CHAPTER 2 [16 bold cap centre]

ASSISTED DYING [16 bold cap centre]

Carmen Draghici [16 bold centre]

For decades, sufferers of locked-in syndrome and terminally ill patients have attempted to persuade lawmakers that their fundamental rights are infringed by laws which criminalise the assistance given to mentally competent adults seeking a peaceful and dignified death. In this debate, the UK and Canada have positioned themselves at opposite ends of the spectrum. In the UK, human-rights challenges to the blanket prohibition on assisted suicide have been consistently unsuccessful (notably the *Nicklinson*[1] and *Conway*[2] cases), as have parliamentary reform initiatives.[3] Conversely, Canada's Supreme Court ruled a similar ban unconstitutional in its landmark *Carter* decision,[4] and the national legislature amended the Criminal Code to allow medical assistance in dying ("MAiD") in some circumstances.[5] This chapter examines the legal and ethical issues underlying these contrasting developments, and suggests – in common with the conclusion reached by other contributors to this volume – that Canada's response has been more rigorous in evaluating and reconciling competing claims.

I. The resilience of the British blanket ban on assisted dying [A heading: 14 bold]

In England and Wales, "encouraging and assisting" another to commit suicide is criminalised under s.2(1) Suicide Act ("SA") 1961[6] and punishable with up to fourteen years' imprisonment;[7] the statute contemplates no exceptions. Parliamentary debates leading to its adoption reveal mainly practical objections to the continued criminalisation of attempted suicide.[8] They indicate that, while decriminalisation was not intended to encourage or condone what was viewed as a mortal sin, it was thought that persons having attempted suicide did not benefit from prison treatment and that the law

[1] *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38.

[2] *R (Conway) v Secretary of State for Justice* [2018] EWCA Civ 1431.

[3] See sections I and VI.

[4] *Carter v Canada (Attorney General ["AG"])* [2015] 1 SCR 331.

[5] *An Act to amend the Criminal Code (medical assistance in dying)*, S.C. 2016, c. 3 (Bill C-14). See new ss. 241.1- 241.3 *Criminal Code*, R.S.C. 1985, c. C-46.

[6] As amended by s.59(2) Coroners and Justice Act 2009. See Wicks (2016) *The State and the body: Legal regulation of bodily autonomy* pp 71-85.

[7] Under Scottish law, the potential consequence is life imprisonment. See Stark (2014) 'Necessity and policy in R (Nicklinson and others) v Ministry of Justice' *Edinburgh LR* 104 at p107.

[8] See *HLD* 2 March 1961 c. 247-276; *HLD* 9 March 1961 c. 535-561; *HLD* 16 March 1961 c. 975-990; *HCD* 14 July 1961 c. 834-845; *HCD* 19 July 1961 c. 1408-1426; *HCD* 28 July 1961 c. 823-825.

ought to focus on society's responsibility to assist them. Concerns were expressed that, without recourse to penal machinery, the police would no longer have compulsory powers to look after such persons and mental health treatment might be refused. There was, conversely, no discussion about the possible exemption of assisters from criminal liability. Several legal challenges to s.2(1) were brought by individuals suffering from irreversible medical conditions and wishing to end their lives, but who either were physically unable to do so without assistance from a family member or healthcare professional or wanted to avoid a traumatic and premature self-inflicted death.

The *Pretty* litigation [B heading; 12 bold]

The first case was *Pretty v Director of Public Prosecutions ("DPP")*.[9] The complainant suffered from motor neuron disease, was paralysed from the neck down, tube-fed and nearly incapable of speaking, with a few-month life expectancy, and wished to be assisted to die before the painful and humiliating final stages of her illness. She challenged the DPP's refusal to issue an undertaking not to prosecute her husband if he helped her travel to Switzerland, where the Dignitas service lawfully provides MAiD.

The House of Lords found that her fundamental rights were not engaged by the DPP's decision. The right-to-life guarantee in Art 2 ECHR did not encompass a right to die.[10] Nor did the denial of proleptic immunity from prosecution constitute inhuman treatment contrary to Art 3 ECHR, insofar as Mrs Pretty's suffering stemmed from her disease, not the impugned decision.[11] The court also rejected the contention that personal autonomy, as protected under Art 8 ECHR, included a right to decide when or how one wished to die.[12] Even if Art 8 was engaged, the Law Lords reasoned, the interference was justified by the need to protect a broader class of vulnerable persons who would otherwise be induced to commit suicide.[13] The court equally dismissed the claim under Art 9 ECHR: freedom of conscience did not include the right to act upon a belief held, and, if the provision was engaged, the restriction aimed to protect vulnerable persons and was permissible.[14] Having found no substantive ECHR right engaged, the court further dismissed the claim that the applicant had suffered discrimination contrary to Art 14 on the ground of disability.[15]

When *Pretty* was examined by the ECtHR, the key distinction from the House of Lords' analysis was the unequivocal recognition that Art 8 applies to right-to-die claims. According to the Strasbourg court, the notion of "private life" covers "the physical and psychological integrity of a person" and "personal autonomy".[16] This extends to conduct threatening one's own life:

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[9] *R (Pretty) v DPP* [2001] UKHL 61. See Pedain (2003) 'The human rights dimension of the *Diane Pretty* case' *Cambridge LJ* 181.

[10] [2001] UKHL 61 at [59], [62], [87].

[11] Ibid at [92]-[97].

[12] Ibid at [61].

[13] Ibid at [26], [30], [99]-[102].

[14] Ibid at [63].

[15] Ibid at [105].

[16] *Pretty v UK* (2002) 35 EHRR 1 at [61]. Arts 3 and 9 claims were dismissed; ibid at [53]-[56], [82]-[83]. See Merkouris (2011) 'Assisted suicide in the jurisprudence of the European Court of Human Rights: A matter of life and death' p107 in Negri (ed) *Self-determination, dignity and end-of-life care. Regulating advance directives in international and comparative perspective*.

[10 normal] [62] [T]he ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned.

The court drew a parallel with patients' right to refuse life-prolonging medical treatment, grounded in the same principle of (potentially self-harming) autonomy.[17] Consequently, criminalising assisted suicide interfered with Art 8 rights and required justification. Despite this favourable premise, the ECtHR accepted that the measure was within the UK's margin of appreciation and proportionate to the aim pursued, ie the protection of the life of vulnerable persons unable to make informed decisions.[18] After *Pretty v UK*, unsuccessful attempts between 2003 and 2006 to pass an Assisted Dying for the Terminally Ill Bill left the law unchanged.[19]

The *Purdy* litigation [12 bold]

In *R (Purdy) v DPP*,[20] the House of Lords followed *Pretty v UK* and recognised the applicability of Art 8 to right-to-die cases. The claimant's position was similar to Mrs Pretty's: she suffered from primary progressive multiple sclerosis, an incurable disease causing gradual deterioration, and needed her husband's assistance to travel to Switzerland to end her life before her condition became intolerable.[21] Her legal claim was, however, different. It neither attacked s.2(1) SA 1961 nor challenged the unavailability of proleptic guarantee of non-prosecution for carers providing assistance. Rather, she questioned the insufficient clarity of s.4 of the Act as regards the DPP's exercise of discretion to allow prosecution, which made it impossible to reach an informed decision on whether to request assistance.[22]

The court cited Lord Hope's acknowledgement of self-determination rights in *Pretty*, endorsed by the ECtHR:[23] "The way she chooses to pass the closing moments of her life is part of the act of living, and she has a right to ask that this too must be respected."[24] According to the judgment, the Code for Crown Prosecutors did not ensure predictability as regards the consequences of aiding a person who is terminally-ill or severely and incurably disabled and wishes to travel to a country where assisted suicide is lawful, having decisional capacity and fully understanding the consequences;[25] therefore, it did not protect the right to exercise a genuinely autonomous choice.[26] The court concluded that the interference with private life was not "in accordance with the law" as required under Art 8(2) ECHR, as it did not satisfy the criteria of accessibility and foreseeability; the absence of a crime-specific

[17] (2002) 35 EHRR 1 at [63].

[18] Ibid at [74]-[78].

[19] See Keown (2012) *The law and ethics and medicine. Essays on the inviolability of human life* pp 235-274.

[20] *R (Purdy) v DPP* [2009] UKHL 45.

[21] Ibid at [17].

[22] Ibid at [30]-[31], [42].

[23] (2002) 35 EHRR 1 at [64].

[24] [2002] 1 AC 800 at [100].

[25] [2009] UKHL 45 at [54].

[26] Ibid at [65].

policy regulating the DPP's consent to prosecution did not allow the public to anticipate how prosecutorial discretion would be exercised in assisted suicide cases.[27]

The judgment led the DPP to adopt new policy guidance in 2010.[28] Whilst the document did not introduce exemptions from s.2 SA 1961, it established that prosecution "is less likely to be required" if:

[10 normal] [45] 1. the victim had reached a voluntary, clear, settled and informed decision to commit suicide; 2. the suspect was wholly motivated by compassion; 3. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance; 4. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide; 5. the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide; 6. the suspect 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.

The policy guidance further states that the list of public interest factors tending against prosecution is not exhaustive; each case must be considered on its own merits.[29]

The *Nicklinson* litigation [B heading; 12 bold]

In 2014, *Nicklinson* belied the prediction that, having grounded a right to die in personal autonomy, *Purdy* heralded the legalisation of assisted suicide.[30] The litigants (Mr Nicklinson, Mr Lamb and Martin) were afflicted by catastrophic disabilities as a result of a stroke or automobile accident, almost completely paralysed and unable to communicate, and described their lives as "miserable", "demeaning", "distressing", "intolerable", "undignified".[31] They had reached a settled decision to end their lives and wished to have a doctor or carer assist them in administering lethal drugs or travelling to Dignitas.

They required the Supreme Court to either interpret s.2 SA 1961 as permitting the assistance sought, so as to reconcile that provision with ECHR rights per s.3 Human Rights Act ("HRA"), or to issue a s.4 declaration of incompatibility. The DPP appealed the lower court's decision that the prosecutorial policy was still insufficiently detailed; Martin's cross-appeal claimed that the decision had not gone far enough.

The Supreme Court majority continued to uphold the blanket prohibition.[32] First, protecting the vulnerable was a legitimate aim under Art 8(2) ECHR:

[10 normal] [171] The main justification advanced for an absolute prohibition on assisting suicide … is the perceived risk to the lives of other, vulnerable individuals who might feel themselves a burden to their family, friends or society and might, if assisted suicide were permitted, be persuaded or convince themselves that they should undertake it, when they would not otherwise do so.

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[27] [2009] UKHL 45 at [40]-[41], [46]-[56].

[28] DPP (2010) *Suicide: policy for prosecutors in respect of cases of encouraging or assisting suicide* (updated 2014); https://www.cps.gov.UK/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide.

[29] Ibid at [47].

[30] See Cleary (2010) 'From "personal autonomy" to "death-on-demand": Will *Purdy v. DPP* legalize assisted suicide in the UK?' *Boston College International and Comparative LR* 289 at p304.

[31] [2015] AC 657 at [3], [8], [9].

[32] [2015] AC 657.

The interference with Art 8 was also found proportionate, insofar as no lesser measure, such as a permissive scheme accompanied by safeguards against error and abuse, could secure that aim. For Lord Neuberger: "it is impossible ... to say with confidence in advance that any such scheme could satisfactorily and appropriately be fashioned."[33]

Conversely, Lady Hale reasoned, dissenting, that a system identifying well-informed requests for assistance in dying was achievable;[34] the law therefore exceeded the minimum interference necessary:

[10 normal] [317] To the extent that the current universal prohibition prevents those who would qualify under such a procedure from securing the help they need, I consider that it is a disproportionate interference with their right to choose the time and manner of their deaths. … It fails to strike a fair balance between the rights of those who have freely chosen to commit suicide but are unable to do so without some assistance and the interests of the community as a whole.

The majority's analysis was further influenced by the role accorded to the legislature in weighing conflicting interests in controversial policy areas and the presence of an assisted dying bill before Parliament; irrespective of the proportionality of the ban, they viewed a s.4 declaration institutionally or constitutionally inappropriate.[35]

For the ECtHR, the Supreme Court's refusal to pronounce on the law's ECHR-compatibility did not breach applicants' Art 8 procedural rights, insofar as the substance of the claim had been heard, it was open to courts to find that sensitive matters were better left to Parliament, and the great weight attached by judges to Parliament's views: "does not mean that they failed to carry out any balancing exercise".[36]

A reform proposal was introduced in June 2016 in the Lords but made no progress. The scheme of the Assisted Dying Bill 2016-2017 was predicated on High Court authorisation of assistance for terminally-ill adults, "reasonably expected to die within six months", who have decisional capacity and express a "voluntary, clear, settled and informed wish" to die, in a declaration countersigned by two medical practitioners verifying those circumstances and that the person has been informed of palliative care options.[37]

The matter soon returned before the courts; post-*Nicklinson* case-law contradicted the expectation that the intervening *Carter* judgment in Canada would prove influential in other common law jurisdictions.[38]

The *Conway* litigation [B heading; 12 bold]

The 2017 challenge to s.2(1) SA in *Conway* differed from *Nicklinson* in four respects: it regarded terminally-ill patients with a six-month prognosis rather than individuals facing acute suffering indefinitely; the applicant was still physically capable of the final act required to end his life; a legislative scheme was offered as an alternative to the blanket ban; and no bill was before Parliament on the matter.[39]

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[33] Ibid at [186], [188].

[34] Ibid at [314].

[35] See section VI.

[36] See *Nicklinson v UK* (2015) 61 EHHR SE7 at [84]-[85].

[37] HL Bill 42 Arts 1-3. See also the End of Life Assistance (Scotland) Bill 2010, discussed in Mason (2010) 'Assistance in dying or euthanasia? Comments on the End of Life Assistance (Scotland) Bill 2010' *Edinburgh LR* 493.

[38] See Attaran (2015) 'Unanimity on death and dignity – legalising physician-assisted dying in Canada' *New England Journal of Medicine* 2080 at p2082.

[39] *R (Conway) v Secretary of State for Justice* [2017] EWHC 2447 (Admin).

The High Court rejected the claim, citing precedent, Parliament's repeated reaffirmations of its position, and 'slippery slope' concerns.[40] The Court of Appeal agreed that Parliament was better placed to assess highly contested policy issues and conflicted evidence and that it had shown readiness to consider reform.[41] The appellate judgment also supported the finding that Mr Conway's scheme did not adequately protect the vulnerable, failed to give proper weight to the sanctity of life, and could undermine trust between doctor and patient.[42]

In 2018, the Supreme Court dismissed Mr Conway's application for permission to appeal, adducing that his claim had insufficient prospects of success.[43] It did not engage in any substantive analysis, merely noting that judges' opinions differed as to whether the absolute ban is a justified interference with Convention rights, and, if so, whether it is appropriate to make a declaration to that effect. Considering the four-year timespan lapsed since, in *Nicklinson*, the court had expressed confidence in Parliament's reconsideration of the law, and the different factual and legal matrix in *Conway*, it may have been in the public interest to allow the debate to continue, informed by the insights of the highest judicial authority.

