challenges in Canada.\textsuperscript{88} In some cases, a person asking for medical assistance in dying is not in contact with anyone who is not involved in their care or who will not be benefited after their passing in the form of an inheritance. For this reason, in 2016 Dying with Dignity Canada started training volunteers who could sign as independent witnesses where no other eligible adult could be found.\textsuperscript{89} If the physician-assisted death defence was created in England, a similar procedure could exist to ensure that such problems do not occur.

However, a requirement of a written request to die is not enough on its own to appropriately shield vulnerable requestors against abuse if a physician-assisted death defence was created. People differ in intellectual ability, experiences or emotional reactions, which might preclude the objective processing of medical information.\textsuperscript{90} Thus, not every decision is worthy of the same amount of respect. Even if the requestor indeed wanted to die, and the grantor simply complied with their wish, it does not follow that this defence should become available. To effectively protect vulnerable people, not every decision to die should be endorsed. We should enforce safeguards to ensure

\textsuperscript{86} Assisted Dying for the Terminally Ill Bill 2004 (n 33) s 4
\textsuperscript{87} Assisted Dying Bill 2019-21 (n 38) s 3
\textsuperscript{88} Dying with Dignity Canada, ‘Get The Facts: Bill C-14 And Assisted Dying Law In Canada’ https://www.dyingwithdignity.ca/get_the_facts_assisted_dying_law_in_canada accessed 9 September 2021
\textsuperscript{89} ibid
\textsuperscript{90} Peter Marzuk, ‘The right kind of paternalism’ (1985) 313(23) The New England journal of medicine 1474, 1476
that these decisions are competent, well-informed and voluntary for the request not to be negated.

**Competent, well-informed and voluntary requests**

The importance of ensuring competence, information and voluntariness are evident in foreign jurisdictions’ legislation. For example, in the Netherlands, it is required that to allow physicians to perform assisted death they must be satisfied that the requestor acted voluntarily and their decision was informed and well-considered. In Belgium, a doctor who assists someone to die, commits a crime if they do not ensure that the requestor is legally competent and the decision voluntary, well-considered and not the result of external pressure. Also in Canada to be eligible for medical assistance in dying the requestor must be capable and their decision voluntary, and informed.

Competence is what makes our choices truly autonomous, as not all people enjoy the same ability to decide freely without interferences, which might preclude the objective taking of decisions. Only a capable individual can make decisions about their future, while choices by mentally fragile people are not to be given legal validity. In the DPP’s guidelines for prosecuting cases of assisted suicide, it is stated that the victim’s voluntary, clear, settled and informed decision to commit suicide is a factor against prosecution. Competence is also a core consideration across various legal fields, but especially interesting to the purpose of this thesis is how competence is used in medical law.

As explained, in the English medical law the test of capacity used was addressed in *Re C* and then placed on a statutory footing by the Mental Capacity Act of 2005. Under the DPP’s factors tending in favour of prosecution for assisted suicide cases, it is also stated that ‘the victim did not have the capacity (as defined by the Mental

---

91 Dutch Act (n 55) s 2(1)
92 Belgian Act on Euthanasia (n 80) s 3
93 Canadian Criminal Code (n 82) s 241.2 (1)
95 Chapter 2.2.2, Table 1
96 ibid 2.3
97 *Re C* [1994] 1 All E.R. 819
Capacity Act 2005) to reach an informed decision to commit suicide’. Assisted deaths are largely a medical decision, as the wish to die, is usually initiated by the requestor’s deteriorating health, which renders them unable to commit suicide on their own. Thus, for the physician-assisted death defence, the best way to assess the competence of the requestors would be to use the test of competence as currently used in medical law.

The use of the Mental Capacity Act to assess competence for assisted deaths was also suggested in some of the past reform Bills introduced in England. The Assisted Dying Bill 2014-15 specified that ‘capacity’ shall be construed following the Mental Capacity Act 2005’. However, due to a lack of time with the impending General Election in May 2015, no further progress was made to the Bill. Following the 2015 Bill, Lord Hayward introduced in the House of Lords the 2016 Assisted Dying Bill, which made similar provisions to the previous Bill and also required that capacity would be construed according to the Mental Capacity Act 2005’. The same provision is made under the Assisted Dying Bill 2019-21.

Nonetheless, there are some important issues, some of which have been discussed in chapter 2, and need to be taken into consideration when this capacity test as defined in Mental Capacity Act 2005 in such important decisions as for assisted deaths. Firstly, this test as currently stands under the Mental Capacity Act requires no in-advance psychological or psychiatric assessment for determining capacity. This is particularly important for assisted deaths, as some people might have a strong emotional reaction to an illness, which will limit their capacity and may cause their wish to die. As Hendin and Foley noted, impaired cognitive function is one of the characteristics of a depressive disorder. This involves a rigid tendency to see only one possible solution, such as death. Nonetheless, it is important to clarify that this

98 Chapter 2.2.2, Table 1
99 Assisted Dying Bill 2014-15 (n 35) s 12
100 Assisted Dying Bill 2016 (n 37) s 12
101 Assisted Dying Bill 2019-21 (n 38) s 12
102 Chapter 2.3.1
104 ibid 1614
is not suggesting that every person thinking of assisted death is mentally ill, as often this decision is reached after extensive and competent deliberation.

In most foreign jurisdictions, there is no requirement for a psychological or psychiatric assessment. In the Swiss right-to-die organisation Dignitas, although there is no such requirement, the physician who agrees on providing the necessary medication can ask to speak to the requestor further to spot particular signs of impaired or doubtful mental capacity, signs of pressure from a third party leading to premature death, or evidence of an acute depressive phase.\textsuperscript{105} Also, some right-to-die organisations have volunteers trained in counselling to identify and refer depressed requestors to a psychiatrist.\textsuperscript{106} In Oregon, one of the legislation’s requirements is that if the attending or the consulting physician of the requestor believes that their judgement is impaired by depression or other psychiatric or psychological disorder, they must refer them for counselling.\textsuperscript{107} However, as Foley and Hendin observe, physicians without formal training on mental disorders are generally not competent to assess the mental state of a requestor.\textsuperscript{108}

Similar requirements have been proposed for some of the reform Bills introduced in England. For example, under the Assisted Dying for the Terminally Ill Bill 2004, it is required that if according to the attending or the consulting physician a requestor may not be competent, they should refer them to a psychiatrist.\textsuperscript{109} The same requirement was included in the Assisted Dying for the Terminally Ill Bill 2005.\textsuperscript{110} Furthermore, under the Assisted Dying Bill 2015 by MP Rob Marris, it was required that if the attending or independent physician doubted the requestor’s capacity they should refer them for assessment to an appropriate specialist.\textsuperscript{111} The same provision was made in

\textsuperscript{106} Ziegler and Bosshard (n 58) 296
\textsuperscript{107} Oregon Revised Statutes (n 81) § 127.825
\textsuperscript{108} Herbert Hendin and Kathleen Foley, The Case Against Assisted Suicide: For the Right to End-of-Life Care (Baltimore, Johns Hopkins University Press, 2002) 39
\textsuperscript{109} Assisted Dying for the Terminally Ill Bill 2004 (n 33) s 8
\textsuperscript{110} Assisted Dying for the Terminally Ill Bill 2005 (n 34) s 3
\textsuperscript{111} Assisted Dying Bill 2015 (n 36) s 3(5)
the Assisted Dying Bill 2016 by Lord Hayward\textsuperscript{112} and in the most recent Assisted Dying Bill 2019-21.\textsuperscript{113}

Battin noted for Oregon that in the absence of a standardised depression screening tool, there is a risk that a physician will fail to recognise depression when it occurs. It is not sufficient to merely rely on the professional competencies of physicians when screening for depression.\textsuperscript{114} According to the Select Committee Report 2004, a problem with the 2004 Bill was that it provided that only if physicians believed that requestors were not competent, they would refer them to a psychiatrist to confirm that they were not suffering from a psychiatric or psychological disorder causing impaired judgement.\textsuperscript{115} However, the experience of Oregon’s law on physician-assisted suicide was that referrals under similar provisions were rare.\textsuperscript{116}

Even on the occasions that the requestor is referred for counselling because the consulting physician believes that their judgement is impaired by depression or some other psychiatric or psychological disorder, the psychiatric evaluation may also fail as a safeguard to shield vulnerable individuals. This is because there will be still the possibility of ‘shopping around’ for an ‘accommodating’ psychiatrist who will provide the desired mental health evaluation. This is illustrated by the case of Kate Cheney.\textsuperscript{117} She was found by a psychiatrist to have had mild, potentially reversible depression.\textsuperscript{118} Kate consulted two other mental health professionals who found her decision-making capacity to be intact.\textsuperscript{119} She also obtained a competency evaluation from a clinical psychologist, who concluded that there was no severe impairment that would limit her ability to make a medical decision.\textsuperscript{120} The differences in mental health evaluations may

\textsuperscript{112} Assisted Dying Bill 2016 (n 37) s 3 (5)
\textsuperscript{113} Assisted Dying Bill 2019-21 (n 38) s 3 (5)
\textsuperscript{115} Select Committee Report 2004 (n 39) para 153
\textsuperscript{116} ibid para 153
\textsuperscript{117} Foley and Hendin (n 108) 156
\textsuperscript{118} ibid
have been because Kate’s impairment was temporary, and therefore different clinicians were seeing her in different conditions.\textsuperscript{121}

A psychiatric assessment should be given by default to anyone asking for assisted death.\textsuperscript{122} This will better ensure that the request is based on a reasoned decision free from external pressure and that the applicant is not suffering from a psychiatric or psychological disorder causing impaired judgement. \textsuperscript{123} Even if the person requesting assisted death does not have mental issues, it is essential to take effective safeguards to exclude this possibility. If the grantor assessing capacity is not able to recognise depression they might offer assisted death to incapable individuals. But even if they recognise it, due to their lack of training, they might believe that the requestor is experiencing an understandable depression following a severe illness, which does not count or is not real depression. Even though physicians are medically trained, they lack the required training for spotting such mental issues when faced with an assisted death request. Therefore, a potential solution would be for this defence of physician-assisted death to amend the application of the Mental Capacity Act and have an independent psychologist or psychiatrist assessing the requestor’s mental capacity. For this purpose, a network of psychiatrists and psychologists must be provided by the NHS. They must be independent, to avoid the possibility of ‘shopping around’ for an ‘accommodating’ psychologist or psychiatrist who will provide the desired mental health evaluation.

Another potential problem with the use of the Mental Capacity Act for the physician-assisted death defence is that it can be easily manipulated by the provider of the information and potentially render the requestor incapable.\textsuperscript{124} As already briefly explained, the way and the degree to which an individual understands the information they are provided is influenced by the nature and the amount of information they receive.\textsuperscript{125} Thus, if someone provides them with confusing and misleading information,

\begin{itemize}
\item \textsuperscript{121} ibid
\item \textsuperscript{122} Select Committee Report 2004 (n 39) para 254
\item \textsuperscript{123} ibid para 254
\item \textsuperscript{124} Chapter 2.3.1
\item \textsuperscript{125} John K. Mason and Graeme T. Laurie, Law and Medical Ethics (Oxford, Oxford University Press, 2016) 83
\end{itemize}
they can render them incompetent following this requirement.\textsuperscript{126} In this way, the provider of the information might have more control over the requestor’s future than the requestor themselves, as they are the judge of the amount and the kind of information they give.\textsuperscript{127} This problem is intensified by the fact that currently there is an unwillingness to provide any meaningful information regarding assisted death.\textsuperscript{128}

A potential solution to this issue is related to another important matter that needs to be considered for safeguarding the assisted death requests in the creation of this defence, which is ensuring the decision is well-informed. Doctors under medical law have a legal duty to give patients all the relevant and accurate information regarding their condition and potential treatments, including any anticipated benefits and risks.\textsuperscript{129} If such strict rules regarding facilitating an informed decision exist in medical law for a simple surgery or medical treatment, then the same should logically be required for the physician-assisted death defence, which is a far more important decision.

The importance of making informed decisions, is also evident from examples from foreign jurisdictions. In the Netherlands under the assisted death legislation, it is required that the physician must inform the requestor of their condition and further prognosis and come to a joint conclusion that there is no other reasonable solution.\textsuperscript{130} In the Swiss organisation Dignitas, to allow assisted suicide the requestors should receive a personal visit by members of the organisation to have an in-depth discussion and at least two personal consultations with an independent physician.\textsuperscript{131} In Belgium, the physician is required to discuss the request, health and life expectancy, and possible therapeutic and palliative treatment available with the requestor.\textsuperscript{132} In Oregon, before being granted access to assisted suicide, the requestor must be informed of all feasible alternatives, such as comfort care, hospice care, and pain-control options.\textsuperscript{133} Furthermore, in Canada, the requestors must be informed of the

\begin{thebibliography}{9}
\bibitem{ibid 83} ibid 83
\bibitem{ibid 83} ibid 83
\bibitem{Chapter 2.2.2, Table 1} Chapter 2.2.2, Table 1
\bibitem{ibid 2.3.1} ibid 2.3.1
\bibitem{Dutch Act (n 55) s 2(1)} Dutch Act (n 55) s 2(1)
\bibitem{Dignitas, ‘Brochure ‘How DIGNITAS works’ (n 105)} Dignitas, ‘Brochure ‘How DIGNITAS works’ (n 105)
\bibitem{Belgian Act on Euthanasia (n 80) s 3} Belgian Act on Euthanasia (n 80) s 3
\bibitem{Oregon Revised Statutes (n 81) § 127.815} Oregon Revised Statutes (n 81) § 127.815
\end{thebibliography}
means that are available to relieve their suffering, including palliative care. Similar requirements are also included in many of the past reform Bills in England. For example, under the Assisted Dying for the Terminally Ill Bill 2004, the attending physician and an independent physician must both inform the requestor of their medical diagnosis, prognosis, the process of being assisted to die; and any alternatives, including palliative care, hospice care and pain control options.

By guaranteeing that the requestor has made an informed decision, the above problem for potential manipulation of the capacity test can be resolved. To achieve this, it is important to allow medical practitioners to provide information on assisted deaths to those interested. Also, the requestor should be referred to an independent consulting physician who must be a specialist in their condition. Through this, they will be able to be more accurately informed about their exact health condition, the process of dying, and any feasible alternatives, such as comfort care, hospice care, and pain-control options.

A network of specialists who can act as independent consulting physicians should be provided by the NHS. This is similar to how in the Netherlands, a state-funded programme called ‘Support and Consultation on Euthanasia in the Netherlands’ ensures that suitably qualified physicians are available in the Netherlands to give expert advice on assisted death and to act as independent consulting physicians. Even though this requirement might not specifically face the above problem of the capacity test, it could allow suicidal individuals to receive information from independent providers, which will reduce the possibility of manipulation.

The final issue which needs to be addressed in regard to assisted death requests for the proposed defence is to ensure that the decision to die is voluntary. The possibility of coercion leading to the requestor asking for assisted death is something that is also acknowledged under the DPP’s guidelines. It is mentioned as a factor in favour of

---

134 Canadian Criminal Code (n 82) s 241.2 (1)
135 Assisted Dying for the Terminally ill Bill 2004 (n 33) s 1
136 Oregon Revised Statutes (n 81) § 127.815
138 Chapter 2.2.2, Table 1
prosecution that the suspect pressured the victim to commit suicide.\textsuperscript{139} It is also stated that prosecution is more likely to be required if the suspect had a history of violence or abuse against the victim.\textsuperscript{140} Additionally, a factor in favour of prosecution is that the suspect was motivated by the prospect of gaining something from the victim’s death.\textsuperscript{141} Thus, upon creating the physician-assisted death defence, it is very important to be mindful in shielding the vulnerable requestors from pressures and abusive behaviour. For this defence to be successful, the court should be satisfied that their decision was truly voluntary and there was no evidence of pressure, physical or psychological.

According to Glover, to avoid abuse, the decision to die should be deliberated over a fairly long period.\textsuperscript{142} This is a commonly used safeguard in foreign jurisdictions to shield against coercion. For example in Canada, it is required that there must be a cooling-off period between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided.\textsuperscript{143} In Belgium, one of the described safeguards is that the request should be repeated and is not the result of any external pressure.\textsuperscript{144} Even the discussion of the requestor’s health condition, possible therapeutic options and palliative treatment, need to be spread out over a reasonable period.\textsuperscript{145} This allows the physician to be certain of the persistence of the requestor’s suffering and the enduring character of the request.\textsuperscript{146} The Swiss right-to-die organisation Dignitas, to ensure that a person is making a voluntary and considered choice for assisted suicide requires repeated initiatives before proceeding.\textsuperscript{147} Also, at least two volunteers from Dignitas must be present at the assisted suicide itself, each of whom is trained to assess the requestor’s decision and free will and to look for possible influence by third parties.\textsuperscript{148} Relatives and friends

\begin{flushright}
\textsuperscript{139} Director of Public Prosecutions, ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 12) para 43(7)
\textsuperscript{140} ibid para 43(9)
\textsuperscript{141} ibid para 43(6)
\textsuperscript{142} Jonathan Glover, \textit{Causing death and saving lives} (Harmondsworth, Penguin Books, 1977) 174
\textsuperscript{143} Canadian Criminal Code (n 82) s 241.2(3)
\textsuperscript{144} Belgian Act on Euthanasia (n 80) s 3
\textsuperscript{145} ibid s 2(2)
\textsuperscript{146} ibid s 2(2)
\textsuperscript{147} Dignitas, ‘Brochure ‘How DIGNITAS works’ (n 105)
\textsuperscript{148} ibid
\end{flushright}
of the requestor are encouraged to participate, allowing a further opportunity to monitor the interaction between the requestor and their loved ones.\textsuperscript{149}

Similar procedures are followed in Oregon, where it is required that there should be two oral requests and one in writing.\textsuperscript{150} There should be two 'cooling-off' periods before a prescription is issued, a 15-day lapse between the requestor’s initial oral request and the writing of a prescription, and a 48-hour lapse between the requestor’s written request and the writing of the prescription.\textsuperscript{151} To ensure that the requestor’s desire for death remains unchanged, and is not the result of pressure, the Act requires that immediately before a prescription is written, the attending physician verifies that the requestor is making an informed decision.\textsuperscript{152} A further restriction imposed in Oregon in regards to written requests is that they must be witnessed by at least two people who can verify that the requestor is competent and that the decision is voluntary and well-informed. At least one witness must not be a relative, the requestor’s beneficiary, or an owner or employee of the treating healthcare facility.\textsuperscript{153} The attending physician is also prohibited from acting as a witness.\textsuperscript{154} This better assures that the request is voluntary and not coerced or influenced by third parties.\textsuperscript{155}

A potential safeguard to better ensure voluntariness in the proposed physician-assisted death defence it is to require repeated death requests over some time. Although, it might seem somewhat difficult to give the right weight to estimations made at different times and in different moods.\textsuperscript{156} Nonetheless, evidence of such repeated initiatives allowing 'cooling-off periods', seem a good way to allow the court to acquire a better impression of the requestor’s actual desire to die.\textsuperscript{157} Additionally, in this way, they will be allowed more time to think about their decision unaffected by temporary emotional distress, and deal with potential pressures or ask for help. However, on some occasions allowing such an extra period of deliberation might somewhat

\textsuperscript{149} ibid
\textsuperscript{150} Oregon Revised Statutes (n 81) § 127.840
\textsuperscript{151} ibid § 127.850
\textsuperscript{152} ibid § 127.830.
\textsuperscript{153} ibid § 127.810
\textsuperscript{154} ibid § 127.810
\textsuperscript{155} Traci Little, ‘Comment, Protecting the Right to Live: International Comparison of Physician-Assisted Suicide Systems’ (1997) 7(2) Indiana International and Comparative Law Review 435, 442
\textsuperscript{156} Glover (n 142) 174
\textsuperscript{157} ibid 185
facilitate, rather than ameliorate, coercion, as abusers will have more time to pressure a vulnerable person into asking for assisted death. Nonetheless, the other proposed safeguards, such as the presence of an independent witness, or the mental assessment by a psychologist or a psychiatrist, can prevent this risk of coercion.

This requirement of repeated initiatives and ‘cooling-off’ periods should sometimes be dispensed, when the requestor has a terminal illness, as there might not be enough time to meet these requirements. This might have implications for appropriately identifying through the described procedures those people who should not be able to plead this defence such as those with an emotional reaction to suffering like depression, or who are generally unable to competently choose death. However, this is a danger we must accept to allow access to this defence.