The latest challenges: *T* and *Newby* [B heading; 12 bold]

R (T) v Secretary of State for Justice[44] and *Newby*[45] further tested the resilience of the British ban. Unlike Mr Conway, Mr T suffered from multiple system atrophy and his death was not foreseeable in the immediate future; he wished to be able to die safely, painlessly and with dignity. In deciding on a preliminary issue regarding evidence, the High Court indicated that it was bound by the intervening *Conway* decision in the Court of Appeal and that Mr T's position was not sufficiently different.[46] Permission to lodge a "leapfrog" appeal to the Supreme Court was denied as premature.[47] As the post-script to the judgment notes, after its circulation to the parties the claimant travelled to Switzerland with assistance to end his life.

In 2019, the *Newby* case cemented the judiciary's reluctance to take a stand on assisted dying. Citing *Conway* and *Nicklinson*, the High Court held that: "the courts lack legitimacy and expertise on moral (as opposed to legal) questions".[48] Not only was Parliament seen as the appropriate forum for controversial ethical questions,[49] but the ruling marked a further retreat on the issue of justiciability:

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[40] Ibid at [115], [127].

[41] [2018] EWCA Civ 1431 at [186]-[189], [200], [205]-[206].

[42] Ibid at [204].

[43] *R (Conway) v Secretary of State for Justice* [2018] UNSC B1 at [7]-[8].

[44] *R (T) v Secretary of State for Justice* [2018] EWHC 2615 (Admin).

[45] *R (Newby) v Secretary of State for Justice* [2019] EWHC 3118 (Admin).

[46] [2018] EWHC 2615 (Admin) at [22].

[47] Ibid at [25]-[26].

[48] [2019] EWHC 3118 (Admin) at [40].

[49] Ibid at [38], [43], [50].

[10 normal] [42] [T]here are some questions which, plainly and simply, cannot be 'resolved' by a court as no objective, single, correct answer can be said to exist. … The private views of judges on such moral and political questions are irrelevant, and spring from no identifiable legal principle.

The *Newby* case included a novel submission: the law prompted the applicant to take his life prematurely before reaching the stage where unassisted suicide became impossible. For the High Court, the considerations on which Art 8 claims failed under *Conway* also applied to Art 2.[50]

Although *Nicklinson* appeared to be "a final warning for Parliament to act",[51] the focus on procedural objections to adjudicating assisted-dying claims in subsequent case-law suggests that a reappraisal of the matter by the judiciary is unlikely in the near future. The open-ended approach in *Nicklinson* was replaced by the view that assisted-dying policy is not governed by legal principles and it would be inappropriate for courts to decide instead of Parliament.

II. The Canadian assisted dying reform: striking a fair(er) balance?

[A heading; 14 bold]

Before June 2016, Canada's approach to assisted dying mirrored the UK's SA 1961. Whilst suicide was decriminalised in 1972,[52] assisters incurred criminal liability as a result of the combined operation of two Criminal Code provisions: s.241(b) made it an offence to aid or abet a person in committing suicide and s.14 established that no person could consent to death being inflicted on them. Legislative reform was triggered, however, by legal challenges under the Canadian Charter of Fundamental Rights ("the Charter").

The *Rodriguez* litigation [B heading; 12 bold]

A first constitutional challenge was brought in 1993 in *Rodriguez v British Colombia*,[53] and the Canadian Supreme Court upheld the absolute ban on assisted dying for reasons similar to those underpinning UK rulings. The appellant, afflicted by amyotrophic lateral sclerosis with a prognosis of 2-14 months, expected to rapidly lose her ability to swallow, speak and move unassisted, and thereafter become unable to breathe or eat without medical equipment. She wished that, when she could no longer enjoy life, a physician be permitted to provide the technical means enabling her to die when she chose. She unsuccessfully sought a declaration that s.241(b) of the Criminal Code breached her Charter rights under s.7 (life, liberty and security of the person), s.12 (protection against cruel treatment) and s.15(1) (non-discrimination).[54]

Unlike the first British assisted-dying ruling, *Rodriguez* recognised the ban's interference with fundamental rights; personal security in s.7 was found to encompass: "personal autonomy, at least ... the right to make choices concerning one's own body, control over one's physical and psychological

[50] Ibid at [49].

[51] Davis and Finlay (2015) 'Would judicial consent for assisted dying protect vulnerable people?' *British Medical Journal* (vol.351).

[52] The provision criminalising attempted suicide (s.238 *Criminal Code* 1892, S.C. 1892, c.29) was repealed by the *Criminal Law Amendment Act* 1972, S.C. 1972, c.13.

[53] *Rodriguez v British Columbia (AG)* [1993] 3 SCR 519. See Freedman (1994) 'The Rodriguez case: sticky questions and slippery answers' *McGill LJ* 644.

[54] [1993] 3 SCR 519 at pp 530-531.

integrity, and basic human dignity".[55] The court conceded that, by depriving the appellant of autonomy over her person, s.241(b) caused her physical pain and psychological stress which impinged on the security of her person.[56] Nonetheless, in a markedly split decision, the court found that the interference was not contrary to the principles of fundamental justice, which require a fair balance between State and individual interests. The prohibition aimed to protect vulnerable persons who might be induced to commit suicide and reflected the State's policy in upholding the value of human life, grounded in society's fundamental belief in the sanctity of life.[57] Additionally, a similar prohibition was the norm in most Western democracies.[58] As regards the alleged s.12 violation, "treatment" required more active State process, rather than a mere prohibition on certain conduct.[59] Finally, the court deemed it preferable not to pronounce on the scope of s.15, but to assume that it was infringed, as any infringement was justified under s.1: the prohibition was rationally connected to the objective of protecting, and maintaining respect for, human life, and no half-way measure could achieve it; there was no assurance that an exception could limit assisted death to patients who genuinely desired it.[60] The majority also accepted that, in this contentious morals-laden area, Parliament had to be afforded flexibility; as long as the government had reasonable grounds to believe that the blanket ban was minimally impairing, it was not the courts' role to speculate whether an alternative was preferable.[61]

For the dissenters, however, the legislative scheme infringed s.7 by placing an arbitrary limit on the autonomy of individuals physically unable to end their lives;[62] nor was that infringement justified under s.1, as the objective of eliminating abuse was already addressed by criminal law and could be supplemented by the condition of court authorisation.[63] Moreover, s.241(b) discriminated against those physically disabled, limiting their capacity to make fundamental decisions about their lives based on an irrelevant personal characteristic; slippery slope concerns could not justify the over-reach of the ban, which went beyond the vulnerable and caught situations of free consent.[64]

The *Carter* litigation [B heading; 12 bold]

MAiD became legal in Canada following the momentous *Carter v Canada* ruling in 2015, which reversed the *Rodriguez* position and held that s.241(b) deprived competent adults who suffered intolerably due to a grievous and irremediable medical condition of their constitutional rights under s.7 of the Charter.[65] The right to life was found to be engaged whenever: "the law or state action

[55] Ibid at p588 (*per* Sopinka J).

[56] Ibid at p589.

[57] Ibid at p595.

[58] Ibid at p605.

[59] Ibid at pp 611-612.

[60] Ibid at pp 612-614.

[61] Ibid at pp 614-615.

[62] Ibid at pp 620-621 (*per* McLachlin J).

[63] Ibid at p617.

[64] Ibid at pp 549-569 (*per* Lamer CJ).

[65] [2015] 1 SCR 331.

imposes death or an increased risk of death on a person, either directly or indirectly".[66] The Supreme Court accepted that the blanket ban on MAiD amounted to indirect deprivation of life, insofar as: "it ha[d] the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable".[67] The rights to liberty and security of the person were also affected, as the prohibition raised concerns about autonomy and quality of life.[68] An individual's response to a grievous and irremediable medical condition was critical to their dignity and autonomy; the impugned prohibition denied them the right to make decisions concerning their bodily integrity and medical care, trenching on their liberty.[69] Moreover: "by leaving them to endure intolerable suffering, it impinge[d] on their security of the person";[70] this finding echoes the unsuccessful submission in *Pretty* that the assisted-dying ban amounted to inhuman and degrading treatment.

The court concluded that the prohibition infringed Charter rights in a manner inconsistent with the principles of fundamental justice. The ban achieved its objective, namely: "to protect vulnerable persons from being induced to commit suicide at a time of weakness",[71] and thus it did not deprive individuals arbitrarily of their rights.[72] However, it caught people outside the class of intended protected persons and therefore was overbroad; the limitation placed on those individuals' rights was not connected to the objective.[73] Given this conclusion, the court found it unnecessary to decide whether the prohibition also violated the principle against gross disproportionality.[74] Having ascertained a breach of s.7, the court also found it unnecessary to consider whether the prohibition deprived physically disabled persons of their right to equal treatment under s.15.[75]

The court further determined that the ban not was saved by s.1 of the Charter. Although it was prescribed by law, which had a: "pressing and substantial objective",[76] the limiting measure was not proportionate to the objective:

[10 normal] [109] The trial judge made no palpable and overriding error in concluding, on the basis of evidence from scientists, medical practitioners, and others who are familiar with end-of-life decision-making in Canada and abroad, that a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error.

The Supreme Court endorsed the trial judge's finding that: "vulnerability can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent

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[66] Ibid at [62].

[67] Ibid at [57].

[68] Ibid at [62].

[69] Ibid at [64], [66], [68].

[70] Ibid at [66].

[71] Ibid at [75]-[78].

[72] Ibid at [84].

[73] Ibid at [85]-[88].

[74] Ibid at [89]-[90].

[75] Ibid at [93].

[76] Ibid at [96].

and decisional capacity in the context of medical decision-making more generally".[77] Consequently, the absolute prohibition was not minimally impairing.[78] Having reached that conclusion, the court found it unnecessary to weigh the impact of the restriction on Charter rights against its beneficial effects for the greater public good.[79]

Without purporting to legislate, the Supreme Court provided several parameters for reform in wording the remedy afforded to the applicants:

[10 normal] [127] The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for *a competent adult person* who (1) *clearly consents to the termination of life*; and (2) has a *grievous and irremediable medical condition* (including an illness, disease or disability) that *causes enduring suffering that is intolerable to the individual* in the circumstances of his or her condition.[80] "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.

The court recognised the systemic nature of the offending law by issuing a declaration of invalidity, suspended for 12 months,[81] rather than a free-standing constitutional exemption.

In January 2016, the federal government obtained a four-month extension of the suspension of invalidity to compensate for the interruption of legislative work between August and December 2015 caused by federal elections.[82] In *Carter v Canada (No.2)*, the Supreme Court, while acknowledging the delay, made the order reluctantly:

[10 normal] [2] To suspend a declaration of the constitutional invalidity of a law is an extraordinary step, since its effect is to maintain an unconstitutional law in breach of the constitutional rights of members of Canadian society. To extend such a suspension is even more problematic. The appellants point to the severe harm caused to individuals by an extension.

The decision further granted Quebec's request to be exempted from the suspension, having already adopted an Act Respecting End-of-Life Care under its concurrent health jurisdiction. The court saw no need: "to unfairly prolong the suffering of those who meet the clear [*Carter*] criteria", and Quebec's exemption: "[rose] concerns of fairness and equality across the country"; consequently, it permitted those who wished to seek MAiD during the extension period to apply to the superior court of their jurisdiction for relief.[83]

Parliament's response [B heading; 12 bold]

The suspension gave Parliament an opportunity to amend the law to cure the incompatibility. The new s.241.2(1) of the Criminal Code allows MAiD if several conditions are cumulatively met: the patient is an adult entitled to health care services in Canada, s/he has a grievous and irremediable medical condition, made a voluntary request without external pressure, and gave informed consent to receiving MAiD after being advised of options to relieve suffering, including palliative care. The "grievous and irremediable medical condition" criterion is satisfied if the four factors in s.241.2(2)

[77] Ibid at [116]-[117].

[78] Ibid at [121].

[79] Ibid at [122].

[80] Emphasis added.

[81] Ibid at [126]-[128].

[82] *Carter v Canada (AG) (No.2)* [2016] 1 SCR 13.

[83] Ibid at [6].

are present: (a) the patient has a serious and incurable illness, disease or disability; (b) s/he is in an advanced state of irreversible decline in capability; (c) that illness, disease, disability or state of decline causes enduring physical or psychological suffering that is intolerable to the patient and cannot be relieved under conditions the patient considers acceptable; and (d) the patient's natural death has become reasonably foreseeable, taking into account all his/her medical circumstances, without a specific prognosis on how long s/he has left to live. Legal safeguards include two witnesses attesting to the patient's written request, two medical opinions, a ten-day waiting period, and reiteration of consent immediately prior to receiving assistance.

By limiting eligibility to patients whose death is already foreseeable, Bill C-14 narrowed the categories granted access to MAiD when compared to *Carter*. A person such as the *Re H.S.* claimant, who refused to live her life sedated and semi-conscious to escape pain,[84] qualified under the *Carter* criteria, but may be ineligible under s.241.2(2). Stewart aptly queried the constitutionality of s.241.2(2): by condemning persons who meet all criteria except "foreseeable death" to suffer indefinitely, the restriction is out of sync with the object of the law (allowing individuals to end permanent suffering) and hence grossly disproportionate.[85] Interestingly, two lower-court rulings finding that "grievous and irremediable" in *Carter* did not mean "terminal"[86] intervened as Bill C-14 was progressing through Parliament, casting doubt on its constitutionality before it became law.[87] Nonetheless, Rahimi predicted that challenges to Bill C-14 would fail, relying on the finding in *R v O'Connor*[88] and *R v Mills*[89] that Parliament can alter common-law standards established in declarations of invalidity as long as its approach remains constitutional; Bill C-14's reconciliation of s.7 rights with the protection of the vulnerable, albeit not identical to that in *Carter*, could be seen as a permissible balancing act.[90]

Unsurprisingly, constitutional challenges to the new MAiD regulation, in particular *Lamb* and *Truchon*, have already targeted s.241.2(2)(d).[91] In *Lamb*, expert evidence before the British Colombia Court showed the expansive interpretation given by doctors to the "reasonably foreseeable" requirement, encompassing cases of refusal of life-prolonging care, and the applicant, who seemingly qualified, requested that the case be adjourned.[92] However, in *Truchon*, the Quebec Superior Court

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[84] See *Re H.S.* [2016] ABQB 121 at [116]: "It is not acceptable to me to live sedated to the point of unconsciousness until I choke on my own bodily fluids."

[85] See Stewart (2018) 'Constitutional aspects of Canada's new medically-assisted dying law' in Ross (ed), *Assisted death: legal, social and ethical issues after* Carter 435 at pp 453-455.

[86] *Canada (AG) v E.F.* [2016] ABCA 155 (Court of Appeal of Alberta) and *I.J. v Canada (AG)* [2016] ONSC 3380 (Ontario Superior Court of Justice).

[87] See Nicolaides and Hennigar (2018) '*Carter* Conflicts: The Supreme Court of Canada's impact on medical assistance in dying policy' p320 in Macfarlane (ed) *Policy change, courts and the Canadian Constitution.*

[88] [1995] 4 SCT 411.

[89] [1999] 3 SCR 668.

[90] Rahimi (2017) 'Assisted death in Canada: An exploration of the constitutionality of Bill C-14' *Saskatchewan LR* 457 at p480. Justifying the cautious federal response to *Carter*, see Lemmens et al (2017) 'Why Canada's medical assistance in dying legislation should be C(h)arter compliant and what it may help to avoid' *McGill JL & Health* S61.

[91] *Lamb v Canada (AG)* 2017 BCSC 1802; *Truchon c. Procureur général du Canada* 2019 QCCS 3792. See McMorrow (2018) 'MAID in Canada? Debating the constitutionality of Canada's new medical assistance in dying law' *Queen's LJ* 69 at pp 81-87.

[92] See https://bccla.org/news/2019/09/release-b-c-supreme-court-adjourns-b-c-civil-liberties-associations-assisted-dying-case/; Downie (2019) 'Two major legal developments in the space of a week on Canada's medical assistance in

ruled s.241.2(2)(d) invalid.[93] It suspended the invalidity for six months to allow provincial and federal legislators to amend the law, while affording the applicants constitutional exemptions. The Supreme Court will not have an opportunity to express its views, as the federal and Quebec governments decided not to appeal,[94] a choice criticised as allowing one judge excessive power to undo what Parliament deemed best for society.[95] The Quebec Superior Court agreed to extend the deadline to July 11, 2020.[96] A further five-month extension of the suspension was requested by the federal government in June 2020, due to the Covid-19 pandemic's disruption of parliamentary proceedings.[97] An amendment of federal legislation, as opposed to the inapplicability of s.241.2(2)(d) in Quebec, would achieve legal certainty and a uniform MAiD regime in all provinces. The repeal of s.241.2(2)(d) would bring Canada's law closer to more liberal MAiD statutes, such as the Belgian and Dutch ones,[98] which include those suffering intolerably from long-term, but not fatal, conditions; that category might arguably benefit the most from choosing the time of their death. O'Reilly and Hogeboom highlight further controversial restrictions in Canadian law when compared to other jurisdictions: the absence of provision for advance directives for individuals likely to lose their ability to consent in the near future,[99] the ineligibility of mature minors[100] and persons complaining of acute mental rather than physical suffering.[101] von Tigerstrom argued that the failure to provide for advance consent to MAiD (by contrast with the option of advance directives to withdraw/ withhold life-saving treatment) might be overbroad, since it condemns some individuals to intolerable suffering without justification, and might violate the right to life, as individuals who risk losing competence or capacity to communicate are pressurised into premature suicide.[102] Intrinsically inconsistent end-of-life

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dying laws could help more Canadians end their suffering' *Policy Options*, https://policyoptions.irpp.org/magazines/september-2019/a-watershed-month-for-medical-assistance-in-dying/.

[93] 2019 QCCS 3792 at [741].

[94] See https://www.ahbl.ca/truchon-v-procureur-general-du-canada-superior-court-of-quebec-finds-limiting-access-to-medical-assistance-in-dying-maid-to-end-of-life-unconstitutional/?utm_source=Mondaq&utm_medium=syndication&utm_campaign=LinkedIn-integration.

[95] See Lemmens and Jacobs, 'The latest medical assistance in dying decision needs to be appealed: Here's why', *The Conversation* (October 24, 2019), https://theconversation.com/the-latest-medical-assistance-in-dying-decision-needs-to-be-appealed-heres-why-124955.

[96] See https://globalnews.ca/news/6618538/quebec-ottawa-four-months-assisted-dying-law/.

[97] See https://www.cbc.ca/news/politics/maid-assisted-dying-lametti-1.5607681.

[98] See Luzon (2019) 'The practice of euthanasia and assisted suicide meets the concept of legalization' *Criminal Law and Philosophy* 329 at pp 329-331; Jackson (2012) 'In favour of the legalisation of assisted dying' pp 62-66 in Jackson and Keown (eds) *Debating euthanasia* 1 at pp 62-66; Mishara and Weisstub (2013) 'Premises and evidence in the rhetoric of assisted suicide and euthanasia' *International JL & Psychiatry* 427; Hillyard and Dombrink (2001) *Dying right: The death with dignity movement* pp 211-234; Cormack (2000) 'Euthanasia and assisted suicide in the post-Rodriguez era: Lessons from foreign jurisdictions' *Osgoode Hall LJ* 591.

[99] On advance directives, see du Bois-Pedain (2007) 'Is there a human right to die' pp 78-81 in Brooks-Gordon et al. (eds) *Death rites and rights*. The main objection is that incompetent patients having made decisions based on value judgments might enjoy unanticipated experiences (ibid at p80).

[100] See MacIntosh (2016) 'Carter, medical aid in dying, and mature minors' *McGill JL & Health* S1, arguing that the exclusion of mature minors from the MAiD regime violates the Charter.

[101] O'Reilly and Hogeboom (2017) 'The framing and implementation of law: Assisted death in Canada' *Journal of Parliamentary and Political Law* 699 at pp 711-714.

[102] von Tigerstrom (2015) 'Consenting to physician-assisted death: Issues arising from Carter v. Canada (Attorney General)' *Saskatchewan LR* 233.

legislation (permitting advance directives in respect of life-support withdrawal, but not MAiD) may affect fundamental rights disproportionately.[103] Some of these objections emerged before the enactment of Bill C-14, in the course of proceedings under *Carter (No.2)*, putting parliamentarians on notice.

Applying the *Carter* criteria to requests for individual constitutional exemption [B heading; 12 bold]

During the period of extension of the suspension of invalidity following *Carter (No.2)*, Canadian courts have addressed questions of capacity to consent, vulnerability and indirect coercion in several cases.

In *H.S. v Canada*, the Alberta Court of Queen's Bench extracted five criteria from para.127 of *Carter*, also endorsed by the Superior Court of Ontario's 2016 decision in *A.B. v Canada*: (1) the person seeking authorisation is a competent adult, (2) s/he has a grievous and irremediable medical condition, (3) the condition is causing intolerable suffering, (4) the suffering cannot be alleviated by any treatment s/he finds acceptable and (5) s/he clearly consents to the termination of life.[104] The Superior Court of Ontario further defined "grievous medical condition" as a condition that greatly interferes with that person's quality of life.[105] Importantly, in *E.F.*, the Alberta Court of Appeal clarified that the constitutional exemption granted in *Carter (No.2)* does not require the person's medical condition to be terminal.[106]

The *O.P. v Canada* ruling rejected the argument that, after the expiration of the suspension of invalidity, physician-assisted dying had become permissible without court order even if Parliament had failed to legislate; the rule of law and the protection of the vulnerable required judicial oversight until a legislative response was available.[107]

Applying the amended Criminal Code [B heading; 12 bold]

Remarkably, the new law does not require judicial intervention. As noted by the Superior Court of Ontario in its 2017 *A.B.* decision:[108]

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[103] See mutatis mutandis *Costa and Pavan v Italy* (54270/10, 28 August 2012); legislation prohibiting embryo pre-implantation diagnosis for sufferers of cystic fibrosis, whilst permitting abortion if the foetus had that condition, violated Art 8 ECHR.

[104] *Re H.S.* [2016] ABQB 121 at [94]; *A.B. v Canada (AG)* [2016] ONSC 1912 at [22]. See further [2016] ONSC 1912 at [23]-[28], discussing these criteria.

[105] [2016] ONSC 1912 at [25]. See also *I.J. v Canada (AG)* [2016] ONSC 3380.

[106] *Canada (AG) v E.F.* [2016] ABCA 155. Before Bill C-14 was adopted, consensus that terminal illness should not be an access criterion was evidenced by reports of the Provincial-Territorial Expert Advisory Group on Physician Assisted Dying (http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf) and Special Joint Committee on Physician-Assisted Dying, a federal parliamentary body (https://www.documentdoud.org/documents/2721231-Report-of-the-Special-Joint-Committee). See Schuklenk (2016) 'Canada on course to introduce permissive assisted dying regime' *Journal of Medical Ethics* 490 at p491.

[107] *O.P. v Canada (AG)* [2016] ONSC 3956.

[108] *A.B. v Canada (AG)* 2017 ONSC 3759. In the UK, the Supreme Court has shifted the decision-making process regarding the withdrawal of clinically assisted nutrition and hydration from patients in a persistent vegetative state from courts to medical professionals; see *NHS Trust v Y and Another* [2018] UKSC 46.

[10 normal] [62] Bill C-14's legislative history (and its language) demonstrates Parliament's intention that the physicians and nurse practitioners who have been asked to provide medical assistance in dying are exclusively responsible for deciding whether the *Code's* criteria are satisfied without any pre-authorization from the courts.

This solution followed the 2015 report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying.[109] Criticising its recommendations, Chan and Sommerville noted that judicial authorisation of MAiD was seen as an essential safeguard by Lord Neuberger in *Nicklinson* and McLachlin J in her dissent in *Rodriguez*, as well as by the *Carter (No.2)* interim regime of individual exemptions, and failing to generalise it in the permanent regulatory regime was unjustified.[110]

The *A.B.* ruling also clarified the meaning of "reasonably foreseeable death" in s.241.2(2)(d), noting that an elderly person: "in an advanced state of incurable, irreversible, worsening illness with excruciating pain and no quality of life" was eligible for assistance.[111] It also emphasised that the natural death referred to in the Criminal Code: "need not be connected to a particular terminal disease or condition and rather is connected to all of a particular person's medical circumstances".[112] In addition, it explained the role of the courts under the amended legislation: whilst they may neither decide for the doctors if a patient qualifies nor pre-determine criminal liability and interfere with prosecutorial discretion, they can nevertheless interpret civil law;[113] this interpretative role was particularly important given the novelty of, and public interest in, the assisted-dying regime and the gravity of the issues at stake.[114]

III. Principled concerns: inviolability-of-life vs self-determination

[A heading; 14 bold]

The starting point of judicial deliberations over legalising MAiD was, in both jurisdictions, whether the law should be subordinated to grand moral principles like sanctity of life or embrace moral neutrality, whilst protecting the vulnerable. Admittedly, the abrogation of the crime of suicide did not establish the law's preference for self-determination over sanctity of life. Finnis argued that, although some British judges saw decriminalisation of suicide as a shift towards autonomy, its objective, found in s.2(1)'s legislative history, lay elsewhere: the offence was not an effective deterrent, it cast unwarranted stigma on the deceased's family, and led to the prosecution of patients recovering from suicide attempts.[115] Sopinka J, delivering the majority judgment in *Rodriguez*, similarly viewed decriminalisation of suicide in Canada as recognising the non-legal roots and solutions of suicide, rather than as evidence of consensus on the prevalence of autonomy.[116] However, medical law in both

[109] Cit fn 106.

[110] Chan and Sommerville (2016) 'Converting the "right to life" to the "right to physician-assisted suicide and euthanasia": An analysis of Carter v Canada (Attorney-General), Supreme Court of Canada' *Medical LR* 143 at pp 172-173, citing [2014] UKSC 38 at [108] and [1993] 3 SCR 519 at p627.

[111] [2017] ONSC 3759 at [87].

[112] Ibid at [81].

[113] Ibid at [63]-[67].

[114] Ibid at [73].

[115] See Finnis (2015) 'A British "Convention right" to Assistance in Suicide?' *LQR* 1 at p5; *Pretty* [2001] UKHL 61 at [35].

[116] [1993] 3 SCR 519 at pp 597-598.

countries unquestionably indicates that society cannot impose the sanctity-of-life belief on individuals over their autonomy rights.

Autonomy and compassion in medical law: refusal of life support, children's medical treatment and involuntary euthanasia for incompetent adults [B heading; 12 bold]

English common law recognises, as vividly captured by Lord Goff in *Bland*, that: "the principle of the sanctity of human life must yield to the principle of self-determination".[117] Competent patients have an absolute right to refuse life-saving treatment. They can do so for irrational reasons or no reasons at all.[118] Continuing to provide life-sustaining treatment to patients against their wishes is also unlawful.[119] Additionally, incompetent patients are entitled to the respect of advance refusal of treatment expressed while they were competent.[120] Through the Mental Capacity Act 2005, Parliament: "has afforded a framework wherein persons in situations far less dire than those of Mr Lamb and Mr Nicklinson can choose to end their lives".[121] Attempts to justify s.2(1) SA by reference to the absolute inviolability of life would be incongruous.

Canadian case-law has also established that patients have a right to refuse life-saving treatment.[122] Courts: "have rejected a vitalist or 'life-at-any-cost' philosophy, and have accepted the legal option of mentally competent free individuals to risk preventable death rather than be compelled to live under conditions they find objectionable".[123] Medical law requires physicians to respect patients' decision to request removal of life support (eg feeding tube, respirator or dialysis) even where they do not deem it in the patients' best interests.[124] As summarised in *Rodriguez*:

[10 normal] To impose medical treatment on one who refuses it constitutes battery and our common law has recognized the right to demand that medical treatment which would extend life be withheld or withdrawn.[125]

Using inviolability-of-life arguments to reject assisted-dying claims is also inconsistent with the law's approach to withdrawal of life support from children with extreme medical conditions. In *Charlie Gard*[126] and *Alfie Evans*,[127] authorising hospitals to discontinue treatment against the parents'

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[117] *Airedale NHS Trust v Bland* [1993] AC 789 at p864.

[118] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

[119] *Re B (Adult: Refusal of Treatment)* [2002] EWHC 429 (Fam).

[120] See Michalowski (2005) 'Advance refusals of life-sustaining medical treatment: The relativity of an absolute right' *Modern LR* 958.

[121] Coggon (2017) 'Judgment 2 – *R (on the Application of Nicklinson and Another) v Ministry of Justice* [2014] UKSC 38' p213 in Smith et al (eds) *Ethical judgments. Rewriting medical law*.

[122] See *British Columbia (AG) v Astaforoff* [1984] 6 WWR 385; *Malette v Schulman* [1990] 72 OR (2d) 417; *Nancy B v Hôtel-Dieu de Québec* [1992] RJQ 361.

[123] Dickens (1993) 'Medically assisted death: *Nancy B* v. *Hôtel-Dieu de Québec*' *McGill LJ* 1053 at p1065.

[124] Schafer (2013) 'Physician assisted suicide: The great Canadian euthanasia debate' *International JL&Psychiatry* 522 at p526.

[125] [1993] 3 SCR 519 at p588. On the right to refuse life-sustaining treatment see du Bois-Pedain op cit fn 99 at p77.