Consequently, to summarise, it is important in the proposed physician-assisted death defence to require a competent, informed and voluntary death request. This request should be in writing and signed by an independent witness to prove that they have clearly communicated their decision. Since assisted deaths are largely a medical decision, the most probable test of competence to use is the one currently described under the Mental Capacity Act 2005. Nonetheless, some additional requirements need to be imposed to address potential problems that might be presented, as this test was not designed for assisted death decisions. There must be a mental assessment by default to all requestors by an independent psychologist or psychiatrist, and make information on assisted death more accessible. This latter requirement will also ensure that the assisted death decision is well-informed. To further ensure this it has been proposed that the requestor should be referred and informed on their health condition, the process of dying, and any feasible alternatives, such as comfort care, hospice care, and pain-control options by an independent consulting physician who must be a specialist in their condition. Finally, to ensure that the request was truly voluntary it must be repeated and deliberated over a fairly long period of time.
5.6.2 The medical condition of the requestor

Autonomy is not enough to overrule the importance typically attributed to life. There should be a combination of a competent, well-informed and voluntary wish to die, along with that being in the requestor’s best interests. Thus, in the context of establishing the appropriate safeguards for the physician-assisted death defence, is important to examine how the issue of whether death is in the requestor’s best interests is to be practically assessed for this defence. Some lives could be ended when there is no option of leading a good quality of life because of the experience of intense suffering. Hence, any assessment on whether death is in our best interests is linked to our medical condition. This assumption has been widespread in informing legislation in foreign jurisdictions.

In Oregon, physicians are allowed to prescribe lethal drugs only to terminally ill adult residents of Oregon. Under the Death with Dignity Act in Oregon, terminal illness is defined as ‘an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months’. Terminal illness was also a requirement in most of the past reform Bills in England. Under the Assisted Dying for the Terminally Ill Bill 2004 medical assistance to die would be offered to competent adults who were suffering unbearably due to terminal illness. For this Bill, terminal illness was an illness which according to the consulting physician was inevitably progressive and was not reversible by treatment, regardless of whether symptoms could be temporarily relieved, and would result in the requestor’s death within a few months. The Assisted Dying for the Terminally Ill Bill 2005 aimed to allow adults who were suffering unbearably due to terminal illness to be assisted in dying. Terminal illness for the Bill meant an illness that was ‘inevitably progressive’, could not be reversed by treatment, and would result in the requestor’s death within six months. The Assisted Dying Bill 2014-15 also aimed to allow adults who were

---

158 Chapter 3.2
159 Oregon Revised Statutes (n 81) § 127.800
160 ibid § 127.800
161 Assisted Dying for the Terminally Ill Bill 2004 (n 33)
162 ibid s 1
163 Assisted Dying for the Terminally Ill Bill 2005 (n 34)
164 ibid s 13
terminally ill to be assisted in dying and also had a six-month prognosis requirement.\textsuperscript{165} The same provisions were made in the Assisted Dying Bill by MP Rob Marris 2015,\textsuperscript{166} the Assisted Dying Bill 2016 by Lord Hayward\textsuperscript{167} and the most recent Assisted Dying Bill 2019-21.\textsuperscript{168}

However, this requirement of terminal illness with a specific month prognosis has been often criticised for being problematic. Accurately predicting the amount of time we have left is not easy.\textsuperscript{169} Requestors who have been given little time to live might survive for many happy years after their diagnosis.\textsuperscript{170} According to evidence given to the Select Committee discussing the Assisted Dying for the Terminally Ill Bill 2004, an accurate prognosis is not possible beyond 8–12 weeks.\textsuperscript{171} According to the Royal College of Physicians, a prognosis of terminal illness is ‘a probabilistic art’ and ‘prognosticating may be better when somebody is within the last two or three weeks of their life.’\textsuperscript{172} ‘When they are six or eight months away from it, it is pretty desperately hopeless as an accurate factor’.\textsuperscript{173}

Similarly, the Royal College of General Practitioners stated that it is possible ‘to make 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’.\textsuperscript{174} This problem can be also seen in Oregon, where according to data by the Oregon Public Health Division annual reports, some terminally ill people who have been given lethal drugs by physicians based on a six-month prognosis but did not consume them, had gone on to live longer.\textsuperscript{175} For example, the 2000 Oregon Public Health Division annual report showed a requestor having received a lethal prescription more than eight months before ingesting it.\textsuperscript{176} The 2004 annual report had a requestor die in 2003,

\begin{thebibliography}{99}
\item\textsuperscript{165} Assisted Dying Bill 2014-15 (n 35) s 2
\item\textsuperscript{166} Assisted Dying Bill 2015 (n 36) s 2
\item\textsuperscript{167} Assisted Dying Bill 2016 (n 37) s 2
\item\textsuperscript{168} Assisted Dying Bill 2019-21 (n 38) s 2
\item\textsuperscript{169} Williams (n 31) 283
\item\textsuperscript{170} ibid 283
\item\textsuperscript{171} Select Committee Report 2004 (n 39) para 118
\item\textsuperscript{172} ibid para 118
\item\textsuperscript{173} ibid para 118
\item\textsuperscript{174} ibid para 118
\item\textsuperscript{175} OPHD, Oregon’s Death with Dignity Act: The Second Years’ Experience (Second Annual Report) 12
\item\textsuperscript{176} ibid 12
\end{thebibliography}
after having obtained a lethal prescription in 2001. The fact that physicians have been inaccurate in their estimation of their death prognoses is evidence that it is difficult to assess the terminal phase. Thus, the six months prognosis requirement used in most of the above examples seems particularly problematic. It has no actual clinical meaning and is somewhat out of step with the realities of medical practice.

Another problem with a terminal illness requirement is that it does not include cases of intense mental suffering. Often psychological suffering is equally or more tormenting to physical deterioration. Even if the requestor of assisted death continues to live physically, their quality of life might be very bad due to the mental suffering they are experiencing. Thus, death might seem the only way to stop the intense mental suffering they are experiencing and the unbearable future they have to endure. Mentally ill individuals should not be forced to live such a miserable life without being able to request assisted death.

Due to such problems, some jurisdictions with a right to die legislation do not use a terminal illness requirement. In the Swiss right-to-die organisation, Dignitas, the requestor of assisted suicide should suffer from a disease that will inevitably lead to death or an unreasonable disability. British citizens who have ended their lives in Switzerland have included those with non-fatal conditions like multiple sclerosis and spinal cord injuries. Cases also include an elderly arthritic British woman who ended her life to avoid ‘prolonged dwindling’, and a British man with progressive dementia. To assess the requestor’s low quality of life Dignitas requires proof by medical documentation. This documentation is passed to a physician who works

177 OPHD, Sixth Annual Report on Oregon’s Death with Dignity Act 4
178 Dignitas, ‘Brochure ‘How DIGNITAS works’ (n 105)
181 Dignitas, ‘Brochure ‘How DIGNITAS works’ (n 105)
independently with the organisation for evaluation, and through a replying letter answers whether they are prepared to prescribe the necessary medication.\textsuperscript{182}

In the Netherlands, physicians are allowed to perform euthanasia or assisted suicide provided they are satisfied that the requestor’s suffering is unbearable and there is no prospect of improvement.\textsuperscript{183} Assisted death in the Netherlands is available to those who are suffering both physical and mental suffering, such as those who are at the onset of dementia. The first reported case of assisted suicide which involved someone suffering from dementia was in 2004.\textsuperscript{184} He had been diagnosed with dementia three years earlier, stated that he did not want to endure the full course of the illness and requested assisted suicide.\textsuperscript{185} It was believed that such suffering leading to the unacceptable prospect of further loss of dignity amounted to ‘suffering hopelessly and unbearably’.\textsuperscript{186}

However, this does not mean that the Dutch Act is extended to every occasion of mental suffering. In 2003 the Supreme Court in the case of \textit{Sutorius} held that it was not lawful for a physician to assist death to simply relieve a requestor of unbearable existential suffering.\textsuperscript{187} In this case, a physician had assisted the suicide of an 86-year-old person who was suffering from physical decline, and struggled with his ‘pointless and empty existence’ and felt socially isolated as all his friends and relatives had died.\textsuperscript{188} The Supreme Court upheld the conviction for euthanasia but imposed no penalty on the physician.\textsuperscript{189} The Court held that a doctor who assists in suicide in a case in which the requestor’s suffering is not predominantly due to a medically acknowledged disease or disorder, but stems from the fact that life has become meaningless for them, acts outside the scope of their professional competence.\textsuperscript{190}

\begin{itemize}
\item \textsuperscript{182} ibid
\item \textsuperscript{183} Dutch Act (n 55) s 2(1)
\item \textsuperscript{184} \textit{Regionale toetsingscommissies euthanasie: Jaarverslag 2004} [Regional Euthanasia Review Committees: Annual Report 2004] (English edn)
\item \textsuperscript{185} ibid
\item \textsuperscript{186} ibid
\item \textsuperscript{187} \textit{Hoge Raad (Strafkamer)} [Supreme Court (Criminal Division)] 24 December 2002 reported in Nederlandse Jurisprudentie 2003 nr167
\item \textsuperscript{188} Tony Sheldon, ‘Existential’ Suffering not a Justification for Euthanasia’ (2001) 323(7326) British Medical Journal Publishing Group 1384
\item \textsuperscript{189} ibid
\end{itemize}
is thus evident that both the Dutch Act and the proposed defence will not be extended to non-recognised mental disorders. However, unlike for the physician-assisted death defence, in the Netherlands, there is no mental health evaluation requirement.

It must be clarified that whether someone under intense mental suffering will be allowed to request to die under this defence will depend both on the nature of their illness and the extent to which it affects the sufferer's capacity, since there will be professional assessments by a psychiatrist or a psychologist. In principle, there is no reason why mental suffering cannot have an impact on our quality of life. Thus, it is important to hold open the possibility that intense mental suffering can justify requesting to die as life has become unbearable. As noted in chapter 4, a person under intense mental suffering might still be mentally competent.\textsuperscript{191} Regardless, there needs to be consideration from people with the required expertise. It is not the purpose of this discussion to describe which exact mental conditions might fit into this defence, as it is something that will be evaluated by a medical practitioner. It will be thus left up to the experts to tell us when the criteria of this defence for intense suffering and capacity have been met.

In Belgium, euthanasia and assisted suicide are allowed, if the requestor is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.\textsuperscript{192} This means that if a requestor refuses treatment for a curable disease, they may remain in a state of unbearable suffering, but the disease will not amount to an incurable one and will not fall under the Act. Therefore, the refusal of potentially curative treatment will prevent access to assisted death under the Belgian Act. The Belgian Act also covers both physical and psychiatric diseases which represent an acknowledgement that these might cause equal suffering to the requestor. The anticipation of a future coma, loss of independence, or progressive dementia could under the Belgian Act constitute 'a medically futile condition of persistent and

\textsuperscript{191} Chapter 4.5.2
\textsuperscript{192} Belgian Act on Euthanasia (n 80) s 3
unbearable mental suffering’ ‘here and now’ that ‘cannot be alleviated as a result of a serious and incurable disorder caused by illness’.

In Canada, the legislation on medical assistance in dying was initially available to those whose natural death was reasonably foreseeable. The legislation does not require a specific prognosis on the specific length of time that the requestors have left. However, in 2020 the Minister of Justice and Attorney General of Canada introduced a Bill to amend the existing legislation. In March of 2021, the Parliament passed revised legislation that made important changes to who may be eligible to obtain medical assistance in dying. The medical assistance in dying was expanded to people who might not face imminent death, but have a ‘grievous and irremediable medical condition’. This means that ‘they have a serious and incurable illness, disease or disability’, ‘they are in an advanced state of irreversible decline in capability’, and this condition makes them endure physical or psychological suffering which is intolerable and cannot be relieved in a way they find acceptable. Thus, through this reform, Canadians who only experience mental suffering and meet the eligibility criteria will be eligible for medical assistance in dying after March 2023. This time gap allows more time to consider how the law can practically work with safety to avoid abuse. To support this work, the government will initiate an expert review to consider protocols, guidance and potential safeguards.

Using these examples from foreign jurisdictions as a reference point for the physician-assisted death defence, a useful safeguard to establish is to require requestors to be under intense suffering which derives from a grievous medical condition. This will include both cases of physical suffering and mental suffering. There will be no

---

195 Canadian Criminal Code (n 82) 241.2
196 Government of Canada, ‘Medical assistance in dying’ (n 194)
197 ibid
198 Canadian Criminal Code (n 82) s 241.2
199 ibid s 241.2
200 Government of Canada, ‘Medical assistance in dying’ (n 194)
201 ibid
202 ibid
requirement for a specific final time prognosis as the proposed defence will be extended beyond cases of a terminal illness. However, no advance consent to die, for example for people suffering from cognitive degenerative disease, will be recognised under this defence. Since much time passes from drafting an advance directive and giving advance consent, the requestor might subsequently change their mind but neglect to update it accordingly.203 Even if someone, while competent, thinks that they would not wish to live with a profound disability or with cognitive degenerative disease, their decision might change and they could be content in a state which would have previously seemed unbearable to them.204 This considerable lapse of time from an advance directive to the time it is carried out makes them not a valid representation of an assisted death request at the time that it is performed.

Understandably, critics of this proposal might object that this requirement of including both physical and mental suffering in this defence is too general. However, in reality, it is not very different from the current legislation in countries such as the Netherlands, Belgium and Canada. When regulating behaviours such as physician-assisted death certain rules might not apply perfectly in all cases. It seems unfair not to include mentally ill people in these safeguards, and force them to continue a life of no true benefit against their will.

The Select Committee Report 2004 heard evidence that suffering is a subjective experience, which cannot be assessed objectively by clinical methods or reliably attributed to the underlying condition.205 It was recommended that instead of ‘unbearable suffering’ future Bills should refer to ‘unrelievable suffering’. This implies that every effort will be made to relieve any suffering and restrict assisted dying to only those whose pain cannot be alleviated by palliative care.206 Thus, a more objective medical assessment is made which ensures that all available steps have been taken to relieve distress.207

204 ibid 24
205 Select Committee Report 2004 (n 39) paras 127–130
207 ibid
Judgements on whether death is in someone’s best interests entail accepting that mistakes might occur. This is true both for physical and mental suffering. Able-bodied people might underestimate a disabled person’s worth of life.\textsuperscript{208} Suffering is a largely subjective experience, which cannot be entirely assessed objectively by clinical methods or reliably attributed to the underlying condition.\textsuperscript{209} Only the person experiencing the suffering can decide on their quality of life and whether is bearable or not. All we can expect from grantors is to make the best estimation they can on the facts that appear to them.\textsuperscript{210} An objective determination could be made by a physician of whether the requestor indeed has a serious physical or mental condition. Also, a subjective determination could be done by the requestor of their intense suffering, which cannot be alleviated to levels acceptable to them and allow them a prosperous and flourishing future.

The requestor making this determination on whether the suffering is at a level acceptable to them should explore beforehand alternative pain relief options that might offer them a better quality of life. These might include the use of strong painkillers, hospice or palliative care or counselling.\textsuperscript{211} There might be no need for the requestor to ask for assisted death as a means to stop their suffering. While these alternative options might be effective in some cases, they might not work for others. In some situations, there is such increased suffering that even with skilled care the requestor will still not consider their life dignified.\textsuperscript{212} Nonetheless, if we have to grant such a full justificatory defence to physician-assisted death it is important to ensure that all available options have been explored. In this way assisted death would be an option of last resort, and not an alternative to other means of medicine. Similarly, in England assisted death should not be offered without being a part of a continuum of medical

\begin{itemize}
\item \textsuperscript{208} Luke Clements, and Janet Read, \textit{Disabled People and the Right to Life} (New York, Routledge 2008) 100-101
\item \textsuperscript{209} Select Committee Report 2004 (n 39) paras 127–130
\item \textsuperscript{210} Williams (n 31) 283
\item \textsuperscript{211} Keating and Bridgeman (n 68) 717
\item \textsuperscript{212} David Harris, Benjamin Richard, Pankaj Khanna, ‘Assisted Dying: The Ongoing Debate’ (2006) 82(970) Postgraduate Medical Journal 479, 479
\end{itemize}
treatment, counselling, and palliative care.\textsuperscript{213} Grantors of wishes to die will treat this as the trigger for exploring alternative therapeutic options to address suffering.\textsuperscript{214}

Palliative care has been a consideration across jurisdictions with right to die legislation. Under the Dutch legislation, is required that the physician must be satisfied that there is no prospect of improvement and discuss the situation with the requestor and come to a joint conclusion that there is no other reasonable solution.\textsuperscript{215} Although this is not an express requirement for the experience of alternative pain relief options, this requirement was sometimes interpreted to include cases where palliative care treatment could have alleviated the requestor’s suffering, but where that treatment option had simply been declined.\textsuperscript{216} Also, in Belgium, it is required that the physician who is performing euthanasia or assisted suicide should discuss the request, health and life expectancy, and possible therapeutic and palliative treatment available with the requestor.\textsuperscript{217} While the Belgian Act does not include a mandatory requirement for a requestor to receive palliative care, as is the proposed requirement in the physician-assisted death defence, according to the Belgian Palliative Care Act, which was passed at the same time as the Belgian Act, every requestor approaching the end-of-life should be able to benefit from palliative care.\textsuperscript{218} A few months after the Belgian Act was passed, the Belgian Medical Disciplinary Board issued a set of guidelines endorsing the Belgian Act, and emphasising that palliative care must be exhausted as an option before resorting to euthanasia.\textsuperscript{219} Hence, every Belgian hospital has a palliative care team, and palliative home care is available nationally.\textsuperscript{220}

\textsuperscript{215} Dutch Act (n 55) s 2(1)
\textsuperscript{216} Paul van der Maas et al, ‘Euthanasia and Other Medical Decisions Concerning the End of Life’ (1991) 338 (8768) Lancet 669
\textsuperscript{217} Belgian Act on Euthanasia (n 80) s 3
\textsuperscript{219} Conseil National de l'Ordre des Médecins, Avis relatif aux soins palliatifs, à l'euthanasie et à d'autres decisions médicales concernant la fin de vie [National Council of the BOP, ‘Advice on palliative care, euthanasia and other medical end-of-life decisions’] https://www.ordomedic.be/fr/avis/conseil/avis-relatif-aux-soins-palliatifs-a-l%27euthanasie-et-a-d%27autres-decisions-medicales-concernant-la-fin-de-vie accessed 9 September 2021
\textsuperscript{220} Jan L. Bernheim and Arsène Mullie, ‘Euthanasia and Palliative Care in Belgium: Legitimate Concerns and Unsubstantiated Grievances’ (2010) 13(7) Journal of Palliative Medicine 798
According to the First Annual Report on Medical Assistance in Dying in Canada of 2019, the majority of recipients of medical assistance in dying also received support services.221 Most recipients were reported to have received palliative care services, and of those that did not, the majority had access to these services but chose not to use them.222 This is very similar to Oregon where there is no requirement for palliative care to allow physician-assisted suicide. However, studies show that most requestors who received a prescription under the Death with Dignity Act were enrolled in hospice care and ultimately the legislation led to more hospice referrals and more training by physicians in palliative care.223 The majority of requestors in Oregon are seeking physician-assisted suicide as an adjunct to palliative care, rather than as an alternative. As Campbell and Cox noted, suicide advocacy groups like Compassion and Choices ‘makes referrals to hospice a primary feature of its patient care counselling’ to ensure that physician-assisted death is practised responsibly.224

Most foreign jurisdictions require requestors to be informed about alternative pain relief options such as palliative care, and not to experience them, as was the proposal for the physician-assisted death defence. As the Select Committee Report of 2004 noted for the Assisted Dying for the Terminally Ill Bill 2004, its requirement that a specialist in palliative care should discuss the option with the requestor is not ideal.225 A future Bill on this issue must make clear that it is offering assisted death as complementary rather than an alternative to palliative care.226 It should consider how requestors seeking to end their lives might experience such care before taking a final decision.227 Therefore, they should experience alternative pain relief options such as palliative care, rather than merely be informed of such care as an option.228

222 Canadian Criminal Code (n 82) s 241.2 (1)
225 Select Committee Report 2004 (n 39) para 269
226 ibid para 269
227 ibid para 269
Also, according to the UK charity for hospice care, Help the Hospices, ‘experience of pain control is radically different from the promise of pain control, and cessation is almost unimaginable if symptom control has been poor’.229 People seeking assistance to die without having experienced pain control options could not be deemed fully informed.230 The importance of requiring that requestors experience alternative therapeutic options in the physician-assisted death defence has already been recognised. Although this requirement is strict, and some might object that it violates our right to autonomy, it is a justifiable kind of paternalism as it is not overly intrusive and is important in facilitating a truly informed decision that would be in our best interests. Thus, requestors before being granted euthanasia or assisted suicide should know that this should be their last option and not an alternative to medical treatment, hospice care or counselling.231

Conclusively, in this section, it has been proposed that along with a request for assisted death, this defence should require that this will be in the requestor’s best interests, based on their medical condition. While in the past it was often proposed that this assessment needs to be based on a terminal illness requirement, this has been rejected, mainly because accurate predictions are difficult to make. This defence should require that requestors are under intense suffering which derives from a grievous medical condition, either physical or mental. Those mental conditions must be recognised, and requestors will be subject to a psychological or psychiatric diagnosis to determine whether their capacity has been impaired. Thus, a subjective assessment will be made by the requestor of their experience of intense suffering along with an objective assessment by a medical professional of whether they indeed have a serious physical or mental condition. Every effort must be made to relieve suffering, and this defence must be restricted to those whose pain cannot be alleviated after experiencing pain relief options.