[126] See https://www.supremecourt.uk/cases/docs/charlie-gard-190617.pdf, refusing permission to appeal *Great Ormond Street Hospital v Yates, Gard and Gard* [2017] EWCA Civ 410. The ECtHR endorsed the decision; see *Gard v UK* (2017) 65 EHRR SE9.

wishes, the UK's Supreme Court implicitly recognised that there is a minimum quality of life below which it is not in the child's best interests to continue living. In *Charlie Gard*, it also accepted that prolonging the child's suffering without realistic prospects of improvement exposed him to significant harm. *Alfie Evans* went further: "it is not lawful for [doctors] to give treatment to [a child] which is not in his interests" even if continued treatment does not cause significant harm.[128] Strikingly, parents, doctors and courts can decide whether the life awaiting sick children is worth living; indeed, courts can authorise termination of treatment even if parents view life support in their child's best interests. If third parties can decide for minor patients when illness reduces their quality of life to unacceptable levels, it appears irrational to prevent competent adults from deciding where that threshold lies for themselves.

Re A (Conjoined Twins)[129] casts further doubt on law's absolute belief in the inviolability of human life. The compromise here was even greater: the hastened death of the weaker twin as a result of surgical separation aimed to secure the best interests of her sister (whose death was avoidable), not her own. For Lewis, the uniqueness of the case did not make it an authority for a defence of necessity in euthanasia cases; the death was inevitable and the act hastening it achieved net saving of life by avoiding another person's death.[130] However, if hastening death is exceptionally accepted as 'the lesser evil', and without the patient's consent, surely the patient ought to be permitted a similar judgment call for their person.

The law's approach to involuntary euthanasia for incompetent adults also undermines the inviolability-of-life justification for the ban on MAiD. In *Bland*, a case concerning an adult in permanent vegetative state (PVS), the court accepted that there is a threshold below which merely being alive procures individuals no participation in, or enjoyment of, life.[131] If the law allows compassionate termination of life at the request of third parties (family/ doctors), *a fortiori* competent patients should be able to decide where they draw the line between a life worth living and one offering no gratification. As Lord Neuberger observed in *Nicklinson*, withdrawal of life support from another is: "a more drastic interference in that person's life and a more extreme moral step" than authorising the assistance in dying sought by the patient.[132]

PVS patients' right to die is based on the assumption that they would refuse the indignities to which the deterioration of their bodies subjects them, albeit unconscious and unperturbed by them. Paradoxically, lucid individuals trapped in decaying bodies, capable of expressing their wish to die, are left to endure, powerless, those indignities. Equally ironic is another judicial inconsistency: given the intense "anguish of awaiting execution", exposing convicts to the 'death-row phenomenon' was recognised as psychological ill-treatment;[133] forcing patients to live with the spectre of a painful and undignified death was not deemed such.

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[127] See https://www.supremecourt.uk/cases/docs/alfie-evans-reasons-200318.pdf, refusing permission to appeal *Evans and James v Alder Hey Children's NHS Foundation Trust, Alfie Evans* [2018] EWCA 984 (Civ).

[128] Ibid at [16].

[129] *Re A (Children) (Conjoined Twins: Medical Treatment)* [2001] Fam 147.

[130] Lewis (2013) 'The failure of the defence of necessity as a mechanism of legal change on assisted dying in the common law world' pp 284-285 in Baker and Horder, *The sanctity of life and the criminal law*.

[131] [1993] AC 789. See Price (2009) 'What shape to euthanasia after Bland? Historical, contemporary and futuristic paradigms' *LQR* 142; Beyleveld and Brownsword (2001) *Human dignity in bioethics and biolaw* pp 244-254.

[132] [2015] AC 657 at [94]. For a comparative survey of case-law on refusal of life-saving treatment, parents' right to refuse treatment for children and guardians' decision-making powers for comatose adults, see Gorsuch (2006) *The future of assisted suicide and euthanasia* pp 181-215. On the distinction active/ passive euthanasia, ie killing/ letting the patient die (eg injecting lethal substances versus withholding life-saving treatment), see Luzon, op cit fn 98 at p333.

[133] See *Soering v UK* [1989] 11 EHRR 439 at [111].

The relative 'absoluteness' of the right to life [B heading; 12 bold]

A rights-based version of inviolability-of-life arguments invokes the absolute nature of the right to life under Art 2 ECHR. According to Finnis: "[s]uch absoluteness not only eliminates margin of appreciation but entails obligations to avoid creating any 'real risk' of violation by *anyone*".[134] This claim is unsupported by the text of Art 2 or its jurisprudential interpretation. By contrast with the unqualified prohibition of ill-treatment (Art 3) or slavery (Art 4(1)), Art 2(2) permits intentional deprivation of life and potentially lethal use of force (eg to defend innocents against third-party violence) as long as they are "no more than necessary". Torturing criminals in a 'ticking bomb' scenario is unlawful;[135] killing terrorists as a last-resort law-enforcement measure is not.[136] Absolute rights do not permit interferences, and the right enshrined in Art 2 does. Outside the human-rights context, Battin noted that: "the intrinsic-wrongness-of-killing argument falls to its counterexamples of war and self-defence without adequate rebuttal".[137]

Moreover, an individual has the *right* to life, not the *obligation* to exercise it; nor are States expected to compel individuals to exercise this right, much like the right to vote (Protocol 1 Art 3) does not oblige citizens to vote and does not require States to prevent electoral absenteeism. Finnis's suggestion that States must protect life against violation by anyone, including oneself, only applies, according to Strasbourg case-law, to the narrow situation of individuals afflicted by mental disorders that include suicidal behaviour, where a limited duty of care arises. *Keenan v UK* established a mere obligation of conduct, not of result, for prison authorities in respect of mentally-ill inmates, ie to take reasonable precautions to prevent suicide.[138] Importantly, in such cases, as Wicks noted, the duty to treat suicide as a risk to prevent, rather than as a choice to respect, stems from the fact that mental disorder may preclude autonomous choices.[139] More clearly dispositive of the issue, *Lambert v France* found legislation permitting end-of-life decisions ECHR-compliant.[140] It is also a well-established principle that the ECHR: "must be read as a whole, and interpreted in such a way as to promote internal consistency and harmony between its various provisions".[141] Art 2 cannot be interpreted as requiring States to coerce patients into receiving life-saving treatment, as this would clash with Art 8 obligations to protect physical self-determination and Art 9 respect for freedom of conscience; for that same reason, it cannot be seen as requiring States to force individuals to stay alive.

Coggon argued that a "high-sounding moral principle" like the sanctity of life cannot justify restrictions on individual rights, and their rationale may only lie in the "rights of others".[142] This is

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[134] Finnis, op cit fn 115 at p6 (original emphasis).

[135] See *Gäfgen v Germany* (2011) 52 EHRR 1; Bjorge (2011) 'Torture and "ticking bomb" scenarios' *LQR* 196 at p199.

[136] See *McCann and Others v UK* (1995) 21 EHRR 97.

[137] Battin (2005) *Ending life: Ethics and the way we die* p39.

[138] See *Keenan v UK* (2001) 33 EHRR 903.

[139] Wicks, op cit fn 6 at p78.

[140] *Lambert v France* (2016) 62 EHRR 2.

[141] *Stec v UK* 43 EHRR 1027 at [48]; *Saadi v UK* (2007) 44 EHRR 50 at [62]; *Hirsi Jamaaa v Italy* (2012) 55 EHRR 21 at [171]; *Demir and Baykara v Turkey* (2009) 48 EHRR 54 at [66].

[142] Coggon, op cit fn 121 at p211. On the inviolability-of-life principle see Keown (2012) *The law and ethics of medicine: Essays on the inviolability of human life* pp 3-22.

particularly true of bans affecting bodily self-determination. To ground s.2(1) SA in a collective philosophical belief is tantamount to saying that patients like Mrs Pretty are compelled to endure death by suffocation because society (*rectius*, the majority) sees it preferable to hastened pain-free death. As Dworkin wrote: "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny".[143]

The moral neutrality of assisted-dying legislation [B heading; 12 bold]

British and Canadian highest courts have accepted that self-determination encompasses a right not to believe in the prevalence of sanctity-of-life considerations over dignity in dying[144] and avoiding incurable suffering. In the UK, post-*Pretty* case-law rejected the sanctity-of-life justification for the ban, seen in competition with the principles of individual autonomy and human dignity.[145] In *Rodriguez*, the Canadian Supreme Court conceded that sanctity of life (understood in the secular sense that human life has intrinsic value), albeit a deeply rooted belief in society, does not prevail over liberty and security of the person; rather, it is: "one of the values engaged" in MAiD deliberations.[146] Nothing in the case-law suggests that the legalisation of MAiD sanctions any particular view on the value of life; the debate largely revolved around the risks of accommodating private opinion on human intervention with the natural course of life and death.[147]

Nicklinson accepted the moral neutrality of assisted-dying legislation and adduced practical concerns about shielding the vulnerable from abuse. Papadopoulou thus noted a change in judicial attitudes since the robust support for the prohibition in *Pretty*: "judges are now dealing not with whether the law should change, but with how the law could change".[148] However, *Conway* marked a conservative retreat from that stance. The High Court reopened the sanctity-of-life debate and found that this principle could justify interferences with private life, being subsumed under the "protection of morals" permitted by Art 8(2) ECHR.[149] The court warned against downplaying the sanctity-of-life principle where a person has six months left to live (Mr Conway's proposed threshold criterion for assisted dying).[150] The Court of Appeal also placed sanctity of life on an equal footing with other legitimate justifications (protecting the vulnerable, promoting trust between patients and doctors),[151] even if the judgement, like *Nicklinson* and *Carter*, focused on pragmatic 'slippery slope' arguments.

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[143] Dworkin (1993) *Life's dominion: An argument about abortion and euthanasia* p217.

[144] According to Velleman (2015) *Beyond Price: Essays on birth and death* p33 the phrase 'dying with dignity' is misleading, as "[t]he operative concept is undignified life, not dignified death". However, both might be at stake: life in distressing circumstances and the foreseeable manner of death.

[145] See *Nicklinson* (fn 1) at [199], [209], [358].

[146] [1993] 3 SCR 519 at pp 585-586.

[147] See also Heywood (2010) 'R. (on the application of Purdy) v DPP: clarification on assisted suicide' *LQR* 5 at p6: "Individuals may attach greater importance to certain lifestyle characteristics than others and that is their choice, in the same way that those who value the sanctity of life above all else make a conscious decision to do so. It is impossible to say either belief is right or wrong for the very reason that they are matters of private opinion".

[148] Papadopoulou (2017) 'From Pretty to Nicklinson: changing judicial attitudes to assisted dying' *European Human Rights LR* 298 at p307.

[149] [2018] EWCA Civ 1431at [47].

[150] Ibid at [33] - [34].

[151] Ibid at [61], [204].

Ethical concerns were revived in *Newby*, according to which: "the court is not an appropriate forum for the discussion of the sanctity of life".[152]

The moral neutrality of MAiD legislation, whereby States merely defer to individual moral beliefs, remains highly contested. Foster labelled MAiD "government-endorsed suicide".[153] White noted that, while the *Carter* plaintiffs invoked human dignity to claim end-of-life choice, intervening disability-advocate groups also relied on dignity to suggest that removing the ban would send the message that life with significant impairment is not worth living.[154] Such submissions overlook the fact that MAiD initiatives proceeded from disabled individuals, not the State, and the change they pursued was not the State's evaluation of what makes a life worth living, but everyone's right to make that subjective judgment for their person.

Similarly, in *Conway*, the Court of Appeal suggested that, to decide on the ban's proportionality, advances in palliative care to manage distressful symptoms had to be considered,[155] which underrated patients' subjective assessment of what constitutes satisfactory treatment. More sensibly, the new Canadian law takes palliative care options into account when assessing MAiD eligibility, not as a justification for a blanket ban. Significantly, under s.241.2(2) of the Criminal Code, the care available must be acceptable to the patient. Whether or not the treatment offers relief without excessively diminishing the patient's quality of life cannot be objectively determined by doctors or courts.

Killing and letting die: the elusive distinction [B heading; 12 bold]

Sanctity-of-life reasoning also underpins the alleged moral distinction between acts and omissions. Its supporters condemn acts causing death (complicity in suicide), but condone fatal omissions (discontinuing life-sustaining treatment).[156] This distinction is largely artificial; in both cases, motivation (compassionate, ie relieve suffering), intention (implement patients' decision) and foreseeable consequence (patients' death) are identical.[157] For Cohn and Lynn, withdrawal of support is different from assisted dying because doctors' intent is to respect patients' wishes not to receive undesired treatment;[158] however, physicians providing MAiD are equally animated by the intention to respect patients' wishes, not to bring about their death. Doctors/ relatives offering assistance in dying have no autonomous intention to end life, they are instrumental to patients' decision, enabling them to exercise control over their body. In terms of moral responsibility for the death, the distinction

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[152] [2019] EWHC 3118 (Admin) at [50].

[153] Foster (2018) 'The fatal flaws of assisted suicide' *The Human Life Review* 51 at p58.

[154] White (2019) 'A role for human dignity under the *Canadian Charter of Rights and Freedoms*' in Albert – Daly – Macdonnell (eds) *The Canadian Constitution in transition* 310 at p320. According to Elliot (2018) 'Institutionalizing inequality: The physical criterion of assisted suicide' *Christian Bioethics 7*, laws making MAiD eligibility dependent on severe health deterioration degrade the very sick and dying, suggesting that their lives are not deemed worthwhile.

[155] [2018] EWCA Civ 1431 at [177].

[156] See Huxtable (2007) *Euthanasia, ethics and the law: From conflict to compromise* at p12.

[157] See also Schafer, op cit fn 124 at p526; Jackson, op cit fn 98 at pp 29-33; Meisel (2012) 'Physician-assisted suicide: A common law roadmap' pp 375-380 in Beauchamp et al (eds) *Contemporary issues in bioethics*. Unlike these authors, I do not consider the intention to be ending life.

[158] Cohn and Lynn (2002) 'Vulnerable people: Practical rejoinders to claims in favor of assisted suicide' p247 in Foley and Hendin (eds) *The case against assisted suicide: For the right to end-of-life care*. Meisel similarly argued that the true justification for passively hastening death is: "self-determination implemented through consent" (op cit fn 157 at p380), but the same legitimises conduct actively hastening death.

between foresight (disconnecting ventilation with the knowledge that the patient will die) and intention (administering drugs that will cause the patient to die) is also tenuous.[159]

Even categorising conduct as (positive) act or (passive) omission is not straightforward. To differentiate between disconnecting the feeding tube and not supplying nutrients down the tube would be spurious.[160] Moreover, to classify the active removal of ventilatory support as *withholding* treatment (an omission) is semantically problematic, although admittedly it is possible to let die (of natural causes) through an act (terminating medical assistance).[161] In *Re A*, the Court of Appeal rejected the lower court's finding that surgical separation of conjoined twins, depriving the weaker one of vital sustenance, was akin to withdrawal of support, and hence an omission.[162] It is also worth noting that the law does not treat the rejection of life-sustaining treatment as suicide (otherwise doctors withdrawing life support would be liable of assistance in suicide), but the distinction between refusal of treatment and self-starvation, which does constitute suicide, is feeble.[163]

Notwithstanding the flaws of the act/omission theory, respondent governments in right-to-die litigation have attempted to distinguish MAiD on this basis from withdrawal/ non-provision of life-saving treatment. Both Supreme Courts received the argument with scepticism. They accepted that medical law prioritises self-determination over preservation of life as an absolute objective, and if a person cannot be coerced into treatment to save their life, the same autonomy should be recognised in relation to assisted dying. The two courts differed on whether curtailing self-determination rights was justified in order to protect the rights of others.