229 Select Committee Report 2004 (n 39) para 258
230 ibid para 258
231 Gostin (n 213) 99
5.7 Burden and standard of proof

When assessing a physician-assisted death plea in court, it is important to ensure that this defence is successful only in cases that fulfil the requirements described above. Criminal law trials might have life-altering consequences for defendants. Thus, we have reasons to care for the appropriate use of this defence, and to take steps to ensure this. For these reasons, there must be an examination of the appropriate allocation of the burden and standard of proof for the proposed defence.

As already explained in chapter 4, in English criminal law, the general rule is that the burden of proving guilt lies with the prosecution, who must prove the guilt of the accused beyond a reasonable doubt. In the majority of defences, such as automatism, loss of control, self-defence duress etc. the defendant bears the evidential burden and the prosecution the legal one. Thus, the defendant should adduce evidence or point to material in the case that supports the defence. Then the prosecution must prove beyond a reasonable doubt that the ground of exoneration does not avail the defendant, and prove their guilt. Nonetheless, sometimes the burden of proof is not allocated to the prosecution, but to the accused, albeit to the lower standard of ‘on a balance of probabilities’. In the defences of insanity and diminished responsibility, the defendant bears the legal burden of persuading the tribunal, and the standard of proof is no higher than in a civil trial, which is on the balance of probabilities. Therefore the defendant must show that the defence is more probably true than not true. Where an accused is charged with murder and

---

233 Woolmington v DPP [1935] A.C. 462
234 Hill v Baxter [1958] 1 Q.B. 277
235 Coroners and Justice Act 2009 s 54
236 Abraham [1973] 1 W.L.R. 1270
237 R v Gill [1963] 1 W.L.R. 841
239 Sheldrake v DPP [2005] 1 A.C. 264, 289
241 Richard Glover, Murphy on evidence (Oxford, Oxford University Press, 2015 ) 87
242 Homicide Act 1957 s 2(2)
243 Coroners and Justice Act 2009 (n 235) s 52
244 R v Carr-Briant [1943] KB 603
raises the issue of insanity or diminished responsibility, the prosecution is allowed to adduce evidence to prove the other of those issues.

According to Lambert reverse burden impositions must be justified and proportionate.\textsuperscript{246} Although, it is not generally agreed which factors make this justified, certain reasons have been identified which can be considered.\textsuperscript{247} These include balancing the defendant’s right and community’s interests, considering the injustice of an incorrect conviction, the exigency of the threat to society and the practicalities of proof. It is not the purpose of this discussion to solve the issue of when, or if at all, a legal burden should be reversed and provide guidance on this. This thesis aims to assess based on the perspective of the current law on reverse burdens whether the legal burden for the physician-assisted death defence is better placed on the prosecution or the accused.

The first factor which needs to be considered when deciding whether a reverse burden would be justified is balancing the defendant’s rights and the community’s interests.\textsuperscript{248} This is important as the presumption of innocence ordinarily places far greater weight on the defendant's rights, while the reverse burden favours law enforcement.\textsuperscript{249} This means that reverse burdens have a greater possibility of mistaken convictions, while the presumption of innocence allows for the greater possibility of mistaken acquittals. Typically the defendant’s rights are favoured because it is considered that a potential erroneous conviction unjustifiably censures, punishes and stigmatises the defendant and in many cases ruins their personal and professional life.\textsuperscript{250} Supporters of the reverse burden have argued that public interest is greatly damaged by favouring the defendant’s rights, due to the increased possibility of mistaken acquittals.\textsuperscript{251} An acquittal provides no deterrence, while a conviction, even if mistaken, could provide this ‘socially beneficial’ effect.\textsuperscript{252}

\begin{flushright}
\textsuperscript{246} R v Lambert [2001] UKHL 37
\textsuperscript{247} Hamer (n 245) 146
\textsuperscript{248} Glover (n 241) 87
\textsuperscript{249} ibid 87
\textsuperscript{250} ibid 87
\textsuperscript{251} Jerome Frank, Courts on Trial: Myth and Reality in American Justice (Princeton, Princeton University Press, 1950) 101
\textsuperscript{252} ibid 101
\end{flushright}
However, critics of the reverse burden have disagreed. They argue that the deterrence of an erroneous conviction would be lost if the mistake came to light.\textsuperscript{253} It would imply that there is no value in complying with the law as you might be wrongly convicted.\textsuperscript{254} To perceive a reverse burden as compatible with the presumption of innocence, the shift of favour to law enforcement must be justified and strike a reasonably proportional balance.\textsuperscript{255} Generally, when the prohibited conduct presents a particularly severe threat, it is considered that is better the community’s interests in law enforcement are given greater weight.\textsuperscript{256} Nonetheless, this argument’s logic can be also used to support the presumption of innocence, as the more serious the charge the stronger the interest in avoiding mistaken convictions.

For the proposed physician-assisted death, it seems that there are advantages in following both the presumption of innocence and a reverse burden under this argument. Given the vulnerability of those requestors, it might be more desirable for physicians to fear punishment if they do not follow the described safeguards of the defence than believing an acquittal will be easy to secure. It could be therefore more desirable to impose a reverse burden even if that will increase erroneous convictions rather than having more wrongful acquittals. However, although a reverse burden means that erroneous acquittals will decrease, the physician will be given less protection as there might be more mistaken convictions. It is questionable how desirable it is to decrease physicians’ legal protection given the unique nature of the profession that faces difficult decisions for people under extreme suffering who might repeatedly ask to die. In this sense increasing the risk of wrongful convictions through imposing a reverse burden would not be beneficial and the presumption of innocence needs to be followed.

Even if in theory there might be arguments both for a reverse burden and upholding the presumption of innocence, this might be the case for many of the different arguments this discussion is examining. Although we can always imagine ‘public

\textsuperscript{254} ibid
\textsuperscript{255} Janosevic v Sweden (2004) 38 E.H.R.R. 22, para 101
\textsuperscript{256} Hamer (n 245) 149
interest’ arguments for imposing reverse burdens, the whole purpose of the presumption of innocence is that these arguments should carry less weight than the avoidance of wrongful convictions. This point is especially valid in the context of more serious offences such as murder which has a very serious sentence of up to life imprisonment. Thus, there is more weight to the argument of avoiding wrongful convictions by upholding the presumption of innocence, since the effects of a mistaken life sentence will be very serious for the defendant.

The second factor in deciding whether a reverse burden is justified is that diminishing the defendant’s rights is considered justified if an incorrect conviction would constitute less of an injustice than usual. A mistaken denial of self-defence which is a full defence would be of greater injustice, as the murder conviction would bring the defendant the heaviest censure, punishment and stigma, but they have behaved in a way that is ‘socially acceptable or even commendable’. Since euthanasia is a particularly serious offence, which is punishable with mandatory life imprisonment, and the proposed physician-assisted death is a full defence, increasing the possibilities of a mistaken conviction through a reverse burden, would seem somewhat of a grave injustice. This is especially true for medical professionals who face hard life and death decisions in their everyday life, instead of being fully exonerated. Thus, this argument is mainly against imposing a reverse burden for the proposed defence.

Nonetheless, this argument is not entirely straightforward, as some could object that given the seriousness of euthanasia and assisted suicide offences it is better to have more mistaken convictions than mistaken acquittals which might result from upholding the presumption of innocence. In this way, by imposing a reverse burden and increasing the possibilities of mistaken convictions, the physician contemplating granting euthanasia or assisted suicide wishes will be fearful of the potential punishment and the stigma attached and will take extra precautions to follow the described guidelines of this defence. Consequently, perhaps a reverse burden might

257 ibid 149
259 ibid 919
be desirable to avoid the possibility of mistaken acquittals that might result from upholding the presumption of innocence.

It is generally accepted that the more serious the offence, the more compelling must be the justification for imposing a reverse persuasive burden. The degree of censure, punishment and stigma flowing from conviction varies for different charges, and there will be a corresponding variation in the injustice of an erroneous conviction.\textsuperscript{260} The least difficulty in upholding a reverse persuasive burden may be in respect of regulatory offences that are viewed as ‘quasi-criminal’ rather than ‘truly criminal’.\textsuperscript{261} This is because they generally do not carry custodial sentences, and bring little stigma.\textsuperscript{262} Thus, following this argument means that a reverse burden might not be justified for physician-assisted death.

It must be noted that this has not been always implemented. An example of defence with a reverse burden applied in serious offences is insanity.\textsuperscript{263} Especially before the introduction of the Criminal Procedure Act 1991, defendants acquitted under the defence were generally subject to indefinite, psychiatric detention.\textsuperscript{264} Accordingly, the defence was rarely used except in serious cases of fatal and non-fatal offences against the person.\textsuperscript{265} Also, the stigma attached seems somewhat akin to the stigma that emerges from a conviction for a serious offence.\textsuperscript{266} In this sense by imposing a reverse burden, the English legal system makes it possible that someone is convicted for a serious crime even if the court accepts a reasonable doubt concerning their guilt.

Nonetheless, following this argument, given the seriousness of physician-assisted death, this defence should uphold the presumption of innocence. Imposing a legal burden on the physician might not be the best approach as it would place them in a difficult position with an increased risk of mistaken conviction. Since this is a full

\begin{footnotes}
\item[260] Glover (n 241) 87
\item[261] \textit{R v Lambert} (n 246)
\item[262] Hamer (n 245) 149
\item[263] Ronnie Mackay, \textit{Mental condition defences in the criminal law} (Oxford, Oxford University Press, 1995)
\item[264] ibid
\item[265] ibid
\item[266] Hamer (n 245) 142-171
\end{footnotes}
defence, a mistaken denial of the plea would constitute greater injustice than a mistaken denial of a partial defence. If the defence is accepted they will be treated as wholly innocent, but if is erroneously rejected, they will be incarcerated and stigmatised. The murder conviction would bring the heaviest censure, punishment and stigma, but the grantors have behaved in a way that is justified, acceptable and we might be even content with their behaviour.  

The final criterion can provide a more straightforward argument on whether a reverse burden is justified. This examines whether there is some significant proof imbalance between the parties. The prosecution would find it extremely difficult to prove guilt without a reverse burden, but a defendant would have no particular difficulty in proving their innocence. In these circumstances, the reverse burden would seem to provide impetus to law enforcement without unduly infringing the rights of the innocent defendant. This proof imbalance between the parties must be extraordinary; beyond the ordinary asymmetrical operation of the presumption of innocence. Where a proof imbalance exists a reverse burden may promise to overcome the prosecution's proof difficulties while endangering a few innocent defendants. It is generally considered that proof is easier for the defendant than for the prosecution where the matter in question is within the defendant's peculiar knowledge. But it is important to note that just because something is difficult for the prosecution to prove it does not necessarily mean that it would be easy for the defendant, as the one does not entail the other.

The easiness of proving something is considered as a criterion for imposing a reverse burden both in diminished responsibility and insanity. According to McQuade, the defence of diminished responsibility places the legal burden on the defendant mainly

---

267 Fletcher (n 258) 919
268 Hamer (n 245) 143
270 ibid 158
271 ibid 161
272 ibid 161
273 ibid 161
274 ibid 161
due to practical reasons.\textsuperscript{275} This is because it would be extremely hard for the prosecution to prove beyond a reasonable doubt that the defendant does not suffer from a mental abnormality.\textsuperscript{276} Also, in insanity, it is considered that one cannot tell from the description of activity whether a person was sane or insane.\textsuperscript{277} It would be very easy for the accused to fake insanity and to raise reasonable doubt, placing an impossibly onerous burden of proof on the prosecution. To explain a killing as a consequence of insanity, the prosecution does not have the evidence needed as it cannot compel the accused to give medical evidence in the trial.\textsuperscript{278}

In the proposed physician-assisted death defence it is likely that there will be objective evidence besides the physician’s medical examination of the requestor for the prosecution to rely on. The proposed defence of physician-assisted death entails strict requirements regarding competence, voluntariness and informed decisions. The fact that the requestor should make a written request to die, signed by an independent witness, will prove that they unequivocally communicated their decision. Also, there will be the testimony of the independent psychologist or psychiatrist who will assess their mental competence, and of the independent consulting specialist who will ensure that they are well informed of their condition and potential alternatives. Furthermore, there will be evidence on whether the requestor has experienced alternative medical treatment options, counselling, and palliative care.\textsuperscript{279}

This is similar to how foreign jurisdictions monitor their legislations’ function on assisted death. In the Netherlands, before being allowed to perform euthanasia or assisted suicide the physician has to consult an independent physician who must examine the requestor and confirm in writing that the attending physician has satisfied the ‘due care’ criteria.\textsuperscript{280} Also, in Oregon, the attending physician together with a consulting physician must confirm that the required conditions to allow access to assisted suicide have been satisfied.\textsuperscript{281} In Canada, a different medical practitioner or

\textsuperscript{275} R v McQuade [2005] NICA 2
\textsuperscript{276} ibid
\textsuperscript{277} ibid
\textsuperscript{279} Gostin (n 213) 99
\textsuperscript{280} Dutch Act (n 55) s 2(1)
\textsuperscript{281} Oregon Revised Statutes (n 81) §§ 127.800, 127.815, 127.820
nurse practitioner than the one providing medical assistance in dying must give a written opinion confirming that the person meets all of the criteria.\textsuperscript{282}

Some jurisdictions have introduced additional monitoring procedures for their assisted death legislation. The Belgian Act is monitored by the multi-disciplinary Belgian Federal Control and Evaluation Commission to which all cases of euthanasia must be reported.\textsuperscript{283} This Commission is also able to monitor the extent to which Belgian physicians have explored and exhausted palliative care treatment before resorting to euthanasia since four of its 16 members are palliative care experts.\textsuperscript{284} In the Netherlands, physicians are required to report the cause of death to the municipal pathologist, who examines the deceased’s body and sends a report to one of the five Regional Review Committees.\textsuperscript{285} The Committee then assesses whether the physician acted following the ‘due care’ criteria.\textsuperscript{286} If they find that the physician failed to comply they report the case to the public prosecution authorities.\textsuperscript{287} The Committees also publish a summary of their finding in an annual report, aimed to detect abuse of the procedures, to the Minister of Health, Welfare and Sport, and the Minister of Justice who then report to Parliament.\textsuperscript{288} Furthermore, in Canada, the Minister of Health may collect personal information relating to written requests for, and the provision of, medical assistance in dying from a provincial or territorial government, or any of its institutions, or from a public body.\textsuperscript{289} Then the Minister has to publish a report at least once a year using the information collected under the medical assistance in dying monitoring system.\textsuperscript{290} These reports provide information on who and why is making medical assistance in dying requests, and under which circumstances this is provided.\textsuperscript{291}

\textsuperscript{282} Canadian Criminal Code (n 82) 241.2
\textsuperscript{283} Belgian Act on Euthanasia (n 80) s 5
\textsuperscript{284} ibid s 5
\textsuperscript{285} Wet op de lijkbezorging van 7 maart 1991 [Burial and Cremation Act of 7 March 1991] Stb 1991 130 sub-s 7.2
\textsuperscript{286} ibid
\textsuperscript{287} Dutch Act (n 55) s 8 and s 9(2)(a)
\textsuperscript{288} Mason Allen, ‘Crossing the Rubicon: The Netherlands Steady March Towards Involuntary Euthanasia’ (2005-2006) 31(2) Brooklyn Journal of International Law 535, 572
\textsuperscript{290} Government of Canada, ‘Medical assistance in dying’ (n 194)
\textsuperscript{291} ibid
Furthermore, across the different reform Bills that have been introduced in England on assisted death, there have been monitoring procedures that this defence could use as a reference point and establish a similar procedure which will also be useful as further evidence in court for the prosecution to rely on. The Assisted Dying for the Terminally Ill Bill 2004 proposed that a number of monitoring commissions would have been created to review its operation and to hold and monitor records.\textsuperscript{292} This commission would have consisted of three members appointed by the Secretary of State, of whom one would be a registered medical practitioner, one legal practitioner, and one layperson having first-hand knowledge or experience in caring for a person with a terminal illness.\textsuperscript{293} If two of its members were to consider that the above qualifying conditions were not met, they would refer the matter to the district coroner.\textsuperscript{294} The Secretary of State would then publish an annual statistical report of information collected under this section.\textsuperscript{295} The 2005 Bill also intended to create monitoring commissions.\textsuperscript{296} This would consist of three members appointed by the Secretary of State of whom one would be a registered medical practitioner, a solicitor or barrister; and a layperson having first-hand experience in caring for a person with a terminal illness. If two members of the commission thought that a declaration had not been validly made, was revoked or that it had not been complied with, they were ought to refer the matter to the district coroner.\textsuperscript{297}

Then the Assisted Dying Bill 2014-15 required that to monitor the procedure, the relevant Chief Medical Officer had to monitor the compliance with the Act’s provisions and any regulations or code of practice made under it.\textsuperscript{298} It was expected to inspect and report to the relevant national authority on any matter connected with the operation of the Act and to submit an annual report on the operation of the Act.\textsuperscript{299} The relevant national authority would publish each annual report or combined report it

\begin{itemize}
\item \textsuperscript{292} Assisted Dying for the Terminally Ill Bill 2004 (n 33) s 14
\item \textsuperscript{293} ibid s 8
\item \textsuperscript{294} ibid s 14
\item \textsuperscript{295} ibid s 8
\item \textsuperscript{296} Assisted Dying for the Terminally Ill Bill 2005 (n 34) s 12
\item \textsuperscript{297} ibid s 12
\item \textsuperscript{298} Assisted Dying Bill 2014-15 (n 35) s 9
\item \textsuperscript{299} ibid s 9
\end{itemize}
receives, and the Secretary of State would lay a copy of each report before Parliament.\textsuperscript{300} For England, the Chief Medical Officer was the Chief Medical Officer to the Department of Health\textsuperscript{301} and the relevant national authority the Secretary of State.\textsuperscript{302} It was the first time that a system like this was proposed, as previous Bills suggested to use a monitoring commission combined with a medical practitioner, a legal person such as a solicitor and a layperson.

It is not the purpose of this discussion to judge which monitoring procedure is the best. But it will be useful to have such arrangements in place for the proposed physician-assisted death defence as it would make it easier to determine in court whether all the relevant steps had been complied with. Thus, in terms of practicality, there will be requirements in place for the grantors in physician-assisted death to produce documents to monitor the procedure. If the prosecution thinks that there are doubts about the documents produced, the police will investigate further. The investigation will focus on whether the right steps and documentation have been fulfilled.

In the physician-assisted death defence, there will be objective evidence for the prosecution to rely on. Thus, the scope of the proposed defence will be very narrow compared to other defences with a reverse burden such as insanity or diminished responsibility. There is nothing to indicate that there will be a significant proof imbalance between the parties for the physician-assisted death defence. All the steps in this proposed defence are documented. It is not like insanity where it is difficult to prove the defendant’s mental state. The nature of the defence is not like other traditional medicalised defences with reverse burdens because we are dealing with professional people who will produce professional documents. Thus, there is no reason that the prosecution will find it extremely difficult to prove guilt, but might be easier for the physician to prove their innocence.

It is thus better for the prosecution to bear the legal burden for the physician-assisted death defence, as a reverse burden could not be justified. The physician will have to find sufficient evidence, which can be adduced from the explained monitoring

\textsuperscript{300} ibid s 9
\textsuperscript{301} ibid s 9
\textsuperscript{302} ibid s 9
procedures, to raise an issue for the defence of physician-assisted death. Then the jury will assume that this defence is satisfied unless the prosecution proves beyond a reasonable doubt that the grantor cannot be absolved on the grounds of physician-assisted death. If the safeguards of this defence are not fulfilled, it should not be difficult for the prosecution to prove this beyond a reasonable doubt as there will be objective evidence to rely on.

However, as noted in chapter 4, in practice in many instances where there would be a physician-assisted death case it is likely that it might not end in a trial at all, as these cases will likely be dealt with through non-prosecution where it will be obvious that the above-prescribed safeguards and the monitoring procedures have been complied with. If there is clear evidence that a physician has complied with all of the guidelines in this defence, the case would not even go to prosecutors, but even if it does, they would likely choose not to proceed further with a prosecution.

5.8 Conclusion

This chapter argued that substantive law reform such as the proposed physician-assisted death defence is preferable to dealing with assisted suicide cases through prosecutorial discretion. Nonetheless, the formalisation of the policy has been instrumental in bringing some ease to assisted suicide requestors and clarifying the relevant law. The argument that the formalisation of the policy will lead to a slippery slope was rejected and it was noted that the previous non-official policy created much uncertainty and distress.

Since a substantive law reform is better than dealing with these cases through prosecutorial discretion, this chapter examined how the substantive law on physician-assisted death can be reformed in England and Wales, to facilitate a more sympathetic approach towards these cases while also appropriately identifying and labelling them. Foreign jurisdictions and past reform Bills are limited to assisted death performed by trained individuals as physicians. We need to recognise the pro tanto wrong in physician-assisted death by creating a relevant defence. Thus, we can selectively allow the request to die, and that being in the requestor’s best interests to explain why
the physician did not conform to the prohibition of assisted death. This will be a justificatory full defence, as there are justifying circumstances making us content to have physician-assisted death performed, and there is no essential value in punishing assisted death under these special justifying circumstances.

It is important to ensure that vulnerable requestors are protected. Thus, potential safeguards for the appropriate functioning of the two main criteria of this defence, the request to die and the requestor’s medical condition were explored. Examples from jurisdictions with right to die legislation and past reform Bills were used as reference points. For the assisted death requests, it was proposed that it is better to require that they are in writing and signed by an independent witness. We should also ensure that the decision is competent, well-informed and voluntary. Since assisted death is largely a medical decision, the most probable test of competence to use is the one under the Mental Capacity Act 2005, currently used in medical law. However, as explained in the previous chapter, this test presents some important problems. It was proposed that there should be an in-advance psychiatric assessment by default to everyone asking for assisted death. Also, the requestor should be referred to an independent consulting physician who is a specialist in their condition to discuss their medical situation. This will also better ensure that the decision is well-informed. To better ensure voluntariness, repeated death requests should be required over a fairly long period.

For the requestor’s medical condition, it was proposed that the commonly used requirement of terminal illness with a specific final month prognosis should be rejected. The amount of time left to requestors is very hard to be accurately predicted. Also, terminal illness does not include cases of mental suffering, which can be equally painful to the requestor as physical suffering. Thus, to use this defence it was proposed that the requestors should be under intense suffering, either physical or mental, which will derive from a grievous medical condition. There should be a medical assessment by a physician on whether the requestor has indeed a serious condition. This should be taken into consideration along the requestor’s own opinion of whether his suffering is indeed intense and cannot be alleviated to levels acceptable to him and allow a flourishing future. A requestor must experience before having access to assisted death, alternative pain relief options. This will ensure that assisted death is an option of last resort and not an alternative to treatment.
In the final section, this chapter explored the appropriate allocation of the burden and standard of proof for this defence. In theory, the first criterion of balancing the defendant’s rights against the community’s interests does not provide a clear answer on how the burden of proof should be allocated for this defence. However, we can always imagine ‘public interest’ arguments for imposing reverse burdens, the whole purpose of the presumption of innocence is that these arguments should carry less weight than the avoidance of wrongful convictions. Thus, there is more weight to the argument of avoiding wrongful convictions by upholding the presumption of innocence, since the effects of a mistaken life sentence will be very serious for the defendant. The second criterion of considering the injustice of a certain conviction, was also not entirely straightforward in indicating the appropriate allocation of the burden of proof. It was noted that it is generally accepted that the more serious the offence, the more compelling must be the justification for imposing a reverse persuasive burden. Since this is a full defence, a mistaken denial of the plea would constitute greater injustice than a mistaken denial of a partial defence.

A more straightforward argument could be drawn from the final criterion, that a reverse burden is justified when there are great difficulties in the practicalities of proof. In this defence, there will be objective evidence for the prosecution to rely on which can be admitted in court. It was further noted that it will be useful to have monitoring procedures in place to effectively determine in court whether the necessary safeguards have been complied with. There should be requirements in place for the grantors to produce documents to monitor the procedure. Thus, since there is nothing to indicate a significant proof imbalance, it is better to impose the legal burden on the prosecution.
Chapter 6: Compassionate killing offence/defence

6.1 Introduction

This chapter discusses how English criminal law can be reformed to facilitate a more lenient approach to cases of compassionate killing. It will be argued that while intentional killing is at least a pro tanto wrong, compassionate motives ethically differentiate some offences from others in the law of murder and thus taking motives into consideration is important for reasons of justice. As is evident from the discussion in chapter 4, there is validity in creating a defence of compassionate killing to facilitate a more lenient approach towards these cases. It will be argued that this should be a partial excusatory defence. A compassionate actor's blameworthiness is mitigated due to their close relationship with the sufferer and the strong compassionate emotions they experience as these circumstances undercut their ability to avoid the killing, but they do not deserve their criminal liability to be fully removed.

Nonetheless, this discussion will argue that even if there is validity in creating a defence, based on a fair labelling view, there are strong reasons to argue that these cases should have a different label than murder and manslaughter. Equating these actors with those acting maliciously would be unfair and will substantially affect their life after their conviction. Therefore, a separate new label of compassionate killing for these cases is warranted. This chapter will use the offence/defence of infanticide as a reference point which can provide a model of how to have both a partial defence of compassionate killing and a separate label for these cases. It will be argued that we need to create a new compassionate killing offence/defence which will work both as a separate offence, a sub-category of homicide similar to manslaughter, and as a separate partial defence, which would reduce murder to compassionate killing.

When this is charged as an offence, the burden of proving the actus reus and mens rea of compassionate killing is very straightforward as it will be on the prosecution. Nonetheless, it is essential to consider what the appropriate burden of proof is when
this is used as a defence. After briefly considering the different reasons for imposing a reverse burden, it will be argued that due to the considerable proof imbalances between the parties, placing a legal burden on the defendant is justified, as it will be hard for the prosecution to find enough evidence if we were to uphold the presumption of innocence.

In the next part of this chapter, the different elements of this offence/defence will be analysed to ensure that it is applied only to those with compassionate motives. These elements will relate to the close relationship of the actor and the sufferer, the sufferer’s medical condition, and the role of a request to die in these cases. Regarding their close relationship, it will be argued that we need to find those cases where there is a proper manifestation of compassion through our actions. This is mainly present in close relationships of love which will also ensure knowledge of the suffering. On the element of the sufferer’s medical condition, it will be argued that since this offence/defence is focused on the actor, a medical diagnosis requirement is not appropriate. It will be suggested that the actor should have an actual belief in the loved one’s suffering that is also reasonable. It will be also supported that since compassionate killing is mostly focused on the actor, a request to die is not entailed in its interpretation. Nonetheless, a request to die might be a mitigating factor in court, and a wish to live an aggravating factor.

Creating such a compassionate killing offence/defence is important and is required even if the physician-assisted death defence exists, as each of these covers very different cases. While there will be a number of cases covered under the physician-assisted death defence, this is very strict and medicalised. As a result, many cases of people who do not fall under the requirements for a request to die, or the described medical condition will not be covered under this defence. Since compassionate motives ethically differentiate some offenders from others in the law of homicide, it is important to create a legal mechanism to deal with and offer a degree of leniency to the cases that will not fall under the physician-assisted death defence.

In the final part of this chapter it will be argued that if a substantive law reform such as a compassionate killing offence/defence or the physician-assisted death defence proposed in the previous chapter are not implemented, we will continue to use
prosecutorial discretion for some cases. Thus, this chapter will consider how the existing DPP's guidelines for assisted suicides should be reformed to achieve the objectives which have been discussed for these two defences. It is important when reforming the DPP's guidelines to achieve four objectives: ensuring that there is a competent, informed and voluntary death request; considering the victim's health condition; effectively evaluating compassionate motives; and finally, reconsidering how the guidelines approach assisted suicides performed by medical professionals.

It will be noted that the first objective of ensuring a competent, informed and voluntary death request is fully aligned with the DPP's guidelines. Regarding the second objective for the victim's health condition, it will be argued that such considerations need to be incorporated into the guidelines as often death requests are prompted by the experience of intense suffering, and compassionate motives are closely related to experiencing pain. It will be further highlighted that medical practitioners are the people able to perform assisted suicides as an act of responsible benevolence and they should not be deterred from assisting. Finally, it will be proposed that the guidelines referring to compassion need to consider the closeness of the relationship between the victim and the suspect. A detailed table of the proposed reforms to the DPP's guidelines will be provided at the end of this chapter.

6.2 Taking compassion into account in law

There is generally no widespread legal duty to act with compassion or exemption from legal sanction where compassion is pleaded.\(^1\) However, compassion is an important topic of legal study for many scholars. After explaining the different definitions of compassion in chapter 3, it was argued that compassion is the feeling of identification and sympathy towards someone who is in serious suffering, along with active regard for their wellbeing.\(^2\) While it is easy to accept that someone will feel compassion for someone close to them, such as a loved one, it is harder to accept the same in a professional relationship with a medical practitioner.\(^3\) A close relationship also allows

---

\(^1\) Dermot Feenan, 'Law and compassion' (2017) 13(2) International journal of law in context 121, 121
\(^2\) Chapter 3.6
the actor to assess whether the suffering experienced was so great that it could not
be alleviated to levels acceptable to the sufferer. There is something deeper about the
compassion you feel for a loved one because the nature of the relationship is different.
Thus, compassionately assisting someone to die can be either appropriate or
inappropriate according to your relationship.4

The idea of considering motives such as compassion in the substantive law is not new.
In civil law jurisdictions, motives seem to play an important part in homicide legislation.
In Germany, a murderer is any person who kills a person for pleasure, for sexual
gratification, out of greed or otherwise base motives.5 In Colombia killing another to
end intense suffering stemming from a serious or incurable illness or a serious injury
is recognised as a compassionate homicide rather than murder.6 Also, the Swiss penal
code classifies assisting suicide as a crime only if the motive is selfish, thus condoning
altruistic assisted suicides.7

Common law jurisdictions, in general, have traditionally deemed motives irrelevant in
criminal law.8 A crime can be committed from the best of motives and yet remain a
crime.9 This has deep roots within the common law tradition and is deeply linked within
social conflicts of the period in which the law was developed.10 In the past, mainly
during the seventeenth, eighteenth and early nineteenth centuries, desperate social
need and indignant claims of right were the motives of the poor.11 By deeming motives
irrelevant, separating them from intention, and focusing on the latter, the law was able
to focus on the question of ‘how’ acts came to be committed, and to exclude the
question ‘why’ they were committed.12 Moreover, the irrelevance of motives was to
some extent dictated by the need for a consistent and effective rule of law in such

4 Chapter 3.6
5 German Penal Code, article 211
6 Colombian Penal Code, article 106
7 Swiss Penal Code, article 114
8 Hazel Biggs, ‘Legitimate Compassion or Compassionate Legitimation? Reflections on the Policy for
Prosecutors in Respect of Cases of Encouraging or Assisting Suicide’ (2011) 19(1) Feminist Legal
Studies 83, 87
9 Alan Norrie, Crime, reason and history: a critical introduction to criminal law (Cambridge, Cambridge
University Press, 2014) 42
10 ibid 44
11 ibid 46
12 ibid 46
issues as definitions of offences and conditions of liability.\textsuperscript{13} If a ‘bad’ motive was to be requisite for criminality or liability, every agent who thought she was doing right, or at least meant to, would be excluded from legal control.\textsuperscript{14} Furthermore, it is generally considered that motives are difficult to ascertain and are easily pretended by the offender so that to make motives material to either the definition of most offences or to liability generally could undermine the efficacy of the law.\textsuperscript{15} Therefore there is currently very little scope to truly acknowledge the links between people and the reasons that drive them to act in the interests of another rather than the self.\textsuperscript{16}

It must be noted that while motives are generally currently not taken into consideration in England, there are some situations in which they are taken into account.\textsuperscript{17} This is mainly achieved through prosecutorial discretion, discretion to convict and discretion in sentencing.\textsuperscript{18} Prosecutorial discretion can operate as a mechanism to select the morally appropriate solution in light of the defendant’s motives.\textsuperscript{19} This can be in terms either of not prosecuting at all or of selecting a lesser offence where two offence categories are available.\textsuperscript{20} Currently, under the DPP’s guidelines for cases of assisted suicide, a factor considered against prosecution is that the suspect was wholly motivated by compassion.\textsuperscript{21} It must be clarified that this does not change the law; the practical discretion and sympathy for these cases has been simply formalised.\textsuperscript{22} Juries can appear more lenient towards certain cases by exercising a ‘good common sense’ approach when the law is somewhat vague or caught between conflicting standpoints.\textsuperscript{23} Then the actor of assisted death may be found not guilty although a guilty verdict would have been possible.\textsuperscript{24} Finally, through discretion in sentencing, we can achieve the mitigation of punishment after the conviction of the accused.\textsuperscript{25} The

\begin{flushleft}
\textsuperscript{13} Christine Sistare, ‘Agent Motives and the Criminal Law’ (1987) 13(3) Social Theory and Practice 303, 315
\textsuperscript{14} ibid 315
\textsuperscript{15} ibid 315
\textsuperscript{16} Keating and Bridgeman (n 3) 704
\textsuperscript{17} Norrie (n 9) 54
\textsuperscript{18} ibid 54
\textsuperscript{19} ibid 54
\textsuperscript{20} ibid 54
\textsuperscript{21} Chapter 2.2.2, Table 1
\textsuperscript{22} Norrie (n 9) 54
\textsuperscript{23} ibid 54
\textsuperscript{24} ibid 54
\textsuperscript{25} ibid 55
\end{flushleft}
judge is offered much discretion in sentencing and they are often more leniently disposed towards the convicted person who acted with a good motive.\textsuperscript{26} Currently in England, under the Criminal Justice Act 2003, a ‘belief’ by the defendant that the murder was an ‘act of mercy’ is a relevant factor that may count towards a reduction of the minimum period of imprisonment.\textsuperscript{27}

Sistare believes that motives are considerably important for reasons of justice.\textsuperscript{28} The idea that all who violate the law should be dealt with in the same manner and with equal severity offends ordinary moral sensibilities.\textsuperscript{29} A person who kills for money and one who kills out of compassion should not have the same treatment.\textsuperscript{30} The emotions that motivate us can make a significant difference to the moral character of the action in question. Although the law is not generally a character test, agent character as expressed through motives can be an important consideration.\textsuperscript{31} Those who kill for money despite the availability of reasonable alternatives for them display a disregard for other persons, for the law, and for the social principles the law attempts to protect.\textsuperscript{32} On the other hand, an offender who kills out of compassion does not necessarily exhibit such disregard. This may indicate that they are unlikely to repeat their crime or to commit other crimes, making them not a danger to the public interest.\textsuperscript{33}

As was already established in chapter 3, intentional killing remains wrongful even if compassionately motivated.\textsuperscript{34} Compassionately motivated killings seem to be somewhat ethically differentiated from other crimes in the law of homicide. Usually, the defendant in killing cases is acting wrongly and is punished for being either aggressive, malicious, dangerous or grossly negligent representing a danger to the public. In contrast, an actor in assisted death is acting in good faith potentially as a response to a wish to die and motivated by the need to stop intense suffering. Therefore, it seems that compassionate killings represent a somewhat different case

\textsuperscript{26} ibid 55
\textsuperscript{27} Criminal Justice Act 2003 s 269
\textsuperscript{28} Sistare (n 13) 313
\textsuperscript{29} ibid 314
\textsuperscript{30} ibid 314
\textsuperscript{31} ibid 314
\textsuperscript{32} ibid 314
\textsuperscript{33} ibid 314
\textsuperscript{34} Chapter 3.6
than other crimes in the law of homicide and we have reason to take this into consideration in the substantive law.

Compassionate motives for certain cases of homicide could be openly acknowledged through reforming the current law. The law embraces a plurality of goals, interests, and guiding principles. Good motives can be the basis of claims to legality but bad motives do not necessarily entail illegality. We have good reasons to attend to some motives but not to others. Considering compassion for some cases of homicides, would not necessarily entail a general change of policy for all offences. When there is tension between the agent's view and that of the law concerning the correctness of some action, the law can make certain allowances even when a prosecution is called for.

Therefore, it is evident from this discussion that while many civil law jurisdictions consider motives in homicide legislation, common law jurisdictions such as England have traditionally deemed them irrelevant to criminal liability. However, while intentional killing should always be at least a pro tanto wrong even if compassionately motivated, taking motives into consideration is sometimes important for reasons of justice. Compassionately motivated killings seem to be somewhat ethically differentiated from other crimes in the law of homicide. Those actors are usually acting in good faith and do not show the same disregard for other people and the social principles we attempt to protect as other offenders. Thus, we have reasons to take compassionate motives into consideration in the substantive law of homicide.

35 Sistare (n 13) 321
36 ibid 321
37 ibid 321
38 ibid 314
6.3 Creating an offence/defence of compassionate killing

6.3.1 A partial defence of compassionate killing

As was discussed in chapter 4, there are valid reasons to apply a defence to cases of compassionate killing.\textsuperscript{39} Since the available defences of diminished responsibility, necessity and consent should not be applied in this context, it is appropriate to create a compassionate killing defence to deal with these cases. In this way, we can recognise the pro tanto wrong of killing but also the special reasons of compassionate motives to engage in it. Offenders will answer in court for the planned and premeditated killing but will deny guilt in respect of that wrong due to their compassionate motives. They will be able to admit responsibility for the killing, but deny liability for that wrong in light of their compassionate motives. They will have to answer in court in fear of conviction but will be able to avert liability by offering the exculpatory answer of their motives to explain why they did not conform to the prohibition against killing.

As already explained in chapter 4, there are two main types of exculpatory defences: justifications and excuses. Each has been defined in many different ways.\textsuperscript{40} Usually, justifications are considered to grant a universal privilege since there is no social harm in the relevant conduct. Excuses are predicated on specific states of mind, and even though the conduct was wrongful, one ought not to be blamed due to the special circumstances.

The notion of compassion seems unsuitable for a justification defence. A compassion defence is motive oriented and thus it will be hard to accept that it could fulfil the forfeiture theory of considering the sufferer to have lost their rights because of their efforts to accommodate their killing. The focus of this defence is on the actor and not on any potential steps taken by the sufferer to override the value of their life. In this sense, since the focus of this defence is on the actor and not the actual circumstances

\textsuperscript{39} Chapter 4.2
\textsuperscript{40} ibid 4.2.2
of the conduct, it is unlikely that Robinson’s theory of justification of being content to have the act performed can be satisfied.\textsuperscript{41} It does not make a difference to the justifiability of the act that the actor experienced compassionate feelings at the time. Just because one was compassionately motivated, does not make us content to have a wrongful act performed.

Compassion seems more compatible with the basis for an excusatory defence. Following Robinson’s description of excuses, it can be argued that a compassionate actor’s blameworthiness is mitigated, as due to their close relationship with the sufferer, they experienced strong emotions when seeing them in pain. They have such a strong desire to end their loved one’s suffering that this is difficult for them to resist, and thus this undercuts their ability to avoid killing the sufferer. This is similar to how with provocation cases some circumstances produce a strong emotional reaction in the actor which greatly impacted the person’s level of self-control. Such compassionate killings are to be avoided whenever possible, even when the excusing conditions exist.\textsuperscript{42}

Perhaps some might find this excuse interpretation of the compassionate killing offence/defence troublesome since the conduct might be a reasoned decision. As Duff notes, the suggestion of an excusatory compassionate killing defence will strike many people as unwarranted, even insulting.\textsuperscript{43} This is not because they regard the action as inexcusably wrong, but because they regard it as justified.\textsuperscript{44} Supporters of a justificatory defence believe that someone who acts in that way, for a compassionate motive, needs no excuse since their actions are right or at least permissible.\textsuperscript{45} To excuse them because their compassion destabilised their practical rationality insults them by suggesting that they acted unreasonably or irrationally.\textsuperscript{46} An excusatory approach would imply that the actor was not in complete rational control of their

\textsuperscript{41} Paul Robinson, ‘Competing Theories of Justification: Deeds vs Reasons’ in Andrew Simester and ATH Smith (eds), 
\textsuperscript{42} ibid 46
\textsuperscript{43} Antony Duff, ‘Criminal Responsibility and the Emotions: If Fear and Anger Can Exculpate, Why Not Compassion?’ (2015) 58(2) Inquiry 189, 213
\textsuperscript{44} ibid 213
\textsuperscript{45} ibid 213
\textsuperscript{46} ibid 213
actions, whereas, they might claim, their action marked a wholly rational, appropriate response to the situation, and manifested their clear-sighted understanding of what was required.\textsuperscript{47}

It is interesting to consider that under the German Penal Code, for some defences both justificatory and excusatory types are recognised.\textsuperscript{48} In Germany, there is a defence of justified necessity (\textit{Rechtfertigender Notstand}), and one of excused necessity (\textit{Entschuldigender Notstand}).\textsuperscript{49} Justified necessity appeals to some version of choice of evils, where the defendant, under extreme circumstances, acts reasonably to avoid a disastrous result but in doing so commits an otherwise unlawful act.\textsuperscript{50} If the outcome ‘sought to be avoided’ by the defendant is sufficiently grave compared to the defendant’s act, then the act is justified by the necessity of the situation.\textsuperscript{51} Another similar example from Germany is self-defence, where there is an excusatory and a justificatory version.\textsuperscript{52} Under the justificatory view, an act committed in self-defence is not unlawful provided the actor has not exceeded the bounds of necessary defence.\textsuperscript{53} However, even if they have exceeded this, by killing instead of wounding the aggressor and therefore their act was wrongful, they will be excused if they exceeded the limits of the defence because of confusion, fear or terror.\textsuperscript{54} A similar example from English law is the defences of necessity and duress of circumstances. It is often considered that there is some clash between these defences, with the duress of circumstances covering many cases which traditionally would have come under necessity.\textsuperscript{55} Nonetheless, necessity is often classified as a justification while duress of circumstances is more closely associated with an excusatory type of defence.\textsuperscript{56}

\textsuperscript{47} ibid 213
\textsuperscript{48} Glenys Williams, ‘Necessity: Duress of Circumstances or Moral Involuntariness?’ (2014) 43(1) Common Law World Review 1, 26
\textsuperscript{49} German Penal Code (n 5) ss 34 and 35
\textsuperscript{50} ibid
\textsuperscript{52} German Penal Code (n 5) ss 32 and 33
\textsuperscript{53} ibid
\textsuperscript{54} ibid
\textsuperscript{55} Williams (n 48) 1
\textsuperscript{56} ibid 3-4
Our characterisation of compassionate killing defence will largely depend on the definitional theory of justifications and excuses used. Under definitions such as Gardner’s, even when conduct is unjustified, it may ‘live up to our expectations’ in the sense that it is a reasonable response to a justified emotion or mistake.\(^{57}\) Hence, excuses are a type of rational explanation of conduct, in Gardner’s view, rather than a denial of responsibility.\(^{58}\) In this sense, the actors’ compassionate actions will be seen as a manifestation of our expectations of them, given their particularly close relationship with the sufferer. Nothing is insulting in considering the compassionate killing defence as an excuse. Following Gardner, they have lived up to our expectations in the normative sense of not bearing to see their loved ones in pain anymore.\(^{59}\) In a way, their compassionate actions might even be seen as somewhat admirable under the circumstances. This does not mean that the act was right. There is a clear acknowledgement that the actor was wrong in killing an innocent person even if they did so compassionately.