In *Conway*, however, the UK's Court of Appeal rationalised the law's permissive approach to withdrawal of treatment by distinguishing "an act or omission which allows causes already present in the body to operate" from "the introduction of an external agency of death".[164] This dichotomy is equally unconvincing. Both allowing the disease to kill and introducing death-hasting substances result in the patient's death, and do so with foreknowledge, the moral authorship of the decision rests with the patient, and the motivation of those implementing it is compassionate. Worryingly, the *Conway* justification gives credence to the ethics of 'allowing nature to follow its course'; suffice it to recall the infamous US cases involving 'faith healing' families, where parents refused to administer medication to their children for religious reasons, and children died from treatable illnesses.[165] They, too, allowed natural causes present in the body to follow their course; applying the *Conway* test, since parents introduced no external cause of death, their conduct was morally virtuous and legally acceptable. Kuhse and Singer highlighted the absurd consequences of the argument that letting die of natural causes is morally distinct from compassionate killing: if starving an infant to death or failing to treat a preventable infection merely allows nature to take its course, parents could ensure the death of unwanted children without being responsible for it.[166] They also criticised the oversimplification

[159] See Smith (2012) *End-of-life decisions in medical care principles and policies for regulating the dying process* pp 78-84.

[160] See Huxtable, op cit fn 156 at p6.

[161] See McGee (2015) 'Acting to let someone die' *Bioethics* 74.

[162] [2001] Fam 147 at pp 189, 215, 247-250.

[163] See Meisel (2004) *The right to die: The law of end-of-life decision-making* at pp 12.14-12.24.

[164] [2018] EWCA Civ 1431 at [176]. For an analogous approach in Canada see [1993] 3 SCR 519 at pp 606-608 (*per* Sopinka J).

[165] See Lederman (1995) 'Understanding faith: When religious parents decline conventional medical treatment for their children' *Case Western Reserve LR* 891.

[166] Kuhse and Singer (2004) 'Killing and letting die' p48 in Harris (ed) *Bioethics*. Omissions causing death can attract criminal liability (eg failure to provide children with food by those who owed them a duty of care); see *R* v *Gibbins and Proctor* (1918) 13 Crim App Rep 134, discussed in Biggs (2001) *Euthanasia, death with dignity and the law* p51.

behind the conclusion that, when doctors refrain from treating patients, the latter's death is caused by nature: "Both the illness and the omission are part of the 'sum total of the conditions positive and negative taken together' which is the full causal account of the death".[167]

Assisted-dying bans: the fundamental rights engaged [B heading; 12 bold]

The same substantive debate led to a different conceptualisation of the rights engaged in Canada and the UK. Both countries recognise an individual entitlement to end-of-life convictions and decisions. However, autonomy, specifically bodily self-determination, is seen as a matter of privacy under Art 8 ECHR, whereas for the Canadian Charter it engages the right to liberty and personal security. There is, of course, no textually explicit 'privacy' right in the Charter; as in the United States, effective recognition of a privacy right in Canadian law has been extracted from other textual sources.[168] The UK's acceptance of end-of-life decision-making as part of privacy rights was relatively recent and driven by the ECtHR. In Canada, the impetus for recognition of self-determination vis-à-vis the time and manner of one's death was purely domestic and dates back to *Rodriguez*, which preceded *Pretty v UK* by a decade.

Although euthanasia and assisted suicide are often used co-terminously, both *Nicklinson*/ *Conway* and *Carter* drew an important agency-based distinction: assisted suicide does not involve deciding about a third-party's life; rather, it means empowering competent adults who, due to devastating disabilities, cannot implement their own decisions over their bodies.[169] Criticising *Carter*, Keown suggested that, if assistance to die benefits patients who suffer, the logical consequence is that it should be available to those who are mentally incompetent, because the duty of beneficence applies even where patients cannot consent.[170] This *reductio ad absurdum* seems based on a questionable interpretation of beneficence as an objective standard in situations of intractable suffering, whereas individual responses differ, and what makes compassionate assistance morally/ legally permissible is the patient's own determination that assistance benefits *them*. Whether death is beneficial or harmful will depend on each patient's perception of their circumstances.[171] As recently recalled in a Court of Protection case, when deciding on life-sustaining treatment for incapacitous persons, their "best interests" under s.4 Mental Capacity Act 2005 depend on their ascertainable wishes, values and beliefs; the presumption in favour of prolongation of life is not absolute.[172] The judge's reflections on respect for personal autonomy in the face of severe illness, eroding quality of life, self-esteem and interpersonal relationships, could apply to MAiD requests as much as to advance directives on treatment:

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[167] Ibid at p50.

[168] See the discussions in the chapters by Beattie and Phillipson (pp --- below); Hatzis (pp --- below); and Taylor (pp --- below). On the various foundations of constitutional challenges to the criminalisation of MAiD in Canada, the UK and the US see Lewis (2007) *Assisted dying and legal change* pp 12-42.

[169] Some distinguish between "doctor-assisted suicide" (patient's self-administration of lethal drugs supplied by the doctor) and "voluntary euthanasia" (drugs administered by the doctor at patient's request); see Otlowski (1997) *Voluntary euthanasia and the common law* pp 7-9. This chapter's reference to "assisted dying" covers all assistance given to competent patients at their request to enable them to control the time and manner of their death (provision and/or administration of drugs, assistance to travel to clinics lawfully offering MAiD).

[170] See Keown (2018) '*Carter*: A stain on Canadian jurisprudence?' p16 in Ross, op cit fn 85.

[171] See also Smith, op cit fn 159 at p127.

[172] *Barnsley Hospital NHS Foundation Trust v MSP* [2020] EWCOP 26 at [20]-[28], citing *Aintree University Hospital NHS Trust v James* [2013] UKSC 67 at [26], *Briggs v Briggs* [2017] 4 WLR 37 at [7].

[47] He has made a practical, utilitarian calculation that life in these circumstances is not what he wants. … this is not a case about choosing to die, it is about an adult's capacity to shape and control the end of his life. This is an important facet of personal autonomy … .

In addition to self-determination, the right to life featured prominently in *Carter* and was unsuccessfully invoked in *Conway*. Whilst the *Nicklinson* pleas came from individuals who could not end their lives unassisted, *Carter* regarded patients whose ability to end their lives was likely to be impaired in the near future and who felt pressurised into doing so prematurely. The Canadian Supreme Court agreed that this interfered with their right to life. Whilst Art 2 ECHR submissions were not before the *Nicklinson* court, the concern was expressed in Lord Neuberger's judgment: by forcing sufferers of degenerative diseases to die while they are still able to do so unassisted, the impugned prohibition "indirectly cuts short their lives".[173] Huxtable recalled cases where "this legal obstacle has prompted some patients to act alone, while they still could …, one of whom made legal history after she suffocated herself with a plastic bag".[174]

Submissions based on the prohibition of inhuman and degrading treatment regrettably failed in English courts. As Mullock argued, the law should balance the protection of the vulnerable against the "'cruelty' of those unwillingly trapped in life to live on".[175] Even in Canada, the law is yet to fully recognise, under the right to protection against cruel treatment, a moral imperative to end human suffering upon request. Albeit not requiring terminal illness or a specified prognosis, Bill C-14 reserved eligibility for assistance to cases of reasonably foreseeable death; further reform is, however, expected after *Truchon*. The latest British Assisted Dying Bill also excluded individuals who are not terminally ill but who suffer from constant pain, with no acceptable palliative care available, and are dependent on others in ways they consider undignified.[176] Such patients arguably have an even greater need to control the timing of their death; prompting this category to seek disturbing alternatives to MAiD appears irrational. Moreover, since patients can request withdrawal of treatment to passively hasten death without being terminally ill, no sound justification exists for making it a pre-condition for requests to actively hasten death.[177]

A related concern, underexplored in litigation but dramatically manifest after the defeat of autonomy claims in *Nicklinson*, is the type of death available in the absence of medical assistance. After losing his High Court battle, Mr Nicklinson embarked upon self-starvation, shortened by pneumonia; Martin engaged in an aborted attempt at self-starvation after the Hight Court judgment.[178] The blanket ban on MAiD forces competent adults having reached a settled decision to end their lives due to constant suffering to resort to agonising suicide methods (sometimes botched attempts, leaving them worse off) instead of a controlled medical procedure. Jackson argued that everyone is entitled to experience a 'good death', which may require assistance in dying, and that in a secular society, recognising different moral views, individuals should not be compelled to deaths they find intolerable.[179] Lord

[173] [2015] AC 657 at [96].

[174] Huxtable, op cit fn 156 at p58.

[175] Mullock (2015) 'The Supreme Court decision in Nicklinson: Human rights, criminal wrong and the dilemma of death' *Professional Negligence* 18 at p28, referring to Lady Hale's statement in *Nicklinson* (fn 1 at [313]) that the appellants "experience the law's insistence that they stay alive for the sake of others as a form of cruelty".

[176] HL Bill 42, Arts 1-2.

[177] See Meisel, op cit fn 163 at pp 12.109-12.110.

[178] [2014] UKSC 38; [2015] AC 657 at [6], [12].

[179] Jackson, op cit fn 98 at pp 1-5. See also Kuhse and Singer op cit fn 166 at p60 on marginally-viable infants: "killing an infant is not worse than letting the infant die. Often it will be better, because the swifter death will cause less suffering".

Goff also noted the law's hypocrisy in allowing doctors to disconnect life support and let the patient die slowly, while prohibiting assistance that would: "put him out of his misery straight away, in a more humane manner, by a lethal injection, rather than let him linger on in pain until he dies".[180] A right to "the least painful death available" may be based on the prohibition of inhuman treatment,[181] engaged whenever the State: "blocks avenues which people might otherwise opt for to secure a less distressing death".[182]

Surprisingly, non-discrimination claims were not given adequate consideration in right-to-die rulings (even *Carter* declining to examine s.15 arguments),[183] although these were eminently equality cases. Since the law recognises patients' right to choose death by switching off the life-support machine or travelling abroad to receive MAiD services, they must be able to ask for assistance from relatives or doctors if, due to disability, they can only exercise that right through a willing other. As Spriggs noted, autonomy may encompass "affirmative demands", ie require acts "fostering autonomous decision making".[184] For patients reliant on others to govern their bodies, medical assistance may be necessary to effectively respect decisional autonomy. To the extent that severely disabled individuals, who cannot act independently, are only left with the tragic option of a slow painful death through self-starvation and self-dehydration, the prohibition on MAiD affects them with particular force.

IV. Pragmatic concerns: the 'protection of the vulnerable' argument

[A heading; 14 bold]

The only arguable justification for curtailing the rights of patients seeking MAiD is the unintended effect of legalisation on vulnerable individuals pressurised into ending their lives. Dworkin noted that opponents of assisted suicide also invoke the principle of autonomy: "they worry that if euthanasia were legal people would be killed who really wanted to stay alive".[185] The argument that the assisted-dying ban pursued the legitimate aim of protecting the vulnerable was readily accepted in the courts of both Canada and the UK.

However, there was surprisingly limited discussion of the notion of 'vulnerability'. Treating all mentally-competent disabled persons as vulnerable and restricting their autonomy in the name of protecting them would be moral paternalism.[186] A narrow definition of vulnerability, based on mental health and personal circumstances, is arguably required. In *Pretty*, the ECtHR expressly rejected the claim that severely disabled persons contemplating suicide were to be regarded as vulnerable.[187] It is worth noting that the applicants for individual exemptions under *Carter (No.2)* were well-educated and well-off, and their relatives had initially opposed the decision to seek MAiD.[188] Importantly, as

[180] *Bland* [1993] AC 789 at p865.

[181] See du Bois-Pedain, op cit fn 99 at p87.

[182] Ibid at p90.

[183] On the trial judge's decision on s.15 and criticising the Supreme Court's refusal to endorse it see Deckha (2016) 'A missed opportunity: Affirming the section 15 equality argument against physician-assisted death' *McGill JL & Health* S69. Against the judge's finding of discrimination see Keown (2014) 'A right to voluntary euthanasia? Confusion in Canada in Carter' *Notre Dame JL Ethics and Public Policy* 1 at 17-20.

[184] Spriggs (2005) *Autonomy and patients' decisions* p82.

[185] Dworkin, op cit fn 143 at p190.

[186] See Draghici (2015) 'The blanket ban on assisted suicide: between moral paternalism and utilitarian justice' *European Human Rights LR* 286 at p296.

[187] (2002) 35 EHRR 1 at [73].

Schafer observed, patients requesting withdrawal of life-sustaining treatment are not deemed vulnerable, even though their life is equally at stake, and they may also be unduly influenced by over-burdened families, emotional hardship or depression.[189] The Canadian Supreme Court judiciously accepted in *Carter* that no different vulnerability concerns arise with respect to assisted dying when compared to other end-of-life decisions:

> [115] [T]here is no reason to think that the injured, ill, and disabled who have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment ... are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying.

Beaudry argued that deliberative autonomy cannot be ascertained satisfactorily, because wilful decisions may be the product of social conditions, and so under the new Canadian MAiD regime: "a desperate, marginalized citizen socially cornered into suicide may … be cast as an autonomous patient that has been treated respectfully".[190] Why 'social autonomy' concerns arise in relation to MAiD, but not withdrawal of life-sustaining treatment, is left unanswered. A double standard, whereby patients requiring third-party assistance to end their lives are treated as vulnerable, while those who can do it unaided are not, is arbitrary and discriminatory.

Furthermore, if the vulnerable require protection against pressure to end their life, a blanket ban on assisted suicide is both overbroad and insufficient: it catches persons outside that class and fails to reach intended recipients. The ban cannot prevent vulnerable individuals from ending their life under pressure as long as this can be achieved by discontinuing treatment or they are physically able to commit suicide or travel to a jurisdiction permitting MAiD. As Mullock noted, this lack of effective protection for vulnerable patients calls into question the rational connection between the ban and its objective.[191] Critically, the ban impacts competent individuals of limited means or who lost command of their body; they are denied a right everyone else has to see their end-of-life decisions respected. Admittedly, this is a narrow category; however, the low number of individuals affected is not a valid justification for restrictions upon fundamental rights. That contention was rejected by Strasbourg authorities.[192] In *Bedford*, the Canadian Supreme Court also clarified that, even if a law has a grossly disproportionate effect on one individual only, it still violates the Charter.[193]

While both Supreme Courts accepted the vulnerability rationale, they differed on whether it had to be addressed through a blanket prohibition, as opposed to a mechanism ensuring that assistance is only provided in appropriate cases. In the unanimous judgment of the Canadian Supreme Court, it was possible to allow MAiD and establish a system of safeguards. Conversely, the majority in the UK Supreme Court felt unable to decide in the absence of a specific legislative scheme, and supported a policy excluding risks of error and abuse. The Court of Appeal in *Conway* concluded that the scheme before it was not fool-proof and similarly preferred a precautionary approach. Nevertheless, the

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[188] See *Re A.B.* [2016] ONSC 2188; *Re H.H.* [2016] BCSC 971; *Re Tuckwell* [2016] ABQB 302; *Patient 0518 v RHA 0518* [2016] SKQB 176; *Re A.A.* [2016] BCSC 570; *C.D. v Canada (AG)* 2016 ONSC 2431; *E.F. v Canada (AG)* 2016 ONSC 2790; *M.N. v Canada (AG)* 2016 ONSC 3346.