A similar excusatory suggestion was made by the Law Commission, as it was commented that compassion might operate as an excuse in cases involving families.\(^{60}\) This can also explain why compassion is a factor against prosecution under the DPP’s policy, while professional assistance is a factor in favour of prosecution.\(^{61}\) Duff, in his discussion of a potential defence to euthanasia, agreed with this proposal of an excusatory defence for loved ones and argued that killing someone is impermissible.\(^{62}\) He argues that even if one is moved by compassion they have no justification.\(^{63}\) The law reflects a strong conception of the importance of life. Thus, depriving life is categorically wrong even with a person’s earnest request to be killed.\(^{64}\)

---

\(^{57}\) John Gardner, ‘Justification under Authority’ (2010) 23(1) The Canadian journal of law and jurisprudence 579  
\(^{58}\) ibid  
\(^{59}\) ibid 579  
\(^{60}\) The Law Commission, A new Homicide Act for England and Wales? (Law Com No 177, 2005) para 8.46.  
\(^{61}\) Duff (n 43) 210  
\(^{62}\) ibid 213  
\(^{63}\) ibid 213  
\(^{64}\) ibid 210
It is thus supported that the proposed compassionate killing makes more sense as an excusatory defence. The compassionate actor could not be justified for killing someone as such conduct is wrongful. Nonetheless, the actors because of their strong compassionate emotions, were unable to resist the desire to relieve their loved one’s suffering and thus proceeded in killing them.\textsuperscript{65} Hence, although they commit a criminal act, given the circumstances and their emotions at the time, we should excuse them.\textsuperscript{66}

Some might question whether loved ones should be entitled to the physician-assisted death defence, or an equivalent defence on the basis that their conduct is justified. As explained in previous chapters a justification for killing in assisted death cases requires a combination of an autonomous death request and that being in the requestor’s best interests. Compassion alone is not enough, and best interests along with autonomy are not entailed in compassion’s interpretation. However, in some cases the reasons that justify physicians, namely the condition of the requestor along with their earnest wish to die might also be present in some killings by loved ones and this should grant them a justification. Someone who is motivated by compassion to kill a loved one might also be acting because it is in their best interests not to continue living and they made a request to die. It is thus reasonable to question why these actors will not be able to plead the physician-assisted death defence, and will only be excused under the compassionate killing defence since these are decisive reasons for justification when the actor is a physician.

As was noted in chapter 5, a justificatory defence should be available only to physicians as a matter of policy.\textsuperscript{67} Thus, although there might be people who are not physicians who assist someone to die and whose conduct has justificatory traits, their actions will not be justified because of the danger to the requestor due to their lack of medical training. Due to their inexperience, they might leave them in a worse condition than before or cause them further pain during the procedure of assisted death. Furthermore, as has been observed, a request to die and this being in the requestor’s best interests are not guaranteed under compassion’s interpretation.\textsuperscript{68} Thus, it will be

\textsuperscript{65} ibid 210
\textsuperscript{66} ibid 210
\textsuperscript{67} Chapter 5.4
\textsuperscript{68} ibid 3.6
hard to establish safeguards, as in physician-assisted death defence to examine these under this proposal. Even if an individual who is not a physician observes these requirements of a death request and that being in the requestor’s best interests, and showed up in court with evidence of these, they would still not be justified in compassionate killing their loved one. Thus, compassionate killing should be characterised as an excuse defence, even if there might be such justificatory characteristics.

Furthermore, as explained in chapter 4, defences are also generally classified as full or complete and partial.\textsuperscript{69} Full defences preclude liability altogether, and partial defences do not completely absolve the defendant of guilt.\textsuperscript{70} As noted, compassionate killing is wrong, but the offender is less blameworthy than the typical offender in the law of homicide, as their choice was made substantially harder by the abnormal conditions they were facing at the time.\textsuperscript{71} There are strong aggravating factors such as the vulnerability of the victim due to poor health conditions and that there might have been planning and premeditation of the criminal act. These might resemble many other crimes in the law of homicide. However, there is also the strong mitigating factor that the actor was acting out of compassion.

Duff argues if we are to recognise an excuse for euthanasia, this should be a partial excuse.\textsuperscript{72} He bases this on the comparison with such defences as provocation and duress.\textsuperscript{73} Duress can serve as an excuse when someone gives in to a threat that they should have resisted, but that was serious enough that it would be unjust to convict and condemn them.\textsuperscript{74} However, English law does not recognise duress as a defence to murder. The logic of this exclusion according to Duff could be doubted.\textsuperscript{75} This is because it is believed that certain wrongs provide no reasons for their commission,\textsuperscript{76} such as deliberate killing. No harm can excuse murders as they are not rationally

\begin{flushright}
\textsuperscript{69} Keating and Bridgeman (n 3) 703
\textsuperscript{70} Chapter 4.2
\textsuperscript{71} Keating and Bridgeman (n 3) 703
\textsuperscript{72} Duff (n 43) 210
\textsuperscript{73} ibid 201
\textsuperscript{74} ibid 201
\textsuperscript{75} ibid 201
\textsuperscript{76} ibid 202
\end{flushright}
attractive. Nonetheless, others believe that duress should serve as an excuse in murder cases. They argue that the wrong of killing has some reasons for its commission. What the defendant did, although unjustified was at least rationally attractive, as a temptation by which it was not unreasonable to be drawn: they had good, although admittedly not good enough, reasons to act as they did.

Duress is different from the defence of provocation, the traditional common law partial defence to murder, which has been now replaced by loss of control in English law. This is a partial excusatory defence for murder, on the basis that the actor was provoked to lose self-control. Their core difference besides their applicability to murder cases is that one who kills under duress kills an innocent victim, while the victim of provocation was not entirely innocent as they provoke the defendant. While Duff notes that its partial status is controversial, its acceptance is based on the consideration that if we could agree that someone who meets the modest standards of virtue or self-control might have responded as they did, we can see some reason for mitigation.

Compassionate killing should be a partial excusatory defence that mitigates the actor’s sentence. Due to the differentiation compassionate motives makes it is desirable to allow them a partial excusatory defence of compassionate killing. As explained, life can be overridden only when there is a combination of a request to die and that is in the requestor’s best interests, and these elements are not necessarily entailed in compassion’s interpretation. Furthermore, the actor’s medical inexperience creates further undesirable dangers for the sufferer. The compassionate motives, are not enough to justify a complete removal of criminal liability for the killing. The actor has given in to their compassionate emotions for the sufferer even though they should have resisted, thus there is a valid reason for mitigation but is not enough to make this a full defence.

---

77 ibid 202
78 ibid 202
79 ibid 202
80 Coroners and Justice Act 2009 s 54
81 ibid s 54
82 Duff (n 43) 202
83 ibid 204
It is thus supported that the circumstances of the compassionate killing should be recognised by a reduction from murder to manslaughter. There is no sufficient reason for a complete acquittal, as even if it was very difficult for the actor to resist, their actions were still misguided.\textsuperscript{84} Although there might have been good reasons for the actor to proceed in compassionate killing, they were not good enough to warrant a complete acquittal. There is a distinctive wrong committed in compassionate killing cases which ought to be reflected in law. We will thus recognise that the deliberate killing in compassionate killing cases of an innocent person is a wrong that a person could be reasonably tempted to commit, even if they should always resist such a temptation, and we should allow for a partial defence.\textsuperscript{85}

Consequently, as it has been argued that there is validity in creating a defence of compassionate killing, which will be a partial excusatory defence. A compassionate actor’s blameworthiness will be reduced due to their close relationship with the sufferer and the strong compassionate emotions they experience as these circumstances undercut their ability to avoid the killing. The compassionate killing is a wrong in which the actor has given in due to their compassionate emotions for the sufferer, but it not a good enough reason to make this full defence. A contributing factor to this is the actor’s medical inexperience which creates further undesirable dangers for the sufferer. Thus, the actor’s actions need to be acknowledged as wrongful through some kind of punishment.

\textbf{6.3.2 Fair Labelling}

While it is evident that there is a valid argument for creating an excusatory compassionate killing partial defence, there are also good reasons to argue that these cases should be labelled differently from other cases of murder and manslaughter. They should not just be another variety of manslaughter, as a new distinct label is required. The normative principle of fair labelling was first introduced by Andrew Ashworth who noted that although the criminal law could operate with only a very small

\\textsuperscript{84} Keating and Bridgeman (n 3) 710
\textsuperscript{85} Duff (n 43) 212
number of offences, with moral culpability reflected in sentencing, the label applied to an offence ought fairly to represent the offender’s wrongdoing.\footnote{Andrew Ashworth, ‘The Elasticity of Mens Rea’ in Colin Tapper (ed), \textit{Crime, Proof and Punishment: Essays in Memory of Sir Rupert Cross} (London, Butterworth, 1981) 45, 53} 

As explained in chapter 4, the term fair labelling could refer to many things.\footnote{Chapter 4.3.1} It could mean the communication of accurate information of the nature or magnitude of the wrong committed.\footnote{ibid} Communicating vague and misleading information could give rise to public speculation and false assumptions.\footnote{James Chalmers and Fiona Leverick, ‘Fair Labelling in Criminal Law’ (2008) 71(2) The Modern Law Review 217, 219} Besides communicating something to the public, labelling might also be important in communicating something of value to the offender, by communicating what they have done wrong and why they are punished.\footnote{ibid 229} Then their punishment can appear more meaningful to them and not just an arbitrary harsh treatment.\footnote{ibid 217} Therefore the offence name needs to communicate to defendants the nature of their wrongdoing because the state should give fair notice of the nature of the allegations against them.\footnote{ibid 230} 

How the public perceives a certain label is likely to differ in various circumstances and environments.\footnote{Andrew Simester et al, \textit{Simester and Sullivan's criminal law: theory and doctrine} (Oxford, Hart, 2013) 30} Murder and manslaughter are very broad labels catching many different types of killing. This creates a risk that the public might misunderstand them, particularly in cases like compassionate killings which are very different from the usual cases encountered in courts. The main concern here is not which of the murder, manslaughter and compassionate killing labels has the greater stigma attached. Regardless of this, it is better that what the offender has done is fairly conveyed in a language that minimises the possibility of misreporting by the media or misunderstanding by the public. 

As Chalmers and Leverick noted, in areas where the criminal law’s structure is less understood by the general public, descriptive labels should be intelligible on a
freestanding basis. Simester and Sullivan argued that criminal law speaks to society as well as wrongdoers when it convicts them, and it should communicate its judgment with precision, by accurately naming the crime of which they are convicted. Compassionate motives differentiate such killings from others in the law of homicide, as actors are usually acting in good faith and do not show the same disregard for other people and the social principles we attempt to protect as other offenders. This differentiation should be represented in the offence’s label. Thus, actors labelled as compassionate under a separate offence would be at least more fairly stigmatised by their exact wrongdoing.

Generally, precisely defined labels are considered better, as the defendant’s criminal record has a deleterious effect on employability and earning power. Employers have a legitimate interest in knowing whether a prospective employee has a criminal record. Also, they are entitled to know at least whether the crime committed was one of dishonesty, violence, sexual misconduct, or a minor public order offence. Employers are unlikely to be legal professionals and thus there is a need for offence labels to avoid confusing 'legal' language or broad terms such as 'breach of the peace' that cover a wide range of conduct. Equating compassionate offenders with those who acted maliciously in other killings under murder and manslaughter could be unfair as it would substantially affect their prospects of continuing their life and flourishing after their sentence. It could be beneficial for these actors that a more specific label such as a compassionate killing offence is used.

However, it is important to note that too specific labels with a too high level of detail might also pose problems. They could over-complicate the law, imposing needless arguments about the appropriate charge for criminal conduct. Also, there is the risk that novel conduct will not be covered at all because offences have been drawn up

94 Chalmers and Leverick, (n 89) 222
95 Simester and Sullivan (n 93) 30
96 Chalmers and Leverick (n 89) 223
97 ibid 217
98 ibid 223
99 ibid 235
100 ibid 222
101 ibid 239
with too high a degree of specificity.  

An example of such particularism is the criminal code of the US state of Colorado where there are offences of first-degree murder, second-degree murder, criminally negligent homicide and manslaughter, as well as more specific offences such as vehicular homicide and first-degree murder of a police officer or a firefighter.  

Another example might be the Larceny Act 1916, now repealed, which used to contain a multitude of offences of dishonesty, classifying offences according to the nature of the property stolen, the identity of the offender and the location in which the offence took place.  

Furthermore, Clarkson identified several types of different homicide offences including ‘intentional killing’, ‘constructive manslaughter’, ‘gross negligence manslaughter’, ‘causing death by driving’, ‘killing resulting from dangerous and unlawful act’, ‘corporate killing’, ‘killing by gross carelessness’, and many others.

There is the danger that if we follow through the above logic of limiting broad offence labels then we will end up with numerous offences. If we need a distinct offence for compassionate killings, then this might lead to the question of why we would not also create distinct offences of the other types that Clarkson identifies. This is because compassionate killings are an exceptional case that is differentiated from other offences to such an extent that a separate label is warranted. Where sentencing is mitigated in murder cases through using a defence such as diminished responsibility or loss of control, we recognise that a different label, that of manslaughter, should exist. A separate label of compassionate killing due to the exceptional character of this act of aiding a loved one to die is even more compelling than in cases of loss of control or diminished responsibility cases.

Labels are significant and thus it is important to seek to reflect qualitative distinctions between how victims are wronged and the conduct’s moral character. Compassionate killing is strongly differentiated from other offences due to the actor’s

102 Glanville Williams, ‘Convictions and Fair Labelling’ (1983) 42(1) Cambridge Law Journal 85, 93
103 Chalmers and Leverick, (n 89) 239
104 Larceny Act 1916 ss 3-18
105 Christopher Clarkson, ‘Context and Culpability in Involuntary Manslaughter: Principle or Instinct?’ in Andrew Ashworth, and Barry Mitchell (eds), Rethinking English Homicide Law (Oxford, Oxford University Press, 2000) 133-165
good faith and the fact that they do not show the same disregard for other people and the social principles as other offenders. Thus, there is a good reason to create a distinct compassionate killing label in comparison to the above labels such as a ‘constructive manslaughter’ offence or ‘killing resulting from a dangerous and unlawful act’. It must be also noted that compassionate killing cases will be fewer in number than the labels discussed above. It is a very specific act and the meaning of compassion is very limited. Therefore, it will not apply to many cases. Thus, there is less risk that it will complicate the law of homicide.

Therefore, while there is a good argument for creating a partial defence of compassionate killing, after examining the fair labelling argument, there are strong reasons for the view that such cases should have a different label. Compassionate motives differentiate these cases as the offenders are acting in good faith and are not disregarding social principles in the same way as other homicide offenders. Equating these actors with those acting maliciously would be unfair as it would substantially affect their life after their conviction. Thus, since these cases are strongly differentiated, they should not be treated as another variety of manslaughter and a new label of compassionate killing is required.

### 6.3.3 An offence/defence similar to infanticide

The difficulty which is presented from this analysis is that while there is validity in recognising compassionate killing as a partial excusatory defence, there are also strong reasons of fair labelling for having a different distinct label for these cases rather than manslaughter. Infanticide which operates both as an offence and a partial defence\(^{107}\) could provide a good example of how to achieve these aims of having compassionate killing as a defence but also facilitating a distinct offence label for such cases.

Infanticide is an offence that also works as a concealed partial defence.\(^{108}\) Under the Infanticide Act 1938 when a mother kills her child who is under 12 months old, and at

\(^{107}\) Infanticide Act 1938

\(^{108}\) ibid
the time the balance of the mother’s mind was disturbed as a result of her not having fully recovered from the effect of giving birth or due to the effect of lactation, then the mother will be guilty of infanticide rather than murder.109 As an offence infanticide works as a sub-category of homicide different to murder and manslaughter. But a mother charged with murder in these circumstances may also raise infanticide as a defence.110 Then the jury may return a verdict of infanticide instead of murder.111 The offence of infanticide is intended to offer a more merciful outcome for the defendant than diminished responsibility, especially given that it can avoid the distress to the mother of an initial charge of murder or a voluntary manslaughter conviction.112

Punishment for infanticide is the equivalent of that for manslaughter, namely a maximum life sentence.113 But in most cases, it results in a noncustodial sentence, albeit often subject to a treatment or hospital order.114 When charged as an offence the burden of proving the *actus reus* and *mens rea* of infanticide is on the prosecution. When raised as a defence the burden of proof is on the prosecution to dispose of the infanticide claim beyond a reasonable doubt.115 This is different from diminished responsibility which, like infanticide, assesses the defendant’s mental impairment. In diminished responsibility, the burden of proof is on the defendant to discharge on the balance of probabilities.116 Similarly, the other mental impairment defence of insanity also places the burden of proof on the defendant.117

Infanticide was created because Parliament wanted to avoid passing a mandatory sentence of death on mothers who killed their babies.118 However, after the creation of diminished responsibility, there were discussions on whether infanticide should be subsumed within it.119 Critics of infanticide noted that postpartum psychiatric disorders

109 ibid s 1(1)
110 ibid s 1(2)
111 ibid s 1(2)
113 Infanticide Act 1938 (n 107) s 1(1)
114 Law Commission, Murder, Manslaughter and Infanticide (Law Com. No. 304, 2006) 157
115 ibid para 8.9
116 Homicide Act 1957 s 2(2)
118 Howard (n 112) 471
119 Law Commission (n 114) para 8.35
should not be distinguished from others with the risk of ‘pathologising’ motherhood.\textsuperscript{120} Also, the life of an infant should not be given less value than that of any other human being.\textsuperscript{121} Nonetheless, the Law Commission disagreed and noted that infanticide merely recognises that some new mothers suffer from psychiatric disorders, and possibly the effects of lactation, and as a result may kill their children.\textsuperscript{122} The Law Commission also highlighted that if infanticide were merged with diminished responsibility it would be classified as manslaughter which is a wrong label for those mothers.\textsuperscript{123} This is because infanticide cases are unique given the status of the offender and victim, but also the connection between childbirth and some kinds of psychiatric disorder.\textsuperscript{124} Also, there will be problems in discharging the burden of proof as a mother who is in denial about her mental state or has no memory of the killing would be incapable of providing evidence of a link to a recognised medical condition.\textsuperscript{125}

This example of infanticide could provide a good alternative approach to compassionate killing. Compassionate killing could work as a separate offence with a distinctive label, a sub-category of homicide, but also as a separate partial excusatory defence. This proposition to create a compassionate killing offence/defence, which will not be extended to assisted suicide cases, might be controversial. However, extending this offence/defence to assisted suicides would require creating a second-degree offence of assisted suicide, and such offences currently exist only in the context of homicide. A compassion defence for assisted suicides might not be necessary as compassion is already taken into consideration under the DPP’s guidelines as a factor against prosecution.\textsuperscript{126} The role of these guidelines in this thesis’ legislative proposals will be discussed later in this chapter. The reason for not prosecuting under the DPP’s guidelines is not communicated to the public. But, since assisted suicide is generally a less serious offence than euthanasia the information which is communicated might have less significance anyway. Nonetheless, compassion could be taken into

\begin{flushleft}
\textsuperscript{120} ibid para 8.35  \\
\textsuperscript{121} Howard (n 112) 471  \\
\textsuperscript{122} Law Commission (n 114) para 8.36  \\
\textsuperscript{123} ibid para 8.37  \\
\textsuperscript{124} ibid  \\
\textsuperscript{125} ibid (n 112) 476  \\
\textsuperscript{126} Director of Public Prosecutions, ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (\textit{Crown Prosecution Service}, February 2010) http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html accessed 11 June 2021
\end{flushleft}
consideration in the sentencing of assisted suicide cases. The main reason for partial
defences in the law of homicide is that we want to avoid the mandatory life sentence
of murder. This is not an issue in the offence of assisted suicide as there is no
mandatory penalty.