[189] See Schafer, op cit fn 124 at p526.

[190] Beaudry (2018) 'The way forward for medical aid in dying: Protecting deliberative autonomy is not enough' p385 in Ross, op cit fn 85.

[191] Mullock, op cit fn 175 at p 22.

[192] See *Dickson v UK* (2008) 44 EHRR 21 at [84]; *Hatton v UK* (2003) 37 EHRR 611, Separate opinion at [14].

[193] *Canada (AG) v Bedford* [2013] SCC 72 at [122].

avoidance of potential risks generates the absolute certainty of curbing some individuals' basic rights on speculative grounds.[194] This in turn speaks to questions of proportionality.

V. Necessity and proportionality [A heading: 14 bold]

The meanings ascribed to the notions of necessity and proportionality in both jurisdictions provide a constant theme for analysis in the chapters in this volume. In the assisted-dying context, three facets of proportionality have particular prominence: the onus of establishing a preferable alternative scheme, 'slippery slope' concerns, and the toleration of assistance in the prosecutorial practice.

Apportioning the burden of proof: must claimants devise unassailable alternatives? [B heading; 12 bold]

The conceptualisation of justifications for interferences is marginally different between Canada and the UK. Under s.7 of the Canadian Charter, interferences must be in accordance with "principles of fundamental justice", ie not arbitrary, overbroad or having consequences grossly disproportionate to the objectives.[195] Section 7 infringements can still be saved by s.1, if they pursued a pressing objective and observed proportionality, the latter being defined by: (1) rational connection; (2) minimal impairment; (3) deleterious effects and salutary benefits. Art 8(2) ECHR establishes a three-pronged test: the measure must be "prescribed by law" (not arbitrary), pursue one of the "legitimate aim(s)" listed, and be "necessary in a democratic society"; the third criterion requires a proportionality test, ie demonstration of a pressing need and recourse to the minimum interference sufficient to achieve the aim.[196] The Charter and the ECHR frameworks legitimising restrictions are therefore similar, even if the algorithms for analysis follow slightly different paths.

In assisted-dying case-law, there are two striking features in the British courts' approach to justification: first, the acceptance without demonstration of great risks associated with regulation, as opposed to complete ban;[197] second, the focus on the exact substitute for the ban, and specifically the claimant's responsibility to devise it. Since it was acknowledged that the blanket ban curtails individual rights, one would expect the respondent to be required to provide cogent justification, absent which the measure breaches the HRA. However, the Supreme Court majority in *Nicklinson* shifted the burden onto applicants to demonstrate that the interference was *not* justified, and nothing short of a fully-perfected legislative scheme met that burden.[198] This influenced the claimant's submissions in *Conway*, which took the unusual form of a legislative proposal; in fact, much of the High Court's assessment revolved around the merits of that solution, instead of examining the *status quo*. The appellate decision also focused on Mr Conway's solution, concluding that it did not offer

[194] See [2015] AC 657 at [352] (*per* Lord Kerr): "section 2(1) applies to many people who are not in need of its protection and who are prejudiced by its application to them. … In the absence of evidence ... that this was required, it is impossible to conclude that the interference with the appellants' rights is proportionate."

[195] See further [2015] 1 SCR 331 at [72].

[196] See Draghici (2017) *The legitimacy of family rights in Strasbourg case law: 'living instrument' or extinguished sovereignty?* pp 300-302.

[197] The absence of realistic examination of risks was already noted in relation to the *Pretty* case; see Morris (2003) 'Assisted suicide under the European Convention on Human Rights: a critique' *European Human Rights LR* 65 at p90.

[198] See Martin (2018) 'Declaratory misgivings: assisted suicide in a post-Nicklinson context' *Public Law* 209 pp 214-215.

adequate protection to the vulnerable. The expectations placed by the Court of Appeal on individual litigants are astounding:[199]

[10 normal] [174] It is not satisfactory to say … that all of those practical and regulatory details could be worked out by Parliament … Those considerations are relevant as to whether the court is in a position to hold section 2(1) to be incompatible in the first place.

By contrast, in *Carter*, the Canadian Supreme Court did not expect claimants to prove that liberty-limiting legislation was disproportionate; rather, it required the respondent to demonstrate the necessity of the restriction pursuant to the *Oakes* test.[200] Nor did it attempt to decide the exact alternative to the *status quo*. The court invalidated the provisions banning all assistance in dying, but the task of revisiting the law was left to Parliament. The only legislative direction included in the judgment was the requirement that any new MAiD rights for patients be reconciled with doctors' rights not to be compelled to provide assistance.[201]

The minority in *Nicklinson* had taken the same approach. For Lord Kerr, the absence of a well-thought-out replacement scheme should not affect the evaluation of the present ban's proportionality:

[10 normal] [354] It is entirely possible to assert that a particular provision would go beyond what it seeks to achieve without having to describe the details of a more tailored measure that would attain that aim. … The measure must be intrinsically proportionate.

This view better reflects the s.4 HRA mechanism, which empowers courts to decide if a law breaches human rights, not how it should be amended; the exact remedy is left to the legislature. It follows that a substitute for the offending law should not be claimants' onus either.

The House of Lords in *Bellinger* refused to strain the interpretation of s.11(c) Matrimonial Causes Act 1973 under s.3 HRA[202] (preferring a s.4 declaration instead) precisely because the court was not the appropriate institution for shaping complex legislative schemes with systemic implications.[203] The *Bellinger* judgment found that the failure to recognise transsexual persons' acquired gender and capacity to marry according to it breached Arts 8 and 12 ECHR. That no clear criteria for gender reassignment were available did not preclude a s.4 declaration (nor had this been an obstacle for the ECtHR in *Goodwin v UK*).[204] Mrs Bellinger was not required to demonstrate how the law would resolve the difficulties regarding medical evidence of intention to live in the new gender permanently, the amount of time in the new social gender required for legal sex change, or the status of mother/ father of children born before gender reassignment. Parliament made those decisions in the Gender Recognition Act 2004. Analogously, judicial assessment of the assisted-dying ban can precede the elaboration of a new legislative scheme to address HRA-incompatibilities.

The 'slippery slope' argument [B heading; 12 bold]

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[199] [2018] EWCA Civ 1431.

[200] See pp--- above for a discussion of the proportionality test established in the early Charter jurisprudence in *R. v Oakes* [1986] 1 SCR 103.

[201] [2015] 1 SCR 331 at [132].

[202] Under s.11(c), repealed by the Marriage (Same Sex Couples) Act 2013, a marriage was void if: "the parties are not respectively male and female".

[203] See *Bellinger v Bellinger* [2003] UKHL 21 at [37].

[204] (2002) 35 EHRR 18.

The crux of the assisted-dying controversy lies in the lack of scope for exceptional authorisation. Proportionality requires that interferences be no more than necessary to safeguard legitimate aims; consequently, blanket bans affecting human rights are rarely defensible, because they make no allowance for special circumstances and do not permit a remedy strictly commensurate with the problem.[205] Moreover, a fair balance presupposes a reasonable reconciliation between competing rights. A blanket ban fails to achieve a balance, as one party is required to sacrifice all. McLachlin J, dissenting, concluded in *Rodriguez*: "Sue Rodriguez is asked to bear the burden of the chance that other people in other situations may act criminally to kill others or improperly sway them to suicide. She is asked to serve as a scapegoat".[206] From a bioethical perspective, law presupposes a 'compromise' between contrasting interests in society: "both sides getting a bit of what they want while neither side gets all of what it wants";[207] the blanket ban on MAiD fails to achieve a reasonable compromise, because it gives one side absolutely nothing.

This extreme position was rationalised in the literature by 'slippery slope' arguments, broadly reducible to two claims: (1) once MAiD is permitted, the practice cannot be contained within its anticipated boundaries, as further demands based on autonomy/ mercy killing will follow; (2) whatever criteria are adopted, abuse cannot be excluded, and patients falling outside those criteria will be assisted to die ('empirical' slippery slope).[208] The second version of the slippery slope was prominent in assisted-dying litigation in both jurisdictions, when courts inquired whether an absolute ban was necessary and proportionate.

For the Canadian Supreme Court, the ban unjustifiably infringed the rights of competent consenting adults suffering intolerably; a permissive regime with proper safeguards could protect vulnerable people from abuse and error. As Schafer explained: "*Oakes* requires that there must be strong evidence (rather than mere a priori speculation) that coercive restrictions are both necessary and sufficient to promote the values in question".[209] The minority in *Nicklinson* also challenged the proportionality of an absolute prohibition. For Lady Hale, the ban violates Art 8 ECHR insofar as: "it does not provide for any exception for people who have made a capacitous, free and fully informed decision to commit suicide but require help to do so."[210]

Conversely, the *Nicklinson* majority accepted speculative scenarios of vulnerable people pressurised into choosing death and noted the absence of an alternative before the court, concluding that the ban struck a fair balance. For the Court of Appeal in *Conway*, where a specific scheme was available, proportionality was satisfied by the theoretic impossibility of removing all risks: "an element of risk will inevitably remain in assessing whether an applicant has met the criteria".[211] The court invoked "the potential for indirect coercion or undue influence"; in particular, it adduced that: [a] sense of being a burden may be projected subconsciously and then expressed … as a genuinely felt belief".[212] Since risks remained a factor in examining proportionality, the court deferred the entire assessment to the legislator:

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[205] On blanket bans in Strasbourg case-law see Draghici, op cit fn 185 at pp 292-293.

[206] [1993] 3 SCR 519 at p621.

[207] Smith (2017) 'Ethical commentary – *Nicklinson* and the ethics of the legal system' p223 in Smith et al (eds), op cit fn 121.

[208] See Arras (1997) 'Physician-assisted suicide: A tragic view' *Journal of Contemporary Health Law and Policy* 361 at pp 368-373. On 'slippery slope' arguments see also Lewis, op cit fn 168 at pp 159-187.

[209] Schafer, op cit fn 124 at p525.

[210] [2015] AC 657 at [321].

[211] [2018] EWCA Civ 1431 at [171].

[212] Ibid at [160].

[10 normal] [171] [T]he weight to be given to that risk, in deciding whether or not the blanket ban on assisted suicide is both necessary and proportionate, involves an evaluative judgement and a policy decision, which ... Parliament is ... better placed than the court to make.

There was no discussion of the consistency of the law, and how the ban protects terminally ill or severely disabled patients who, ridden with subconscious guilt or subjected to undue influence, retain the capacity to disconnect a breathing tube or travel to Dignitas. The court further voiced concerns over medical complications potentially arising from assisted dying,[213] without considering premature or botched suicide attempts prompted by the lack of professional assistance, causing injury or a more painful death.

The Court of Appeal also over-emphasised the six-months eligibility criterion and the impossibility of accurate predictions.[214] This focus on a precise diagnosis stands in contrast with the fluid language of s.241.2(2)(d) of the Canadian Criminal Code, requiring that the patient's "natural death has become reasonably foreseeable". Addressing a difference of medical opinion on a patient's eligibility in *A.B. v Canada*, the Ontario Court stressed that, according to its legislative history, s.241.2(2)(d) was deliberately flexible, to indicate that its purpose was not to require terminal illness, but rather: "to ensure that people who are on a trajectory toward death in a wide range of circumstances can choose a peaceful death instead of having to endure a long or painful one".[215]

The UK and Canadian courts' position varied radically on whether court authorisation is a reliable safeguard against mistake and abuse. *Conway* expressed strong doubts about the costs and effectiveness of judicial supervision.[216] It is worth noting that the Crown Prosecution Service reported only 138 assisted suicide cases between 1 April 2009 and 31 January 2018.[217] The trifling average number each year (even considering a possible increase if MAiD becomes available) does not support the objection that courts lack resources to assess MAiD requests.[218] Moreover, the lack of confidence in courts' expertise cannot be reconciled with their existing role in medical cases: "doctors – and sometimes judges – already have to assess the capacity of individuals to make life-and-death choices in the related context of a patient's wish to refuse treatment necessary to keep her or him alive".[219]

By contrast, in *Carter (No.2)* the Canadian Supreme Court characterised the regime of judicial authorisation of individual exemptions during the extended suspension of invalidity as "an effective safeguard against potential risks to vulnerable people".[220] The cases decided under *Carter (No.2)* confirmed courts' ability to assess consent. In *Re H.S.*, the first of such cases, the Court of Queen's Bench of Alberta reviewed testimony that the applicant had been inquiring into assisted-dying options for two years, had shown resolve to end her life peacefully in multiple discussions with medical professionals, family and friends, had received counselling regarding palliative care, and had been informed of risks associated with physician-assisted death.[221] Examining further petitions for

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[213] Ibid at [173].

[214] Ibid at [142].

[215] [2017] ONSC 3759 at [43], citing AG's speech in the House of Commons.

[216] [2018] EWCA Civ 1431 at [174], [183].

[217] See https://www.cps.gov.UK/publication/assisted-suicide.

[218] State funding is already required to appoint guardians *ad litem* for children or to represent incapacitated persons. The resources required to secure the rights of the narrow category of persons seeking MAiD should not hinder reform.

[219] Pedain (2002) 'Assisted suicide and personal autonomy' *Cambridge LJ* 511 at 513.

[220] [2016] SCC4 at [6].

permission to proceed with MAiD, provincial courts conducted similar inquiries and were satisfied without hesitation that the applicants met the *Carter* criteria.[222]

Significantly, when assessing proportionality in *Pretty,* the ECtHR accepted that the general prohibition on assisted suicide was mitigated by the "flexibility … provided for in individual cases by the fact that consent is needed from the DPP to bring a prosecution" and by "a system of enforcement and adjudication which allows due regard to be given in each particular case to the public interest in bringing a prosecution".[223] What the ECtHR had not considered, and became manifest in *Purdy*, was that the unpredictable exercise of DPP discretion deterred patients from requesting assistance and physicians/ carers from providing it. It also meant that assistance will usually involve relatives' help to travel abroad, which is costly and unavailable to patients without immediate family, like Martin in *Nicklinson*. The fact that few cases are prosecuted[224] is distinct from an anticipatory exemption, especially given the stakes: deprivation of liberty, criminal record, social stigma attached to committing a criminal offence. Lord Rees highlighted the impact on relatives offering assistance during parliamentary debates on the Assisted Dying Bill 2016-17: "Those acts may not result in prosecution, but a shadow of criminality hangs over them and adds to the grief of those whose motive is compassion."[225] While the ECtHR was satisfied that, overall, the regime was within the boundaries of the UK's margin of appreciation, domestic courts can take a stricter approach to Parliament's balancing act.

Proleptic immunity for assisters vs ex post facto prosecutorial assessment [B heading; 12 bold]

Rather alarmingly, the combination of legislative ban and prosecutorial toleration disadvantages the class of vulnerable individuals whom the ban should protect. The evidence before English courts showed that compassionate assistance in dying is rarely prosecuted, despite its criminalisation. As Lord Neuberger suggested in *Nicklinson*, the practice comes close to tolerating assisted dying.[226] In Canada, a similar trend was noted before the 2016 reform, resulting from prosecutorial and judicial discretion.[227]

This practice casts doubt on the proportionality of the interference with fundamental rights. As Adenitire argued, the expectation to immunity from prosecution, generated by the DPP's guidelines and consistent non-prosecution policy, shows that the blanket ban is not truly necessary.[228] There is also a troubling discrepancy between the law (criminalising all assistance) and the State's/ society's recognition that exceptional assistance is morally appropriate. In *Bland*, Hofmann LJ held that euthanasia: "is not an area in which any difference can be allowed to exist between what is legal and

[221] *Re H.S.* [2016] ABQB at [103]-[108].

[222] See fn 187 for references.

[223] [2002] 35 EHRR 1 at [76].

[224] The DPP prosecuted two out of 124 cases referred between 1 April 2009 and 25 April 2016 (one involving a vulnerable adult with mental health issues and no compassionate circumstances); see Adenitire (2016) 'A conscience-based human right to be "doctor death"' *Public Law* 613 at p627.

[225] *HLD* 6 March 2017 c. 1183.

[226] [2014] UKSC 38 at [111].

[227] Schafer, op cit fn 124 at p523.

[228] See Adenitire, op cit fn 224 at pp 625-629.

what is morally right".[229] The same stands true of assisted dying. The law should not collide with, but accommodate, the treatment of individual cases. Lord Sumption controversially suggested that: "the law should continue to criminalise assisted suicide, and … be broken from time to time";[230] this approach avoids finding a legal solution and perpetuates the separation between law and morality.

On a practical level, non-prosecution instead of anticipatory authorisation of assistance undermines the protection of the vulnerable. Lord Mance noted in *Nicklinson* that individuals are currently assisted despite the prohibition and without prior review.[231] The DPP's retrospective assessment of circumstances cannot adequately protect the vulnerable.[232] The scrutiny of planned assistance, under a regime of exceptional authorisations, would better serve the aim of the law: more evidence would be available, consent and undue influence could be more accurately ascertained, and improper assistance could be prevented. Moreover, for patients' and assisters' peace of mind, the *certainty* of prior authorisation is fundamentally different from the *likelihood* of subsequent condonation.

From an institutional perspective, Parliament is abdicating its mandate if, in difficult areas, it relegates to prosecutors the task of adjusting the inequities of the law. In *R (Kenward) v DPP*, rejecting the claim that the DPP's amended policy for prosecutors placed vulnerable individuals at risk, the High Court struggled to establish that the policy: "does not remove bright lines ... and no assistance or encouragement is rendered lawful", while admitting that the decision whether to prosecute: "will always involve a very detailed consideration of all the facts and, ultimately, a balanced judgement".[233] A bright-line rule and a composite judgment are mutually exclusive, and the statute should be amended to reflect the latter approach.

Moreover, since Parliament has set a blanket ban and compassionate assistance in dying is in practice decriminalised, a conflict emerges between primary legislation and prosecutorial policy, buttressed by the courts' ambivalence. Lewis has criticised the: "opaque process of informal legal change by prosecutors".[234] However, as Stark observed: "[i]f the DPP's prosecution policy becomes too specific it may constitute a (presumably illegitimate) usurpation of this clear legislative statement by carving out an area of assisted suicide that is, *de facto*, decriminalised".[235] From a constitutional standpoint, it is undesirable for courts to endorse a *contra legem* administrative policy as a corrective tool, instead of prompting Parliament to devise statutory exceptions, also more attuned with the certainty-of-law principle.

VI. The constitutional role of the judiciary in highly divisive ethical debates

[A heading; 14 bold]

British and Canadian assisted-dying rulings revealed similar concerns over how the legal system is structured to decide sensitive ethical matters: whether they are the exclusive realm of Parliament or

[229] [1993] AC 789 at p825.

[230] Bowcott (2019) 'Ex-supreme court justice defends those who break assisted dying law' *The Guardian* (17 April 2019) <https://www.theguardian.com/society/2019/apr/17/ex-supreme-court-jonathan-sumption-defends-break-assisted-dying-law>, citing Lord Sumption's BBC Reith Lectures speech.

[231] [2015] AC 657 at [186].

[232] See Reidy (2012) 'English law on assisted suicide: a dangerous position' *Medico-Legal Journal of Ireland* 68 at p74.

[233] *R (Kenward) v DPP* [2015] EWHC 3508 (Admin) at [53].

[234] Lewis (2011) 'The limits of autonomy: Law at the end of life in England and Wales' in Negri (ed) *Self-determination, dignity and end-of-life care. Regulating advance directives in international and comparative perspective* 221 at p247.

[235] See Stark, op cit fn 7 at p108.

the role falls on Parliament assisted by the courts. The different answers to this question might be explained in part by British courts' limited prerogatives under HRA 1998 when compared to the constitutionally entrenched strike-down power of Canadian courts under the Constitution Act 1982.[236] However, courts' function under s.4 HRA is not merely an advisory one; they are called upon to authoritatively assess the law's respect for human rights. Rather, the outcome of applications appears explained by judges' personal views of their mission and of the justiciability of the dispute. An interpretation of the margin of appreciation left to States under the ECHR as parliamentary discretion acts as an additional break on judicial review. This is compounded by the UK's strict adherence to precedent, by contrast with lower courts' ability to revisit the validity of laws according to Canadian jurisprudence.

Democratic law-making and judicial self-restraint [B heading: 12 bold]

British and Canadian courts view the role of the judiciary very differently in ethically divisive policy areas. In *Carter*, the Canadian Supreme Court showed no institutional self-doubt in assessing Charter-compatibility regardless of the subject-matter of the dispute. Conversely, many British judges deemed certain policy areas non-justiciable or considered that judicial intervention should be limited in deference to parliamentary sovereignty. Lord Bingham in *Pretty* suggested that the court was unable to make ethical and moral decisions, insofar as it was not a legislative body.[237] In *Nicklinson*, the court was extremely divided as regards its proper role. For several justices, the issue engaged an important determination on social policy and a moral judgment on the balance between competing rights, and the legislative process was best placed to resolve controversial and complex questions.[238] However, Lord Neuberger noted courts' historical engagement with moral choices:

[10 normal] [98] [T]he mere fact that there are moral issues involved plainly does not mean that the courts have to keep out. Even before the 1998 Act came into force, the courts were prepared to make decisions which developed the law and involved making moral choices of this type.

The idea that courts adjudicating HRA claims are not competent to entertain disputes involving questions of morality is unconvincing. Most cases occasioning s.4 declarations concerned morally sensitive issues: recognition of transsexuals' acquired gender, sham marriage and immigration control, posthumous fatherhood, detention without trial of foreign terrorist suspects, decriminalisation of certain consensual sexual behaviour.[239] Indeed, proceedings leading to s.4 declarations are unlikely to concern straightforward matters, which Parliament could have easily regulated without affecting human rights. Stark insisted that: "resolving such value conflicts is not the courts' constitutional role".[240] However, rights cannot be dissociated from values. The scope of a right depends on the boundaries between the competing values engaged, and courts are tasked to interpret rights. Insofar as this is a mandate given by Parliament, it does not contravene parliamentary sovereignty. Admittedly, morals-laden disputes can attract greater deference to Parliament when courts assess balancing acts, but the justiciability of the claim should not be questioned. As Coggon

[236] See Martin (2017) 'A human rights perspective of assisted suicide: Accounting for disparate jurisprudence' *Medical LR* 98 at p106.

[237] [2002] 1 AC 800 at [2].

[238] [2015] AC 657 at [228]-[232].

[239] See Draghici, op cit fn 185 at p295.

[240] Stark, op cit fn 7 at p106.

argued: "For a functioning, democratic system to operate, the last thing the courts must do is shirk their responsibilities simply because of moral controversy and ethical disagreement".[241]

However, British assisted-dying decisions disclose institutional unease with upholding challenges to legislative measures. Concerns were expressed in *Nicklinson* over institutional remits: "the legislative function is committed to Parliament and courts must not usurp it".[242] Although for five judges the court had the constitutional authority to declare the ban incompatible with Art 8, only two (Lady Hale and Lord Kerr) were prepared to do so; they reasoned that, when issuing a s.4 declaration, courts do precisely what the HRA empowered them to do, ie remit an issue to Parliament for a political decision.[243] While the limited reach of declarations of incompatibility might be expected to stimulate greater scrutiny of legislative action, the High Court in *T* justified self-restraint precisely by contrast with Canadian courts' powers: [244]

[10 normal] [19] The provisions of the [Charter] give the Canadian courts a central role, as, in effect, a constitutional court, interpreting a written constitution, with no question of any inhibition derived from the role of the Canadian legislature.

This analysis may unduly diminish the pivotal role of judicial protection of human rights under the UK's unwritten constitution and downplay the HRA mandate for British courts. In a country lacking a formal constitution, statutes "of constitutional importance", within the meaning of *Thoburn v Sunderland City Council*,[245] such as HRA 1998 should carry particular weight. The different legal effect of a finding of incompatibility as opposed to a judgment of invalidation already absorbs any distinction between the UK Supreme Court and a constitutional court; a further self-imposed restriction *ratione materiae* on judicial oversight would constitute a double ceiling on courts' democratic control.

Given the history of consistent parliamentary accommodation of declarations of incompatibility,[246] some judges might view s.4 as more powerful in practice than under the statute,[247] almost tantamount to legislative decisions made by an institution lacking democratic credentials. This position, however, would entail that, when enacting HRA 1998, Parliament intended for courts to use s.4 powers only for uncontroversial issues, requiring marginal changes. By removing the most critical issues from the scope of judicial supervision and diminishing human-rights protection, such an interpretation would go against the purpose of the statute. Nor is there any unwritten constitutional rule that all s.4

[241] Coggon, op cit fn 121 at p210.

[242] [2015] AC 657 at [259].

[243] Ibid at [325], [343]-[344]. Under s.4(6)(a) HRA, a declaration "does not affect the validity, continuing operation or enforcement of the provision".

[244] [2018] EWHC 2615 (Admin).

[245] *Thoburn v Sunderland City Council* [2002] EWHC 195 (Admin).

[246] See *Responding to human rights judgments. Report to the Joint Committee on Human Rights on the Government's response to human rights judgments 2018–2019* (October 2019), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/842553/responding-human-rights-judgments-2019.pdf; see Stark (2017) 'Facing facts: Judicial approaches to section 4 of the Human Rights Act 1998' *LQR* 631 at p649, noting that all but one breaches signalled by s.4 declarations were remedied.

[247] See King (2015) 'Parliament's role following declarations of incompatibility under the Human Rights Act' pp 165-192 in Hooper et al (eds) *Parliaments and human rights: Redressing the democratic deficit*, suggesting that other government branches apparently feel obligated to act upon s.4 declarations.

declarations must be followed, as shown by the failure to address prisoners' right to vote following *Smith v Scott*[248] (admittedly, not a Supreme Court decision and one lacking popular support).[249]

Another qualification on the use of s.4 added by the case-law is that courts should refrain from issuing a declaration on matters before Parliament. In *Nicklinson*, three justices found that SA 1961 might breach HRA provisions, but it would be inappropriate for the court to assess compliance before giving Parliament an opportunity to reconsider its position.[250] *Conway* confirmed this *a contrario*; the High Court held that, since Parliament was not actively considering the law at the time of the proceedings, nothing precluded it from revisiting the matter.[251] Not only does s.4 not require courts to abstain from issuing a declaration on matters pending in Parliament, but that seems, conversely, an auspicious time for courts to contribute their legally trained views. One purpose of s.4 is, in fact, to invite the legislature to re-examine a statute with the benefit of the highest courts' professional opinion.

The refusal in *Nicklinson* to issue a s.4 declaration due to the contemporaneous parliamentary debate was an unfortunate departure from *Bellinger*, [252] where the court took the opposite view on the dialogue between courts and Parliament on HRA-incompatibility issues:

[10 normal] [55] [W]hen proceedings are already before the House, it is desirable that in a case of such sensitivity this House, as the court of final appeal in this country, should formally record that the present state of statute law is incompatible with the Convention.

Crawford noted that, in several cases in which s.4 declarations were issued: "the process of amending the impugned legislation was well underway, or indeed completed, by the time the court made the declaration of incompatibility".[253]

An equally questionable requirement read into s.4 HRA by the *Nicklinson* majority is that courts must have a viable legislative alternative in order to issue a declaration of incompatibility. This requirement is nowhere in the statute, and for courts to choose the 'correct' alternative would actually be out of step with the separation-of-powers principle.[254] The dissenters in *Nicklinson*, who saw their remit as deciding if the law breached fundamental rights and demanded rethinking, criticised the majority's demand for a ready-made replacement. Regrettably, the Supreme Court majority's approach in *Nicklinson* was magnified by the Court of Appeal, for whom the court's role in *Conway* was to assess the litigant's legislative proposal rather than the impugned law: "the court is restricted to considering the suitability of the precise scheme proposed by Mr Conway".[255] *Conway* thus consolidated the view that, under the HRA, courts must decide not only if the *status quo* breaches any rights, but also – as a prerequisite for that conclusion – how the breach should be remedied.

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[248] *Smith v Scott* [2007] S.C. 345.

[249] See Crawford (2013) 'Dialogue and declarations of incompatibility under section 4 of the Human Rights Act 1998' *The Denning LJ* 43 at pp 76-77.

[250] [2015] AC 657 at [116].

[251] [2018] EWCA Civ 1431 at [9].

[252] [2003] 2 AC 467.

[253] Crawford, op cit fn 249, citing *Re an Application for Judicial Review by McR* [2002] NIQB 58, *Blood and Tarbuck v Secretary of State for Health* (High Court, 28 February 2003, unreported), *Bellinger v Bellinger* [2003] UKHL 21, *R (M) v Secretary of State for Health* [2003] EWHC 1094 (Admin), *R (Wilkinson) v Inland Revenue Commissioners* [2005] UKHL 30, *R (Wright) v Secretary of State for Health* [2009] UKHL 3.

[254] See Martin, op cit fn 198 at p217.

[255] [2018] EWCA Civ 1431 at [187].