Upon creating the compassionate killing offence/defence, the prosecution will be able
to charge the actor with the offence of compassionate killing. Thus, a separate offence
label will be created for such cases which as explained is warranted for reasons of fair
labelling. If the prosecution decides that the action does not fall under the
compassionate killing offence category, and choose to charge the actor with murder,
then the actor will be able to plead the defence of compassionate killing and leave it
to the judgment of the jury. When compassionate killing is pleaded as a defence it
would reduce a murder verdict to one of compassionate killing.

6.4 Burden and standard of proof

When charged as an offence the burden of proving the actus reus and mens rea of
compassionate killing is very straightforward, as it will be on the prosecution. It is
nonetheless very important to consider the appropriate burden and standard of proof
for a compassionate killing defence plea. Deciding who should bear the burden of
proof in relation to a defence, as noted in the previous chapter, is not straightforward.
When assessing compassionate motives, it might be difficult to distinguish those
cases in which killing was indeed a compassionate response to pain and suffering
from acts of despair or self-interest. Someone who feels overpowered by the liability
of caring for another might want to kill them to avoid the burden. Alternatively,
someone might want to gain something from another’s passing, which is not
uncommon in the form of an inheritance. Reverse burdens on the accused must be
justified and proportionate. As explained in the previous chapter, the cases in which
a reverse burden is considered justified include balancing the defendant’s rights and

---

127 Keating and Bridgeman (n 3) 703
128 John Hardwig, ‘Is There a Duty to Die?’ (1997) 27(2) The Hastings Center 34
129 Director of Public Prosecutions ‘DPP Policy for prosecutors in respect of cases of encouraging or
aiding assisted suicide’ (n 126)
130 Chapter 5.7
community’s interests, considering the injustice of an incorrect conviction, the danger of the threat to society and the practicalities of proof.\textsuperscript{131}

The criterion of balancing the defendant’s rights, since the presumption of innocence places greater weight on the defendant’s rights, while reverse burdens favour law enforcement, can be linked to the second criterion of thinking about the injustice of an incorrect conviction. A reverse burden has a greater possibility of mistaken convictions, while the presumption of innocence has a greater possibility of mistaken acquittals.\textsuperscript{132} The more serious the offence, the most compelling must be the justification for imposing a reverse persuasive burden. The increased possibility of mistaken conviction through a reverse burden might provide more deterrence, and would better balance society’s interests in not having people killed. Nonetheless, this argument is not determinative. Failure of this defence would mean a murder conviction and mandatory life imprisonment. Thus, the stakes for the defendant are very high. While it is important to punish an ill-motivated person who might be abusing a vulnerable sufferer, it might be more serious to mistakenly convict a compassionate actor of murder and to impose the most serious sentence, thus it might be more beneficial to uphold the presumption of innocence.

An important argument to consider is that a reverse burden will gain more strength if there is considerable imbalance and difficulty of proof for one of the parties.\textsuperscript{133} Then a reverse burden may promise to overcome the prosecution’s proof difficulties while endangering few innocent defendants, as generally it is considered that proof is easier for the defendant when the matter is within their peculiar knowledge. The easiness of proving something in regards to holding some special knowledge is considered as a criterion for imposing a reverse burden both in diminished responsibility and insanity. Nonetheless, just because something is difficult for the prosecution to prove it does not necessarily mean that it would be easy for the defendant, as the one does not entail the other.

\textsuperscript{131} ibid
\textsuperscript{132} ibid
\textsuperscript{133} ibid
In compassionate killing cases, there could be potentially objective evidence that the actor was ill-motivated in killing or aiding the sufferer to die. An indication of such objective evidence is the case of Mrs McShane who was in serious financial difficulty and was captured on video attempting to persuade her mother to commit suicide and was convicted under the Suicide Act 1961.\textsuperscript{134} In some cases, there might be other sources of information such as medical evidence about the extent of the victim's suffering or testimony from other family and friends. Nonetheless, such evidence of ill-motives will not always be present.

However, being the person who is uniquely placed to have special knowledge does not mean it is easy to prove something, as proving your good motives is not as easy as for example, submitting a driver’s license. The proposed compassionate killing defence does not rely on medical evidence, as the defence of diminished responsibility does, but is subject largely to how the actor will describe their feelings. Therefore, a reverse burden might be hard for the actor to discharge. This is also one of the reasons that we do not normally take motives into consideration since there are considerable problems of proof. Nonetheless, compassion seems somewhat like diminished responsibility and insanity, in the sense that if there ever was a matter which could be said to be peculiarly within a person’s knowledge it is the state of their mind.

Placing the legal burden on the prosecution might be essentially extremely difficult to discharge and a reverse burden is desirable. As with insanity, in compassionate killing cases, there will often be nothing external purely from the description of the activity for the prosecution to say that this is something other than compassion. It is more appropriate for a compassionate killing defence to have a reverse burden. Thus, the legal burden should be on the defendant to prove this defence on the balance of probabilities.

The actor will have to adduce evidence regarding their close relationship with the deceased to show that their claim to have had compassionate motives is more likely to be true than not. This will require imposing strict safeguards to ensure their compassionate motives are credible. The actor simply testifying that they were

\textsuperscript{134} R v McShane (1978) 66 Cr. App. R. 97
compassionate would not be enough. The court will require them to showcase that they showed compassionate emotions for the sufferer even before the killing. Examples of this might be talking to someone such as a neighbour or other relative about how you cared deeply about that person. Hence, it might seem as an easy defence to claim but it will not be necessarily easy for everyone to provide evidence of this as the defendants will need to have evidential background to claim this successfully. Therefore, when compassionate killing is used as a defence, similarly to diminished responsibility or insanity, the defendant will bear the legal burden of persuading the tribunal\textsuperscript{135} and the standard of proof will be no higher than in a civil trial, which is on the balance of probabilities.\textsuperscript{136} The defendant must show that the claim of compassion is more probably true than untrue.\textsuperscript{137}

6.5 Elements of compassionate killing offence/defence

One could argue that strictly on the definition of this offence/defence, safeguards are not required, as what we care about is the compassionate motive. However, the danger of not having safeguards to ensure that the defendant had such a motive would be significant in potentially allowing manipulation and abuse of this plea. Someone who might have killed out of selfish and abusive motives might claim compassion as a way to avoid the punishment they would otherwise get. Certain people might be vulnerable to encouragements or pressured by family members to die to spare financial or emotional strain.\textsuperscript{138} Therefore, it is essential to use safeguards for this compassionate killing offence/defence.

As explained, a proper manifestation of compassion through our actions is defined as a sense of identification and sympathy to someone close to us such as a loved one who is in serious suffering, along with active regard for their good.\textsuperscript{139} Thus, the two elements identified for this compassionate offence/defence are the relationship

\textsuperscript{135} Coroners and Justice Act (n 81) 2009
\textsuperscript{136} R v Carr-Briant [1943] KB 603
\textsuperscript{138} Christine McPherson et al, 'Feeling Like a Burden to Others: A Systematic Review Focusing on the End of Life' (2007) 21(2) Palliative Medicine 115
\textsuperscript{139} Chapter 3.6
between the actor and the sufferer, and the suffering experienced. Safeguards regarding a medical condition were also established in the physician-assisted death defence. Furthermore, as noted above, there will be cases of compassionate killings where there will also be a request to die. Thus, we need to consider the role of a death request for this offence/defence. This was one of the most important elements of the physician-assisted death defence. However, regarding establishing intense suffering and considering death requests for compassionate killings, it needs to be noted that this offence/defence has a very different context than the proposed physician-assisted death defence.

6.5.1 Close relationship requirement

As explained in chapter 3, it is hard to accept that medical professionals will feel genuine compassion for their patients.\textsuperscript{140} Also, while we might feel genuine compassion for a person we do not know, such as a starving child on a television programme, not all instances of compassion have the same driving force to be taken into consideration for this offence/defence. Although compassion is naturally included in human relationships, a proper manifestation of compassion through our actions is present for those close to us, such as our loved ones. Expressions of compassion can be either appropriate or inappropriate according to the circumstances. Consequently, for this offence/defence we should think when something is a case of genuine compassion and when this is an appropriate expression.

For compassion, we need knowledge and understanding of the suffering another person is experiencing and the situation in which they are experiencing it, which are common in close relationships of love, care and affection.\textsuperscript{141} Such a relationship will allow assessing whether the suffering could be alleviated to levels acceptable to the sufferer and whether there are future possibilities of flourishing. For this reason, an essential requirement for establishing compassion is that the actor and the sufferer had a close relationship with each other. A close relationship might include siblings, parents, neighbours and many others.

\textsuperscript{140} ibid 3.6
\textsuperscript{141} ibid 3.6
However, this interpretation of knowledge to the sufferer’s pain might add an extra element to this safeguard which is that the loved ones might have to be familiar with the extent of pain the sufferer faces in their everyday life. This can be through living with or taking care of the sufferer in a non-professional capacity for some time. In this way, they might be better able to assess whether the suffering could be alleviated to levels acceptable to the sufferer and whether there are future possibilities of flourishing. Nevertheless, this interpretation is very restrictive and will leave outside of the scope of this offence/defence some important cases of genuine compassion.

We might still feel a very strong sense of compassion and being able to appreciate someone’s suffering from the overall relationship we have established with them, even if we are not currently living with them or taking care of them. For example, children will still feel compassion for their parents who might suffer intensely due to their advanced age, even if they live in care homes. Parents will feel compassion for their children even if they are living in nursing homes due to an accident they had. An indication of this is the previously explained case of Frances Inglis. Siblings who are living in different cities and do not see each other often might still feel compassion for each other. Additionally, parents whose children moved to another city, for studies or work will still love and care for them. Thus, limiting the close relationship in terms of living and taking care of someone is not ideal.

A better approach will be broadening the scope of this definition to include more instances of compassion. It will impose an evidential question of whether it was credible for the actor to end the sufferer’s pain based on their relationship. This is a substantially wider definition as it can include parents, foster parents, stepparents, former-foster and adoptive parents, children and stepchildren, siblings and half-siblings, grandparents, aunts and uncles, cousins, nephews or even close friends and neighbours. Thus, a general test is proposed which will assess whether the proximity of the relationship warranted the actor to feel compassion, which will be judged case-by-case. There should be an assessment of the evidence presented to decide whether the proximity of the relationship warranted the actor to feel compassion to the extent

142 R v Inglis [2011] 1 W.L.R. 1110
that they would kill their loved one. Nonetheless, there will be difficult borderline cases that the court will have to rule on.

It is always important to be conscious of killings that seem compassionate but might be in fact carried out to satisfy a personal interest, whether financial, professional or affective.\(^\text{143}\) For example, a son in serious financial debt might decide to kill his mother to inherit her property. Also, a husband who is cheating on his wife might decide to kill her to remarry. A selfish ground would also be recognised if the person acted to avenge, to relieve of a maintenance order or simply to get rid of a hated person.\(^\text{144}\) Such an example would be a wife who after enduring years of physical and emotional abuse decided to kill her now disabled husband. It is important to note that not every case where the actor seems to be gaining something, such as being able to remarry or inherit something from a loved one, will be selfishly motivated.\(^\text{145}\) We need to be mindful of these potential dangers, but each case will be eventually considered on its own merits and the evidence presented. Thus, these dangers should be dealt with through the process of assessing evidence. They will not affect the substantive scope of this offence/defence.

Another way to assess potential abuse in such cases is to attempt to comprehend the wider practical context which made the killing appropriate. The court must question why the actors chose to kill the sufferers and not discuss with them some other way of alleviating their pain such as placing them in palliative or hospice care.\(^\text{146}\) Therefore we need to try to understand the reasons that prompt the actors to compassionately kill.\(^\text{147}\) This entails addressing frequently unacknowledged, issues of the nature and the extent of care provided. This will be especially important in cases where the actor was also the basic carer of the sufferer. It is important to note that although such considerations are relevant, sometimes even in cases of considerable help by caring agencies, one will continue to feel compassion as often intense suffering cannot be completely alleviated.

\(^{144}\) ibid 30
\(^{145}\) Director of Public Prosecutions ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 126)
\(^{146}\) Keating and Bridgeman (n 3) 715
\(^{147}\) ibid 715
Consequently, the offence/defence of compassionate killing will be drafted to require a close relationship between the actor and the sufferer. This requirement will be part of the test of this defence and will impose an evidential question of whether it was credible for the actor to end the sufferer’s pain based on their relationship which will be judged case-by-case. There could be consideration of whether the actor was someone living with or taking care of the sufferer, but this requirement will not be limited to these situations. We should also be mindful of potential abuse, as occasionally some people might want to kill someone close to them for personal benefit. The court could try to consider and understand the reasons that prompt the actors to compassionately kill, which might include in some cases examining the extent of the care provided. However, these two considerations are just relevant factors for the court to consider in applying this test and they will not be explicitly mentioned in the legislation.

6.5.2 The medical condition of the sufferer

Since compassion is closely related to the experience of suffering, there must be some consideration regarding the sufferer’s health condition. The difficulty with such a requirement concerning a motive-based offence/defence is that the actors do not experience compassion because of a medical diagnosis, but because they see their loved ones suffering. Regardless of whether there is a reliable medical opinion that the sufferers might get better in the future if at the particular time they are experiencing pain, the actors might feel compassion. Therefore, to use this offence/defence the sufferer should experience intense suffering which provoked the compassionate killing, but this should not be based on a medical diagnosis. It is thus a more subjective rather than objective requirement of an experiential judgement. The actors based on their knowledge of the sufferers judge whether their suffering was extreme.

As was proposed for physician-assisted death defence in the previous chapter, it is important to note that this suffering could be either physical or mental, as often psychological suffering might be equally painful to physical deterioration and might make life extremely miserable. Treating mental illness is complex and usually does
not result in a ‘cure,’ per se.\textsuperscript{148} Rather it aims to make the patients feel better, get better, and eventually no longer need treatment.\textsuperscript{149} But even then, professionals are reluctant to state that they have been cured of their condition.\textsuperscript{150} This reluctance comes from the belief that mental illness is far more recurring than many physical diseases.\textsuperscript{151} Therefore, it would be unfair to exclude offenders who compassionately kill because their loved one was experiencing mental rather than physical suffering. If they are equally tormenting for the sufferer then theoretically both could provoke compassionate responses from a loved one.

One might object that suffering is largely an individual experience, which someone other than the sufferer might overestimate. The fact that no medical diagnosis would be required will further intensify such concerns. Inevitably a suffering safeguard without any medical examination requirement will have the dangers of being over-inclusive in many different cases. This subjective interpretation of suffering which is not based on a medical diagnosis raises an important question about the construction of this offence/defence. This is whether the actor’s assessment of suffering should be based on an honest or reasonable belief. Under the first, the actor must have an honest belief that the victim was suffering intensely either physically or psychologically. In contrast under the second test, the actor must have a reasonable belief that the victim was experiencing intense suffering either physical or psychological.

There is generally much debate on whether criminal liability must be based on what we honestly believe or what we reasonably ought to believe. There are many reasons in favour of and against both approaches. One might argue that the ethical basis of the actors’ actions is the same whether their belief is reasonable or unreasonable, as their motivation is on both occasions compassion. Supporters of a reasonable belief standard believe that sometimes our rational grasp of the world can be fallible, making our compassionate emotions often irrational and not proportionate to the relevant

\textsuperscript{148} John M. Grohol, ‘How Do You Cure Mental Illness?’ \textit{(Psych Central, 8 July 2018)}
\url{https://psychcentral.com/blog/how-do-you-cure-mental-illness/} accessed 3 October 2021
\textsuperscript{149} ibid
\textsuperscript{150} ibid
\textsuperscript{151} ibid
evidence. Such an approach entails viewing compassion as an emotion that can be either appropriate or inappropriate according to the circumstance of each case.

An example of an offence where a reasonable belief standard is used is rape. For a conviction of rape, the prosecution must prove both that the complainant was not consenting and that the defendant did not reasonably believe the complainant was consenting. Whether a belief is reasonable is to be determined having regard to all the circumstances, including any steps which the defendant has taken to ascertain whether the complainant consents. This is a subjective test with an objective element. The best way of dealing with this issue is to ask two questions. Firstly, whether the defendant believed the relevant issue, which is the subjective element of the test. Secondly, whether this belief was reasonable, which will be for the jury to decide; that represents the objective element. Consequently, when compassionate killing is used as an offence, if we use a reasonable person test, the prosecution should prove that the defendant reasonably believed that the victim was suffering. When this is used as a defence, the defendant would have to prove on the balance of probabilities that they reasonably believed the sufferer was experiencing intense pain. Then the jury will decide if this has been proved to the required standard.

A contradictory argument to a reasonable person test is that if the motive is the real concern, perhaps an honest belief standard is a better approach. This is because if compassion is what led the defendants to offend, this might be better assessed on what they thought about the particular situation. This can be compared to the defence of duress, which imposes a requirement for a reasonable belief as to what the coercer said or did and the defendant’s fear of death or serious injury. Such considerations seem different than the ones we need to have in regard to this offence/defence of

---

152 Duff (n 43) 210
153 ibid 210
154 Sexual Offences Act 2003 s 1(1)(b)
155 ibid s 1(1)(b)
156 ibid s 1(1)(c)
158 ibid
159 ibid
160 R v Graham [1982] 1 W.L.R. 294
compassion. This is because motives, unlike threats, are internal elements of which the defendant holds special knowledge. Therefore, compassion seems more like recognising that the defendants were in a difficult situation that was unique to their relationship and experiences with the sufferers and we ought to acknowledge their reactions to this.

An honest belief standard was used for rape before the Sexual Offences Act of 2003. But this approach was heavily criticised for having insufficient regard to sexual autonomy and authorising the assumption of consent regardless of the victim’s wishes. A similar criticism could potentially apply if such a test is used for the proposed offence/defence. An assumption that the defendant was acting out of compassion could be made regardless of whether the victim’s suffering prompted the killing. But it must be noted that this is also true for a reasonable belief standard, as a reasonable belief could also be mistaken. Another problem with an honest belief standard is that it will necessarily include some cases for which it is questionable whether we want to mitigate. For example, a daughter who kills her blind father with the honest belief that he is suffering intensely will be granted access to this offence/defence. While she acted compassionately, including such cases is not right since often able-bodied individuals underestimate the life of others, which could lead to discrimination.

There are reasons in favour of and against both tests. Deciding the appropriate test is not a difficulty that is unique to this thesis, as whatever standard is eventually used will be controversial. But this is a choice that we should make to appropriately construct this offence/defence. Through this discussion, the argument is more inclined towards choosing a reasonable person test. While it is true that the focus of this proposal is the motives of the actors, which are internal to what they thought of the particular situation, their actions should be a proper expression of compassion. Compassion can be either appropriate or inappropriate according to the circumstances. There are external elements that the prosecution can use to infer

---

161 *DPP v Morgan* [1976] A.C. 182
163 Duff (n 43) 210
this motive based on whether the person ought to reasonably feel compassion under the facts of each case. Consequently, what would be required to examine compassion in regard to a medical condition is an actual belief in suffering that is also reasonable.

6.5.3 Role of a death request

While a death request was a very important element of the physician-assisted death defence, it does not seem an appropriate requirement for such a motive-based offence/defence. Compassionate killing is mainly focused on the actor and a request to die by the sufferer is not entailed in compassion’s interpretation. This is supported by the recommendation of the Criminal Law Revision Committee for a mercy killing offence, which although as explained included a quality of life evaluation, did not refer to the victim’s state of mind or request.\(^{164}\)

This lack of a requirement for a request to die in compassionate killing might give rise to potential objections. A request would have been a form of guarantee that the killing was not abusive or paternalistic and that the sufferers wanted to die. The actors simply complied with their wishes and by killing them they did not deprive them of something they valued. The basic reason for the rejection of the 1976 Criminal Law Revision Committee proposition of a mercy killing offence was that its lack of a consent requirement would cause the weak and the handicapped to receive less effective protection from the law than the fit and well.\(^{165}\) The proposed offence only required that the defendants killed from mercy and that they believed the victims to be permanently subject to great bodily suffering or permanently helpless from bodily or mental incapacity, or subject to rapid and incurable bodily or mental degeneration.\(^{166}\)

Nonetheless, these are concerns that we must accept if we want to consider compassion. We can limit these dangers if we effectively enforce the above safeguards for a personal relationship and a reasonable belief in the experience of intense suffering. Ensuring that the actors indeed had a close relationship with the

\(^{164}\) Fourteenth Report of the Criminal Law Revision Committee on Offences Against the Person, Cmd 7844 (1980)

\(^{165}\) ibid

\(^{166}\) McPherson et al (n 138) 115
sufferers will validate the fact that they were likely to experience emotional pain along with them due to their close personal bond, leading them to offend. This should be accompanied by ensuring that the actors had a reasonable belief that the victims were experiencing intense suffering either physical or psychological that prompted their compassionate response. But as already noted, these requirements will also be regarded in the wider context of the killing to trace potential selfish motives, and why the actor chose the killing instead of seeking some other pain alleviation and treatment method. By ensuring these we would be able to better exclude instances of facilitating abusive and ill-motivated killings.

This would still leave us with killings that are genuinely motivated by compassion, where the actor believes there is intense suffering, but the sufferer expressly says that they want to carry on living. For example, a seriously ill son might repeatedly tell his mother that he does not want to die. However, the mother who cannot bear to see him like that, convinced that he is not thinking straight, decides to kill him. Then the mother would have access to this defence/offence. Also, there might be killings of people who are incapable of expressing their wishes entirely. A mother who sees her son unable to walk and talk after an accident will feel compassion for him which might lead her to kill him to stop what she sees as pointless suffering. This can be contrasted to a seriously ill son who repeatedly urges his mother to kill him as he cannot bear the pain he is enduring any longer. The actors in both of these examples could use the compassionate killing offence/defence.

However, as noted in this thesis, when we consent to die, in a sense we are not wronged by being killed, or at least not in the same way as when this is done against our will. Therefore, there is something more detrimental about killing against our express wishes, or the absence of a request, which makes it questionable to place all these scenarios in the same category. Actors who have received no request to die, even though they will have access to the compassionate killing offence/defence, will still face some liability. The actors’ conduct will still be condemned as wrong, but they will be offered some mitigation for their compassionate motives. We can somewhat acknowledge the differentiation of these cases, in terms of having a request to die, in sentencing. The court, once an offence is established, considers potential aggravating
and mitigating factors to adjust the sentence within the relevant range. Therefore, a request by the sufferer to die might be a mitigating factor for this offence/defence, while an earnest wish to live might be an aggravating factor.

One could respond that this suggestion will cause labelling problems since the severity of sentencing seems a very blunt tool to assess the level of wrongdoing. However, if through this offence/defence we are truly focusing on deeply felt compassion, then these examples, although undeniably different in terms of consent, should be placed under the same category as the motive is the same. A mother could feel compassion for her son when he is seriously ill whether he consents to die or not. Therefore, although consent is important and should make a difference to the way the mother is punished, it is not so significant in terms of labelling for this offence/defence.

There might be critics who will argue that this offence/defence should not be offered in cases of killing people that were not at least conscious of their suffering, since then it is pity and not compassion which prompts the act. This is based on Nussbaum’s interpretation of compassion since as Carr noted when the suffering is unfelt, while we may feel for the sufferers, judging their life to be pitiable, we do not ‘feel with’ them since they cannot feel their misfortune. In this sense, compassion is seen as an empathetic emotion that requires a feeling of suffering. This might have important implications for this offence/defence as it implies that it should be the sufferer who judges whether the pain is serious or trivial. Also, it might exclude the application of compassionate killing to cases where the sufferer has lost the use of reason or does not understand the pain they are in. In this sense, we cannot claim to compassionately end the life of another who was suffering from severe brain damage, or was brain dead or in a coma, as a compassionate act requires consciousness on the part of the person of their suffering.

---

168 Chalmers and Leverick, (n 89) 223
170 ibid 421
171 Liezl Van Zyl, Death and Compassion: A Virtue –based Approach to Euthanasia (Farnham, Ashgate, 2000) 89
172 ibid 193
There is some validity in this argument, but often, even if the suffering is not felt a family member may be concerned about the way their loved one will die. For example, in the previously mentioned case of Inglis, the mother was increasingly concerned about the way her son would die if food and water were withdrawn, and she thus decided to kill him. As she said, she could not ‘bear the thought of him dying of thirst or hunger’ as ‘that would be so cruel’. That is why she found a painless way to kill him through a drug overdose. Hence, compassion can be experienced not only when the sufferers feel pain, but also when they are enduring physical and mental incapacity or deterioration. Seeing them being demoted from fully functioning persons to a lower standard, having to endure the humiliation of being taken care of even for the most basic tasks like taking a bath might provoke compassionate feelings by their loved ones even if the victims are not conscious themselves. This is also linked to the close personal knowledge the loved ones have of the sufferers, knowing whether they would want to live like this or not. As Francis Inglis said, her son Tom would not want to live in total dependence. Consequently, this offence/defence should not be limited to those cases in which the sufferer was able to articulate or feel the suffering.

6.6 Reforming the DPP’s guidelines on assisted suicide

If the substantive law reform proposals made in this chapter and chapter 5 are implemented, it is questionable whether the DPP guidelines and prosecutorial discretion would still be needed. It will be odd if Parliament legislates on these issues and implements strict criteria and safeguards under which full or partial removal of criminal liability will be possible in these cases, and yet we still have a policy saying that those who fail to meet these criteria might not be prosecuted. Having a policy that continues to allow systematic non-prosecution in cases where the required safeguards

175 ibid
176 ibid
have not been complied with will essentially undermine the purpose of having these legislative reforms. It could create further confusion in an already complicated area of the law, as we will have both legislation on how to deal with these cases and the safeguards to follow, but also a policy issued by the DPP for non-prosecution.

However, since over the years there have been many unsuccessful attempts to change the law on assisted suicides in England and Wales,\footnote{Chapter 2.2} it is important to consider how the current prosecutorial guidelines on cases of assisted suicide should function if the reform proposals made are not implemented. As Lord Bingham explicitly stated in the case of Pretty, the ‘policy of the law remained firmly adverse to suicide’.\footnote{R (Pretty) v DPP [2001] UKHL 61 para 35} This reluctance of Parliament to legislate on the issue of assisted suicide led to the creation of the prosecutorial policy and the publication of the guidelines. Thus, assuming that the physician-assisted death defence and compassionate killing offence/defence are never implemented into legislation, prosecutorial discretion will continue. There needs to be some consideration of how these guidelines can be reformed to achieve the objectives of the proposed legislation discussed for physician-assisted death defence and compassionate killing offence/defence.

It must be noted that the compassionate killing offence/defence is not concerned with assisted suicides, while the physician-assisted death defence is concerned as much with killings as with assisted suicides. However, these guidelines apply only to cases of assisting suicide. Thus, if there is no substantive law reform, this will leave a gap in how we deal with euthanasia cases. Whether there ought to be a similar formal policy for euthanasia cases is an issue that will not be considered here. However, it must be noted that prosecutorial discretion currently plays a role in euthanasia even if there is no official prosecutorial policy.\footnote{CPS, ‘The Code for Crown Prosecutors’ (CPS, 26 October 2018) https://www.cps.gov.uk/publication/code-crown-prosecutors accessed 11 August 2021} This discussion will thus focus on how the assisted suicide guidelines need to be reformed.

It is important to note that the majority of the factors in favour of and against prosecution under the DPP’s guidelines seem to be much more geared towards the
situation covered by the proposed compassionate killing defence than to those covered by the physician-assisted death defence. There are generally four important objectives that the prosecutorial guidelines need to take into consideration. Firstly, the existence of a competent, informed and voluntary request to die must be taken into account. In the physician-assisted death defence, this is one of the most important factors which make the act fully justified. The second objective which has been analysed both for physician-assisted death and compassionate killings, and needs to be taken into consideration in the DPP’s guidelines, is the health condition of the deceased. Thirdly, it is important to look into the importance of compassion for the guidelines and how this is established. Fourthly, there needs to be some consideration of the way the guidelines approach assisted suicides performed by medical professionals such as physicians.

For ensuring the first of these objectives, the current prosecutorial guidelines place particular emphasis on ensuring that the assisted suicide request was competent, informed and voluntary. The factors against prosecution include that the victim was an adult, was capable under the Mental Capacity Act 2005 (which is the same test proposed for the physician-assisted death defence), and reached a voluntary and informed decision.180 Such conditions might contribute to deterring people who intend to abuse vulnerable individuals in convincing them to request assisted suicide, as they know they most likely will be prosecuted. Thus, it seems that the prosecutorial guidelines as they currently stand have strong considerations on the first objective of making allowances for cases of competent, informed and voluntary assisted suicide requests.

Regarding the second objective that needs to be achieved in the DPP’s guidelines, the deceased’s health condition, there are important concerns expressed by Greasley. According to her argument, the post-Purdy formalised approach already presents untenable symbolic and practical ramifications.181 Such ramifications are grounded in the symbolism of identifying which lives are worth living since prosecutions are

180 Director of Public Prosecutions ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 126) para 43(2)
181 Greasley (11) 326
avoided in specific circumstances, and in accepting assisted suicide as an accessible and normalised solution.\textsuperscript{182} The symbolic statement of formalising the policy and in a way permitting assisted death in certain circumstances may lead to a change of how severely disabled people and those around them view their condition and their options.\textsuperscript{183} Eventually, there could be greater social pressurisation and manipulation of the vulnerable.\textsuperscript{184} Therefore this formalisation of the policy has a greater risk of abuse, imposition of social pressure to die, and identifying which lives are worthy.\textsuperscript{185}

However, Greasley’s criticism of untenable symbolism in the post-\textit{Purdy} approach is somewhat overstated. The DPP’s policy as it currently stands does not make any mention of the victim’s medical condition. The interim policy used to include a factor that tended against prosecution where the victim had a terminal illness, a severe and incurable physical disability, or a severe degenerative physical condition.\textsuperscript{186} As Heywood noted, these criteria have been criticised because they might have a discriminatory nature as people suffering from a disability may perceive the policy as placing less value on their lives.\textsuperscript{187} As such, all references to the particular condition from which the victim must be suffering have now been removed.\textsuperscript{188} Therefore, it seems questionable how symbolism regarding the requestor’s health condition could arise if no mention of their health condition is currently made.

Nonetheless, as already noted in chapter 3, this argument about untenable symbolic ramifications is not enough to indicate against this interpretation of the importance of life.\textsuperscript{189} Judgements on people’s worthwhileness of life are already made when deciding to withdraw life-sustaining treatment from incompetent patients and hastening death through palliative medication.\textsuperscript{190} Looking into the victim’s medical condition is important in establishing other factors of the policy, such as that ‘the suspect was

\textsuperscript{182} ibid 326
\textsuperscript{183} ibid 326
\textsuperscript{184} ibid 326
\textsuperscript{185} ibid 326
\textsuperscript{187} ibid 431
\textsuperscript{188} ibid 431
\textsuperscript{189} Chapter 3.2
\textsuperscript{190} ibid
wholly motivated by compassion’ and that ‘the victim had reached a voluntary, clear, settled and informed decision to commit suicide’.\textsuperscript{191} Compassionate feelings are closely linked to the experience of intense suffering.\textsuperscript{192} Also, often death requests are prompted by the experience of intense suffering that makes the requestor’s life unbearable.\textsuperscript{193} Thus, changing the guidelines to include consideration of the victim’s health condition can further help to establish those two factors.

Thus, the guidelines should also include a factor against prosecution that the victim was under extreme suffering, either physical or mental. A similar consideration can be created for the factors in favour of prosecution when the suspect was not under extreme suffering. The DPP will be able to assess the existence of this suffering through finding evidence of a medical diagnosis, similar to what has been proposed in chapter 5 for the physician-assisted death defence. Alternatively, the DPP could assess whether the suspect was under a reasonable belief that their loved one was under extreme suffering as was proposed for the compassionate killing offence/defence.

An issue that is linked to this is that in the guidelines it is a consideration in favour of prosecution that the victim is physically able to undertake the act that constitutes assistance themselves.\textsuperscript{194} This is justified, as a person who wants to die, and can act on their own should do so without involving third parties.\textsuperscript{195} Nonetheless, this does not take into account those individuals with severe mental issues causing extreme suffering, who, although they might be physically capable of undertaking the act of suicide, may lack the mental capacity to do so. Therefore, such a provision is better removed from the prosecutorial guidelines. A requirement about being unable to undertake the act of suicide was also not included in the proposal for the physician-assisted death defence.

\begin{footnotes}
\item[191] Director of Public Prosecutions ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 126) paras 45(2) and 45(1)
\item[192] Chapter 6.5.2
\item[193] ibid 5.6.1
\item[194] Director of Public Prosecutions, ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 14126) para 43(10)
\item[195] Heywood (n 32186) 433
\end{footnotes}
Another problem that should be addressed is that under the current guidelines it is a factor in favour of prosecution if the suspect was a medical professional. Furthermore, it is stated that it counts as a factor in favour of prosecution if the suspect was ‘a person in authority, such as a prison officer, and the victim was in his or her care’. The intention was probably to safeguard vulnerable individuals from professionals who would take the opportunity to abuse their power and trustworthy position. Also, it was thought important to distinguish between someone who is motivated by compassion and those who were engaged in the delivery of professional services or a business that would routinely bring them into conflict with the law. Nonetheless, it is unclear whether this provision involves physicians who perform assisted suicide or simply provide a patient with their medical records for them to seek an assisted suicide abroad. It would be a breach of Article 8 of the European Convention on Human Rights for a physician to refuse a patient their medical records.

Having such a provision risks that any assistance will be given by amateurs and inexperienced individuals. It would be very difficult to obtain any meaningful or practical help with assisted suicide in England. This creates significant risks, of botched suicide which might leave the requestor in a worse condition than before, or cause them to experience great suffering in the process. It might also encourage some to look for help in right-to-die organisations abroad and assisted suicide sooner than they might otherwise, due to the need to travel abroad whilst they can still do so physically. In this manner, the DPP’s Policy may succeed in keeping the number of assisted suicides that take place entirely within England and Wales relatively low.

196 Director of Public Prosecutions, ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 14126) para 43(14)
197 ibid para 43(14)
201 Mullock (n 45199) 452
202 Baker (n 44198) 98
203 Mullock (n 45199) 450
However, if this is achieved at the cost of exporting suicidal Britons to a jurisdiction where assisted suicide is easily available, then the law is less than satisfactory.

Health care professionals have the expertise to provide assisted suicide as an act of responsible benevolence and not leave the requestor in a worse condition than before. They also have at their disposal medical substances which can be used to allow the requestor not to suffer during the procedure and they can use them accordingly due to their medical training. Thus, this consideration is better removed entirely from the factors in favour of prosecution. Being a medical professional could count as a factor against prosecution since it is a way to further guard people against failed suicide attempts or further suffering during the procedure.

The difficulty in obtaining meaningful help under the current guidelines can be also linked to some other factors in the prosecutorial guidelines. It is stated as a factor in favour of prosecution that the suspect who was unknown to the victim encouraged or assisted them in suicide by providing specific information. Furthermore, it is stated as factors in favour of prosecution that the suspect might have encouraged or assisted more than one victim without knowing them personally or that they were paid for their conduct. Therefore, it will be hard to acquire any meaningful information on assisted suicide from people who might have some special expertise or knowledge on the issue and the procedure. This reluctance to provide any meaningful information is also evident from the factor in favour of prosecution that the suspect was involved in the management of an organisation or group and provided the physical environment to allow suicide. These factors can be also linked to the factor against prosecution that the suspect’s actions ‘may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide’. Any further encouragement, such as helping the requestors by providing specific information on the procedure for assisted death, will thus be detrimental to the suspect’s case.

204 Chapter 4.5.1
205 Director of Public Prosecutions, ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (n 14126) para 43(11)
206 ibid para 43(12)
207 ibid para 43(16)
208 ibid para 45(5)
Since it is important to ensure that the requestor is making an informed decision to die it is best to encourage access to information for assisted suicide. Such information might come from a variety of sources. But we should be especially encouraging of professionals such as healthcare workers, palliative care specialists and so on to provide such information as they would be in the best position to give meaningful and informed advice. Therefore, it is better that such factors are not considered in favour of prosecution and they should be removed from the policy.

As noted above, most of the factors in favour of and against prosecution examined so far seem to be much more geared towards the situation covered by the compassionate killing defence, than that covered by the physician-assisted death defence. This is partly because there is a particular focus on discouraging any kind of professional help. One of the most important provisions in the DPP's guidelines, is the protection it gives to those well-meaning suspects who are compassionately motivated. It is a factor against prosecution that ‘the suspect was wholly motivated by compassion’. But there is also an equivalent factor in favour of prosecution, regarding cases when the suspect was not motivated by compassion.

Another consideration that might be relevant to this assessment of motive in the guidelines is that it is considered as a factor against prosecution that ‘the suspect had sought to dissuade the victim’. On the question of compassionate motives, consideration is given to whether the suspect had something to gain, but each case is judged on its facts. An example of such a case where the suspect gained something from the requestor’s passing is the case of Sir Edward Downes and his wife, Lady Edwina Downes, who were both accompanied by their son to Dignitas, where they ended their lives. The DPP decided that there was no evidence that the son was motivated by the financial gain he received upon their deaths.

---

209 ibid para 45(2)
210 ibid para 45(6)
211 ibid para 45(4)
212 ibid para 44
214 ibid
It has been suggested by Horder that this focus on motives in the DPP’s policy represents ‘an excusatory as opposed to a justificatory approach’\(^{215}\) where ‘the granting of an excuse is in part linked to the experience of conscience-driven emotional pressures arising from the suspect’s special relationship with the victim’.\(^{216}\) The introduction of a compassionate motive in the DPP’s policy is a departure from the usual standards of criminal law. The classic elements of a crime are the *actus reus* and *mens rea*, with motive being irrelevant.\(^{217}\) Such a policy in which the accused’s motive for acting is stated to be a key consideration serves to distinguish those who intentionally acted with a benevolent motive from others who intentionally performed an act capable of assisting a suicide.

A ‘compassionate’ motive was a consideration against prosecution for assisted suicide, even before the DPP’s policy was published.\(^{218}\) For example, it is one of the most important factors speculated to have influenced the DPP’s decision not to prosecute the parents of Daniel James, a 23-year-old rugby player who suffered from tetraplegia after sustaining a spinal injury in a rugby accident.\(^{219}\) After his third failed suicide attempt, James decided to end his life at Dignitas.\(^{220}\) James’ parents assisted with his correspondence with Dignitas, organised his flights with a friend’s help, accompanied him to Dignitas, arranged for Swiss carers, attended two suicide consultations between James and his Swiss doctor, and attended the Dignitas clinic on the day of the suicide.\(^{221}\) Despite the amount of support and assistance given by James’ parents, the DPP decided not to prosecute them for assisted suicide.\(^{222}\)


\(^{216}\) ibid 228

\(^{217}\) Hazel Biggs, ‘Legitimate Compassion or Compassionate Legitimation? Reflections on the Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide’ (2011) 19(1) Feminist Legal Studies 83, 90 Biggs (n 8) 90

\(^{218}\) ibid 86

\(^{219}\) ibid 86


\(^{221}\) ibid

\(^{222}\) ibid
However, further explanation of the exact meaning of compassionate motive would be necessary for the guidelines. The reference to compassionate motives is too broad and could create further vagueness regarding the application of the policy. Not all instances of compassion have the same driving force. As we saw in chapter 3, compassion provokes a subject-oriented approach that pays heed not just to the perceived suffering, but also to that person’s attitude to suffering.223 An assessment of compassion would necessarily involve knowledge, as it requires an understanding of what another person is experiencing and the situation in which they are experiencing it.224 Such an understanding of suffering and knowledge are common in close relationships of love, care and affection. Such a relationship will allow an assessment of whether the suffering could be alleviated to levels acceptable to the sufferer and whether there are future possibilities of flourishing. There is something deeper about the compassion we may feel for a loved one because of the nature of our relationship. A stranger compassionately assisting someone to die would thus be inappropriate. As was also suggested for the offence/defence of compassionate killing we should not only think when something is a case of genuine compassion but also when someone’s actions are an appropriate expression of compassion. The closeness of relationship one has with the sufferer makes a difference in assessing their motives. Consequently, the provision against prosecution regarding compassion needs to be amended to take into consideration the victim’s and the suspect’s close relationship.

---

223 Chapter 3.6
6.6.1 Reformed DPP policy suggestions for assisted suicide

*Table 2: Proposed public interest factors for the DPP's Policy*

<table>
<thead>
<tr>
<th>Factors tending in favour of prosecution (numbered as per DPP’s Policy, para 43)</th>
<th>Factors tending against prosecution (numbered as per DPP’s Policy, para 45)</th>
</tr>
</thead>
</table>
| **The victim:**  
was under 18 years of age.  
did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide.  
had not reached a voluntary, clear, settled and informed decision to commit suicide.  
had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect.  
did not seek the encouragement or assistance of the suspect personally or on his or her own Initiative.  
was not under extreme suffering either physical or mental. | **The victim:**  
had reached a voluntary, clear, settled and informed decision to commit suicide.  
was under extreme suffering either physical or mental. |
<table>
<thead>
<tr>
<th>The suspect:</th>
<th>The suspect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim (On the question of whether a person stood to gain, the police and the reviewing prosecutor should adopt a common sense approach. It is possible that the suspect may gain some benefit - financial or otherwise - from the resultant suicide of the victim after his or her act of encouragement or assistance. The critical element is the motive behind the suspect's act. If it is shown that compassion was the only driving force behind his or her actions, the fact that the suspect may have gained some benefit will not usually be treated as a factor tending in favour of prosecution. However, each case must be considered on its own merits and on its own facts.)</td>
<td>was wholly motivated by compassion, prompted by a close relationship with the victim. had sought to dissuade the victim from taking the course of action which resulted in his or her suicide. Reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.</td>
</tr>
<tr>
<td>pressured the victim to commit suicide.</td>
<td>The actions of the suspect:</td>
</tr>
<tr>
<td>did not take reasonable steps to ensure that any other person had not</td>
<td>although sufficient to come within the definition of the offence, were of only minor encouragement or assistance.</td>
</tr>
<tr>
<td>Pressured the victim to commit suicide.</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Had a history of violence or abuse against the victim.</td>
<td></td>
</tr>
<tr>
<td>Was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present.</td>
<td></td>
</tr>
</tbody>
</table>
6.7 Conclusion

This chapter has proposed the creation of a compassionate killing offence/defence. As noted in earlier chapters of this thesis, compassionate motives ethically differentiate killings, and they should be taken into consideration to accommodate a more lenient approach in some cases. As was explained in chapter 4, there is validity in creating a defence of compassionate killing. It has been supported in this chapter that this should be a partial excusatory defence, as the actor’s blameworthiness is mitigated due to the circumstances which undercut their ability to avoid the killing. Since the compassionate killing is a wrong in which the actor has given in due to their compassionate emotions for the sufferer it does not deserve to be a full defence. A contributing factor to this is the actor’s medical inexperience which creates further undesirable dangers for the sufferer.

Nevertheless, after examining the fair labelling argument, it was argued that there are strong reasons why such cases should have a different label. Compassionate offenders are acting in good faith and are not disregarding social principles in the same way as other offenders in cases of murder and manslaughter. Since these cases are strongly differentiated, they should not be treated as another variety of manslaughter and a new label of compassionate killing is required. The offence/defence of infanticide was used to provide a model of how these arguments of having a partial excusatory defence and a different label can be achieved. Thus, it has been proposed that there should be a compassionate killing offence/defence. There will be a separate offence label, but if the prosecution decides that the action does not fall under the compassionate killing offence category, and choose to charge the actor with murder, the defendant will be able to plead the defence of compassionate killing. If this defence is successful it will reduce a murder verdict to one of compassionate killing.

When compassionate killing is charged as an offence, the burden of proving the actus reus and mens rea of compassionate killing is very straightforward as it will be on the prosecution. But when it is used as a defence the argument on the appropriate burden of proof becomes more complicated. After considering the different justifications for imposing a reverse burden of proof, it was noted that due to the significant proof
imbalances, placing a legal burden on the defendant is justified as there will be nothing external in many cases for the prosecution to find.

Then, this chapter discussed the different elements of this defence in ensuring compassionate motives. These relate to the actor and the sufferer having a close relationship, and to the sufferer’s medical condition. As was discussed, is important to find cases where there is a proper manifestation of compassion through our actions. This is mostly in close relationships of love and affection which ensure knowledge of suffering. Since this offence/defence is mainly focused on the actor’s motives, we need to differentiate it from being medically oriented. Thus, a medical diagnosis requirement is not appropriate. The actor should be under an actual belief in the loved one’s suffering that is also reasonable. The requirement which was previously proposed for the physician-assisted death defence of having a competent request to die is not included in the interpretation of compassion. Nonetheless, since there will be cases where there will be such requests by the sufferer, it was suggested that we could consider them as a mitigating factor in court. In contrast, earnest expressions of a wish to live will be aggravating factors.

However, if the substantive law reform of creating a compassionate killing offence/defence and the previously proposed physician-assisted death defence are not implemented, we will continue to deal with these issues through discretion. Thus, in the final part of this chapter it was discussed how the existing prosecutorial guidelines on assisted suicide cases can be reformed to achieve the objectives explained as important in these two reform proposals. For the first objective which needs to be achieved of ensuring a competent, voluntary and informed decision, it was argued that the guidelines as they currently stand give sufficient consideration to ensuring these. For the second objective of placing some consideration on the victim’s health condition, it was noted that although previous references to this were removed to avoid symbolic and practical ramifications, the guidelines need to be reformed to include this. Intense suffering, either physical or mental can frequently lead to the decision to die, or could cause the compassionate motives that will make someone assist in suicide. Thus, considerations about the victim’s intense suffering need to be included in the guidelines. Related to this, it was proposed that the factor against prosecution that the victim was unable to commit suicide on their own is better
removed from the guidelines. Regarding the third objective which must be achieved, of allowing medical practitioners to be actively involved in the process as they are the best ones to assist without causing further pain or failed suicide attempts, it was argued that it is important to reflect this in the guidelines. Finally, it is important to amend the guidelines relating to compassion to reflect the definition of compassion as described in this thesis. For this reason, the DPP’s guidelines need to take into consideration the closeness of the relationship between the victim and the suspect, as usually compassion is created in close bonds of identification and knowledge with loved ones’ suffering.
Chapter 8: Conclusion

This thesis challenged the current criminal law prohibition of euthanasia and assisted suicide in England and Wales as there are generally important moral questions regarding its defensibility. While life is a very important value and it is always at least a pro tanto wrong to kill another, assisted death should be allowed when it is in one’s best interests to die because of the experience of intense suffering. However, our best interests must be considered along with whether there are autonomous requests to die. A combination of autonomy and best interests has been widespread in informing foreign jurisdictions which have some form of assisted dying legislation. Thus, this thesis argues that assisted death should be allowed in some situations provided it is in our best interests to die because of the experience of intense suffering, and we have autonomously requested to die. These two factors have equal and interdependent weight.

A more lenient approach to assisted death can be achieved by applying a criminal law defence to such cases. The wrong of the assisted death will be acknowledged but a degree of exculpation will be offered in recognition of the particular circumstances. Nonetheless, after examining the available defences of diminished responsibility, necessity and consent it was concluded that they should not be accepted in this context. Diminished responsibility, before its reform in the 2009 Act was often used in euthanasia cases, but after its reform it became much more medicalised and strict. Thus, it is very hard to apply successfully to euthanasia cases as it currently stands. Even with a sympathetic judge and jury ready to accept this plea, there would be considerable problems of fair labelling, due to its medicalised and stigmatising nature.

For necessity, while it is a defence that is inapplicable to killings, there might be some validity in considering its exceptional application to euthanasia upon a redefinition of the importance typically attributed to life. Nonetheless, it would be hard for the courts to accept this defence for alleviating intense pain. But even if a necessity plea was accepted there are other important issues in considering such as that a request to die
cannot be guaranteed under its interpretation, making this available in cases of non-voluntary and involuntary euthanasia. Given that this is a full defence that provides full removal of criminal liability, it was questioned whether its application in this context is appropriate.

Lastly, while the defence of consent is not currently used for assisted deaths, there are good reasons in the public interest to exceptionally allow its application upon a redefinition of the importance typically attributed to life. However, because this is not a defence specifically designed to be used for assisted deaths, there are some important limitations and problems with its application. It has been argued that even with an incremental expansion of the existing consent defence, it is unlikely that this would be sufficient when applied in assisted death cases.

Generally, a substantive law reform is preferable in dealing with assisted death cases than through prosecutorial discretion. Therefore, since the available defences were rejected this thesis constructed two new reform proposals to achieve a more lenient approach to assisted death cases. These are the creation of a physician-assisted death defence and a compassionate killing offence/defence. Thus, generally the discussion on assisted deaths was divided between those performed by physicians and those compassionately motivated. Many foreign jurisdictions limit their legislation to some form of physician-assisted death, but often assisted deaths are performed by individuals who are motivated by compassion in seeing their loved ones suffer.

The physician-assisted death defence will be a justificatory full defence, as there are justifying circumstances making us content to have physician-assisted death performed, and there is no essential value in punishing assisted death under these special justifying circumstances. Potential safeguards to protect vulnerable individuals from abuse for this defence are the request to die and the requestor’s medical condition. For the assisted death requests, it was proposed that requests should be in writing and signed by an independent witness. We should also ensure that the decision is competent, well-informed and voluntary. Since assisted death is largely a medical decision, the most probable test of competence to use is the one under the Mental Capacity Act 2005, currently used in medical law. To address potential problems presented from this test it was proposed that there should be a prior psychiatric
assessment to everyone asking for assisted death. Also, the requestor should be referred to an independent consulting physician who is a specialist in their condition to discuss their medical situation. This will also better ensure that the decision is well-informed. To better ensure voluntariness, repeated death requests should be required over a fairly long period.

For the requestor’s medical condition, it was proposed that the commonly used requirement of terminal illness with a specific final month prognosis should not be used for the proposed defence, as the amount of time left is very hard to predict accurately. Also, it was noted that cases of mental suffering can be equally painful to the requestor as physical suffering. Thus, to use this proposed defence the requestors should be under intense suffering, either physical or mental, which will derive from a grievous medical condition. There should be a medical assessment by a physician of whether the requestor indeed has a serious condition. This should be taken into consideration alongside the requestor’s own opinion of whether their suffering is indeed intense and cannot be alleviated to levels acceptable to them to allow for a flourishing future. The requestor must experience alternative pain relief options before having access to assisted death. This will ensure that assisted death is an option of last resort and not an alternative to treatment. Finally, it was argued that this defence should impose the legal burden on the prosecution, mainly because there is nothing to indicate a significant proof imbalance between the parties.

For the compassionate killing offence/defence it was supported that since compassionately motivated actors are ethically differentiated from other offenders in the law of homicide, their motives should be taken into consideration to accommodate a more lenient approach in some cases. It was proposed that there is validity in applying a defence to such cases and this should be characterised as a partial excusatory defence since the actor’s blameworthiness is mitigated due to the circumstances which undercut their ability to avoid the killing. Compassionate killing is a wrong which the actor has committed due to their compassionate emotions for the sufferer, but it should not be a full defence. A contributing factor to this is the actor’s medical inexperience which creates further undesirable dangers for the sufferer. Nevertheless, there are strong reasons to indicate that such cases should have a different label. Compassionate offenders are acting in good faith and are not
disregarding social principles in the same way as other offenders in cases of murder and manslaughter. Since these cases are strongly differentiated, they should not be treated as another variety of manslaughter and a new label of compassionate killing is required.

The offence/defence of infanticide was used as a reference point, and it was suggested that there should be a compassionate killing offence/defence. This is a separate offence label, a sub-category of homicide, similar to manslaughter, but if the prosecution decides that the action does not fall under the compassionate killing offence category, and choose to charge the actor with murder, the defendant will be able to plead the defence of compassionate killing. If this defence is successful, it will reduce a murder verdict to one of compassionate killing. When this is charged as an offence, the burden of proving the \textit{actus reus} and \textit{mens rea} of compassionate killing is straightforward as it will be on the prosecution. But when is used as a defence, it was argued that the legal burden will be on the defendant as there are significant proof imbalances making it hard in many cases to impose this on the prosecution.

It is important to find cases where there is a proper manifestation of compassion through our actions. Thus, this offence/defence is limited to close relationships of love and affection which ensure knowledge to suffering. It was argued that since this is mainly focused on the actor’s motives, a medical diagnosis requirement, as in the physician-assisted death defence, is not appropriate. The actor should be under an actual belief in the loved one’s suffering that is also reasonable. Lastly, a requirement of having a competent request to die is not included in the interpretation of compassion. Rather, we could consider, such requests as a mitigating factor in court, while earnest expressions of a wish to live will be aggravating factors.

While substantive law reform as the proposal for a compassionate killing offence/defence, is preferable to dealing with assisted death cases through prosecutorial discretion, if the proposals for such law reform are not implemented, we will continue to deal with these issues through discretion. This is particularly relevant for assisted suicides as their prosecution is subject to the consent of the DPP, who has published guidelines in favour of and against prosecution of these cases. However, the existing guidelines should be reformed to achieve the objectives.
explained in the context of compassionate killing offence/defence and the physician-assisted death defence. The guidelines, as they currently are, ensure a competent, voluntary and informed decision. Among the factors considered problematic is that there is no reference to the victim’s health condition. Intense suffering, either physical or mental, can frequently lead to the decision to die or could lead to the compassionate motives that will make someone assist in suicide. Thus, considerations about the victim’s intense suffering need to be included in the guidelines. For this reason, the factor against prosecution that the victim was unable to commit suicide on their own should be removed from the guidelines. It was also considered important to allow medical practitioners to be actively involved in the process as they are the best ones to assist without causing further pain or failed suicide attempts. Thus, it was proposed that the guidelines should be reformed to reflect this. Furthermore, it was argued that references to compassion in the guidelines need to be changed to take into consideration the closeness of the relationship between the victim and the suspect, following the definition provided in this thesis. Specific reference to the proposed reforms can be found in Table 2 in chapter 6.
BIBLIOGRAPHY

Books


Beauchamp T and Childress J, *Principles of Biomedical Ethics* (Cary, Oxford University Press 2001)


Quill T, *Death and Dignity; Making Choices and Taking Charge* (New York, WW Norton, 1993)


Williams G, *The sanctity of life and the criminal law* (London, Faber and Faber, 1958)

**Material in Edited Volumes**


Fortson R, ‘The Modern Partial Defence of Diminished Responsibility’ in Alan Reed and Michael Bohlander (eds), Loss of Control and Diminished Responsibility: Domestic, Comparative and International Perspectives (Ashgate, Farnham, 2011)


Raus K and Sterckx S, ‘Euthanasia for Mental Suffering’ in Michael Cholbi and Jukka Varelius (eds), New Directions in the Ethics of Assisted Suicide and Euthanasia (Cham, Springer International Publishing, 2015)


Journal Articles


Berman M, ‘Provocation as Partial Justification and Partial Excuse’ (2011) 52(4) William and Mary law review 55


Biggs H, ‘From dispassionate law to compassionate outcomes in health-care law, or not’ (2017) 13(2) International Journal of Law in Context 172

Biggs H, ‘Legitimate Compassion or Compassionate Legitimation? Reflections on the Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide’ (2011) 19(1) Feminist Legal Studies 83

Bingham S, ‘Refusal of treatment and decision-making capacity’ (2011) 19(1) Nursing Ethics 167


Branthwaite M and Jeffrey D, ‘Should patients be able to choose physician-assisted suicide at the end of their lives?’ (2006) 7(7) Lancet Oncology 602


Carr B, ‘Pity and Compassion as Social Virtues’ (1999) 74(3) Philosophy 411


Feenan D, ‘Law and compassion’ (2017) 13(2) International journal of law in context 121

Ferguson P, ‘Causing Death or Allowing to Die? Developments in the Law’ (1997) 23(6) Journal of Medical Ethics 368


Fumagalli R, ‘Slipping on slippery slope arguments’ (2020) 34 (4) Public Health Ethics 412


Gillon R, ‘Ethics needs principles: four can encompass the rest and respect for autonomy should be ‘first among equals’ (2003) 29(5) Journal of Medical Ethics 307

Gillon R, ‘Medical ethics: four principles plus attention to scope’ (1994) 309(6948) British Medical Journal Publishing Group 184


Greasley K, ‘Sex, Reasons, Pro Tanto Wronging, and the Structure of Rape Liability’ (2020) 15(2) Criminal law and Philosophy 159


Hardwig J, ‘Is There a Duty to Die?’ (1997) 27(2) The Hastings Center 34


Kleinig J, ‘Consent as a Defence in Criminal Law’ (1979) 65(3) Archives for Philosophy of Law and Social Philosophy 329


Lewis P, ‘Informal legal change on assisted suicide: the policy for prosecutors’ (2011) 31(1) Legal Studies 119


Martyn S and Bourguignon H, ‘Now is the Moment to Reflect: Two Years of Experience with Oregon’s Physician-Assisted Suicide Law’ (2000) 8(1) The Elder Law Journal 1


Otlowski M, ‘Getting the law right on Physician Assisted Suicide’ (2011) 3(1) Amsterdam Law Forum 127


Pellegrino E, ‘Doctors Must Not Kill’ (1992) 3(2) The Journal of Clinical Ethics 95


Schauer F, ‘slippery Slopes’ (1985) 99(2) Harvard law review 361


van der Maas P et al, ‘Euthanasia and Other Medical Decisions Concerning the End of Life’ (1991) 338 (8768) Lancet 669


Williams G, ‘Defence of Necessity’ (1953) 6 Current Legal Problems, 216


Other Sources


Campaign for Dignity in Dying, ‘Assisted Dying’ (Dignity in Dying) https://www.dignityindying.org.uk/assisted-dying/

Campaign for Dignity in Dying, ‘Our Position’ (Dignity in Dying) https://www.dignityindying.org.uk/assisted-dying/our-position/


Conseil National de l’Ordre des Médecins, Avis relatif aux soins palliatifs, à l’euthanasie et à d’autres décisions médicales concernant la fin de vie [National
Council of the BOP, ‘Advice on palliative care, euthanasia and other medical end-of-life decisions’
https://www.ordomedic.be/fr/avis/conseil/avis-relatif-aux-soins-palliatifs-a-l%27euthanasie-et-a-d%27autres-decisions-medicales-concernant-la-fin-de-vie

CPS, ‘Defences - Duress and Necessity’ (CPS, 19 October 2018)

CPS, ‘Public Consultation Exercise on the Interim Policy for Prosecutors in respect of Cases of Assisted Suicide Issued by the Director of Public Prosecutions, Summary of Responses’ (February 2010)
www.cps.gov.uk/consultations/as_responses.html

CPS, ‘Rape and Sexual Offences - Chapter 3: Consent’
https://www.cps.gov.uk/legalguidance/rape-and-sexual-offences-chapter-3-consent

CPS, ‘Sentencing – Overview’
https://www.cps.gov.uk/legal-guidance/sentencing-overview

Dignitas, ‘Brochure ‘How DIGNITAS works’

Director of Public Prosecutions, ‘DPP Policy for prosecutors in respect of cases of encouraging or aiding assisted suicide’ (Crown Prosecution Service, February 2010)
http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html

Director of Public Prosecutions, ‘Latest Assisted Suicide Figures’ (Crown Prosecution Service, January 2018)
https://www.cps.gov.uk/publication/assisted-suicide

Dying with Dignity Canada, ‘Get The Facts: Bill C-14 And Assisted Dying Law In Canada’
https://www.dyingwithdignity.ca/get_the_facts_assisted_dying_law_in_canada

Fourteenth Report of the Criminal Law Revision Committee on Offences Against the Person, Cmnd 7844 (1980)


Government of Canada, ‘Medical assistance in dying’
https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

Government of Canada, ‘Regulations for the Monitoring of Medical Assistance in Dying: SOR/2018-166’
Government of the Netherlands, ‘Euthanasia, assisted suicide and non-resuscitation on request’ https://www.govemment.nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request


Holt G, ‘When suicide was illegal’ BBC News (3 August 2011) https://www.bbc.co.uk/news/magazine-14374296

House of Lords, Debate 30, vol 99, June 2009


Law Commission, Murder, Manslaughter and Infanticide (Law Com. No. 304, 2006)

Meredith C, ‘Pensioner becomes first British dementia sufferer to die at Dignitas suicide clinic’ Express (30 May 2013) https://www.express.co.uk/news/uk/403700/Pensioner-becomes-first-British-dementia-sufferer-to-die-at-Dignitas-suicide-clinic

Mr Eric Fletcher HC Deb 28 July 1961 vol 645

Murphy C, ‘The right to die for Jehovah’ BBC News (5 November) http://news.bbc.co.uk/1/hi/health/7078673.stm


Official Report HC, No 287 Col 1380 (27 March 2012)

OPHD, Oregon’s Death with Dignity Act: The Second Years’ Experience (Second Annual Report)

OPHD, Sixth Annual Report on Oregon’s Death with Dignity Act
Parliament, ‘National Health Service (Family Planning) Act 1967’


Pidd H, ‘I know Tom would not want to live. He had lost his life’ The Guardian (20 January 2010)

Politics, ‘Monarchy’
https://www.politics.co.uk/reference/monarchy/

Public Health Division, ‘Oregon Death with Dignity Act 2020 Data Summary’

Regional Euthanasia Review Committees, ‘Annual Report 2019’
https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports


Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL] Vol I (2004-05, HL86-1)

Select Committee Report 2004 House of Lords Vols I, II and III

Smith R, ‘Tragedy of couple in suicide pact as husband survived’ (Mirror, 20 August 2010)

Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001

The Law Commission, A new Homicide Act for England and Wales? (Law Com No 177, 2005)

https://www.bbc.co.uk/news/uk-england-leeds-57516431
https://plato.stanford.edu/entries/doing-allowing/#Conc