The Court of Appeal also justified self-restraint by stressing courts' limited ability to gauge social support for reform: "Unlike Parliament, … the court cannot conduct consultations with the public … and cannot engage experts and advisers on its own account".[256] Since the s.4 declaration would remit the issue for consideration to Parliament, the latter can launch public consultations before any legal change is effected. Additionally, nothing precludes courts from considering the evidence of societal support for reform publicly available. Indeed, various surveys indicate substantial popular support for MAiD in the UK.[257]

Importantly, s.4 declarations are agenda-setting. So far, most attempts at reform have failed due to lack of parliamentary time, bills failing to progress after the formality of the first-reading stage, which does not involve debate.[258] A s.4 declaration would place the issue firmly on the British Parliament's agenda. It would be erroneous to infer from the lack of success of parliamentary attempts to date[259] that the matter has been adequately considered and the prevailing view is that the blanket ban is preferable to a nuanced solution. In the Canadian Parliament, sixteen legislative attempts at changing assisted-dying policy took place before *Carter*, none of which government bills.[260] It was the Supreme Court's ruling that finally galvanised legislative efforts.

Hogg and Bushell argued, addressing claims that judicial review under the Canadian Charter is undemocratic, that a Charter decision: "causes a public debate in which *Charter* values play a more prominent role";[261] it forces Parliament to examine a topic, but this 'dialogue' between institutions: "culminates in a democratic decision".[262] Their sequel article clarified: "since the last word can nearly always be (and usually is) that of the legislature, the anti-majoritarian objection to judicial review is not particularly strong".[263] The same holds true (even more so) of the relationship between courts and legislature under the HRA scheme.

Some hesitation as to courts' proper role was also seen in the earlier right-to-die Canadian case-law. In *Rodriguez*, while the majority did not feel precluded from examining Charter-compatibility by the moral complexities of the case, it was overly deferential in its examination of proportionality.[264] That position was abandoned in *Carter*, which adopted a more stringent standard of review. Many saw the

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[256] Ibid at [189]. This appears inconsistent with the finding in [204]: "it is impossible to say that the Divisional Court did not have material on which properly to come to their conclusions on the inadequacy of the proposed scheme to protect the weak and the vulnerable…".

[257] See Bowcott 'Legalise assisted dying for terminally ill, say 90% of people in UK' *The Guardian* (3 March 2019), citing a National Centre for Social Research survey https://www.theguardian.com/society/2019/mar/03/legalise-assisted-dying-for-terminally-ill-say-90-per-cent-of-people-in-uk; Davis and Finlay, op cit fn 51, citing Populus' Dignity in Dying poll (March 2015), www.populus.co.uk/wp-content/uploads/Dignity-in-Dying-Poll-March-2015-WEBSITE-DATATABLES.pdf; Dyer (2013) 'Assisted suicide for the dying would reduce suffering, says Falconer' *British Medical Journal* vol. 346 at p5.

[258] Parliament was prorogued after the first reading of Assisted Dying Bills [HL] 2013-14, 2015-16 and 2016-17, and for the 2014-15 bill, after the committee stage. The Assisted Dying (No.2) Bill 2015-16 did not pass the second reading.

[259] On post-*Nicklinson* bills see Martin, op cit fn 236 at p101.

[260] See Snow and Puddister (2018) 'Closing a door but opening a policy window: Legislating assisted dying in Canada' pp 44-45 in Macfarlane, op cit fn 87. On attempts to pass legislation decriminalising MAiD see also O'Reilly and Hogeboom, op cit fn 101 at p701.

[261] Hogg and Bushell (1997) 'The Charter dialogue between courts and legislatures (or Perhaps the Charter of Rights isn't such a bad thing after all)' *Osgoode Hall LJ* 75 at p79.

[262] Ibid at p80.

[263] Hogg et al (2007) 'Charter dialogue revisited – or "much ado about metaphors"' *Osgoode Hall LJ* 1 at p54.

[264] [1993] 3 SCR 519 at pp 614-615.

ruling as a legitimate exercise of a function conferred by the Constitution. In fact: "the *Charter* enables Supreme Court justices to push forward policy through rights-based litigation".[265] Others viewed *Carter* as an expression of judicial activism, with reference, in particular, to the detailed remedy provided. Newman lamented the court's "over-specificity in itself crafting a regime within its declaration that … constrains parliamentary choices".[266] It is difficult to see, however, how the judgment could have defined the scope of the breach without identifying those unlawfully caught by the ban: competent adults suffering from a grievous medical condition with no acceptable treatment available and having reached an informed decision to end their lives.

Opinions also differed on the practicality of the remedy in *Carter*. For Surtees, the court: "wisely provided Canadians with a default regulator in the event that our elected representatives choose not to act".[267] Conversely, Ettel criticised *Carter* for the unclear remedy, should Parliament not respond to the declaration.[268] The limited usefulness of declarations of incompatibility for individual applicants might be an inevitable consequence of the court's strike-down, as opposed to legislative, powers and the system's reliance on inter-institutional cooperation. Even so, *Carter (No.2)*, by offering interim constitutional exemptions, better reconciled the separation of powers with practical remedies to applicants (and others in their position). This solution was, however, not exempted from criticism. Rahimi described it as: "a vivid example of the judiciary usurping the legislative role of Parliament by implementing a de facto regulatory system overseeing [MAiD]".[269]

The *Lamb* case presented the Supreme Court with an opportunity to relax its control over the MAiD regime by upholding Parliament's scheme notwithstanding its contrast with the more liberal *Carter* criteria. According to Rahimi: "Endorsing Bill C-14 as constitutional would allow the courts to reverse the prescriptive judgment in *Carter*, which was arguably an overreach by the SCC".[270] With the *Lamb* case adjourned, and the finding of invalidity in *Truchon* unchallenged, the Supreme Court no longer has to choose between full rights protection and democratic concessions to Parliament.

Canada's recent experience – courts' willingness to tackle sensitive policy choices and Parliament's response to findings of invalidity – suggests that a dynamic legislative process relies on inter-institutional prompts and checks. Meanwhile, British courts seem to be moving towards a complete referral to Parliament on assisted-dying regulation, rather than co-shaping this area of law.

Charter 'dialogue' and the suspension of declarations of invalidity [B heading: 12 bold]

The suspension of the declaration of invalidity in *Carter* was met with doctrinal criticism, given the historical rationale for suspensions as emergency tools,[271] and practical objections, since it imposed

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[265] Ma (2016) 'A critical assessment of Supreme Court judicial reasoning: The constitutionality of health care policies in Canada' *Journal of Parliamentary and Political Law* 397 at p408.

[266] Newman (2015) 'Judicial method and three gaps in the Supreme Court of Canada's assisted suicide judgment in Carter' *Saskatchewan LR* 217 at p223.

[267] Surtees (2015) 'The authorizing of physician-assisted death in Carter v. Canada (Attorney General)' *Saskatchewan LR* 225 at p231.

[268] See Ettel (2018) '"To the extent of the inconsistency:" Charter remedies and the constitutional dialogue' *National J Const L* 279.

[269] Rahimi, op cit fn 90 at p484.

[270] Ibid.

[271] See Burningham (2015) 'A comment on the Court's decision to suspend the declaration of invalidity in Carter v. Canada' *Saskatchewan LR* 201 at pp 201-204.

an additional year of suffering on individuals whose rights *Carter* found violated and who meanwhile could lose capacity to consent.[272] Burningham noted that, unlike the power to strike down legislation, grounded in s.52 of the Constitution Act 1982, the suspension of declarations of invalidity is a judicial creation, designed to prevent intolerable situations,[273] whereas ordering the immediate invalidity of s.241(b) would not have generated either legal chaos or danger to the public (as per *Schachter v Canada*).[274] The text of s.52 indeed suggests that a finding of unconstitutionality attracts the immediate nullity of the offending law,[275] the declaration merely acknowledging that it was void *ab initio*. However, it is not far-fetched to argue that danger to the public existed: without careful regulation, vulnerable individuals could have resorted to MAiD in unwarranted cases. For that very reason, *Carter (No.2)* temporarily replaced regulation with judicial scrutiny in provincial courts.

Hogg et al have defended the practice of suspensions of declarations of invalidity based on a different rationale in Charter jurisprudence after *Schachter*: inter-institutional dialogue, a theory recognising that Parliament is better placed to design corrective laws and select from several alternatives.[276] However, given the urgency for those deprived of constitutional rights and the potentially irreversible damage, a better compromise, halfway between exceptionalism and dialogue, might have been a suspension of invalidity accompanied by individual constitutional exemptions, similar to the regime introduced after the original 12-month suspension. Ultimately, the decision in *Carter (No.2)* to suspend the invalidity and grant individual exemptions as an interim emergency measure also shows adherence to the 'dialogue' doctrine, observing the different remits of Parliament and courts.[277]

'Margin of appreciation' under the ECHR and s.4 HRA declarations [B heading: 12 bold]

In *Pretty*, the ECtHR found the British assisted-dying regime consistent with Art 8(2), and subsequent judgments did not alter ECHR standards. According to *Haas v Switzerland*, the minimum common denominator in Europe on the scope of privacy did not encompass a right to receive assistance in dying, and a wide margin of appreciation continued to apply to end-of-life issues; European States: "are far from having reached a consensus with regard to an individual's right to decide how and when his or her life should end".[278] A wide margin was confirmed in *Koch v Germany*.[279] As evidenced by *Lambert v France*, authorising withdrawal of artificial life-sustaining treatment is a legitimate exercise of State discretion.[280]

Simplistically, it might be thought that, if the right to assisted dying under the ECHR has been declined in Strasbourg proceedings, a different conclusion by UK courts is unwarranted. This would overlook, however, the margin left to States to reassess the boundaries of Art 8 in *non liquet* cases,

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[272] Ibid at p206.

[273] *Re Manitoba Language Rights* [1985] 1 SCR 721.

[274] *Schachter v Canada* [1992] 2 SCR 679. See Burningham, op cit fn 271.

[275] See s.52 Constitution Act: "[A]ny law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect".

[276] Hogg et al, op cit fn 263, at pp 14-18.

[277] See Burningham, op cit fn 271 at p203.

[278] *Haas v Switzerland* (2011) 53 EHRR 33 at [55]. *Pretty v UK* (and subsequent case-law) reflected the ECtHR's cautiousness not to alienate States by restricting discretion in areas where domestic policies vary; see Merkouris, op cit fn 16 at p125.

[279] *Koch v Germany* (2013) 56 EHRR 6 at [70].

[280] (2016) 62 EHRR 2.

where the court does not take a stand, accepting both the impugned law and its opposite as ECHR-compatible.[281] The ECHR is the minimum European common standard, and domestic authorities can afford greater protection.[282] British courts have accepted that "Convention rights" under the HRA may go beyond the level required for international compliance with the ECHR. In *Fitzpatrick*, the House of Lords recognised that committed same-sex partners constituted "family life" under Art 8[283] before the ECtHR did so in *Schalk and Kopf v Austria*.[284] The finding in *Ghaidan v Godin-Mendoza* that s.3 HRA required housing legislation to be read as assimilating same-sex cohabitants to couples living as spouses for the purposes of succession to tenancies[285] did not imply that all ECHR parties had that obligation.

The House of Lords confirmed the possibility of a distinct claim of HRA-incompatibility even where there is no ECHR breach in *Re G (Adoption: Unmarried Couple)*.[286] The dual scope of ECHR rights in international and domestic perspective was upheld by the ECtHR in *Oliari v Italy*: legal recognition for same-sex couples in Italy was a constitutional entitlement enforceable in ECHR proceedings, even if no such pan-European right existed.[287] In *Conway*, the High Court recalled that: "the interpretation of the domestic version of the Convention rights in the HRA does not simply mirror the Convention rights in the ECHR".[288] Consequently, a declaration of incompatibility does not always signal a breach of international obligations; it may regard an inconsistency with a Convention right as understood domestically. The s.4 declaration in *Z (A Child) (No.2)*, concerning single persons' ineligibility for parental orders following surrogacy arrangements,[289] was not based on ECHR regulatory standards, surrogacy remaining an area of wide State discretion.[290]

Moreover, a s.4 declaration based on Art 8 taken in conjunction with Art 14 (and many claimants in right-to-die cases invoked their right to non-discrimination) can also be granted in respect of purely domestic rights linked with ECHR rights.[291] The Supreme Court accepted this in *Steinfeld*, issuing a s.4 declaration in relation to the bar in s.3 Civil Partnerships Act 2004, which excluded heterosexual couples, although there was no ECHR right to form such partnerships.[292]

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[281] See eg *Evans v UK* [2007] 1 FLR 1990 (destruction of embryos created with gametes from a partner withdrawing consent to implantation), *S.H. v Austria* [2012] 2 FCR 291 (heterologous fertilisation); both rulings found the respondents' legislative solution within their margin of appreciation, but also deemed the applicants' proposed solutions consistent with the Convention.

[282] See Draghici (2014) 'The Human Rights Act in the shadow of the European Convention: are copyist's errors allowed?' *European Human Rights LR* 154 pp 167-168.

[283] See *Fitzpatrick v Sterling Housing Association Ltd* [2001] 1 AC 27 at [80].

[284] *Schalk and Kopf v Austria* 29 BHRC 396.

[285] *Ghaidan v Godin - Mendoza* [2004] UKHL 30.

[286] *Re G (Adoption: Unmarried Couple)* [2008] 3 WRL 76.

[287] *Oliari v Italy* [2015] ECHR 716. See Draghici (2017) 'The Strasbourg Court between European and Local Consensus: Anti-Democratic or Guardian of Democratic Process?' *Public Law* 11.

[288] [2017] EWHC 2447 (Admin) at [45].

[289] *Z (A Child) (No.2)* [2016] EWHC 1191 (Fam).

[290] See Draghici, op cit fn 196 at pp 146-149.

[291] See Draghici (2017) 'Equal marriage, unequal civil partnership: a bizarre case of discrimination in Europe' *Child and Family LQ* 313 at pp 313-319.

[292] See *R (Steinfeld & Another) v Secretary of State for International Development* [2018] UKSC 32.

The potential HRA-incompatibility of s.2(1) SA, notwithstanding the finding in *Pretty v UK* that it did not breach ECHR obligations, was recognised in *Nicklinson* and emphasised by the High Court in *T*. The latter judgment expressly indicated that the case was adjudicated only under the HRA, insofar as Strasbourg authorities allowed for a wide margin of appreciation in end-of-life matters.[293] Nonetheless, judicial views varied on whether all government branches contribute to the domestic balancing act within that margin. According to Lord Mance in *Nicklinson*, this is a shared responsibility:

[10 normal] [163] Where a "considerable" margin of appreciation exists at the international level, both the legislature and the judiciary have a potential role in assessing whether the law is at the domestic level compatible with such rights.

By contrast, for Lord Hughes, the discretion left by the ECtHR must be exercised by Parliament as a matter of constitutional law:

[10 normal] [267] It is true that Strasbourg thus regards the question as one to be resolved by individual States within their margin of appreciation. But in this country, with our constitutional division of responsibility between Parliament and the courts, this is very clearly a decision which falls to be made by Parliament.

Newby suggested even more bluntly that courts should not reverse parliamentary decisions: "courts are not the venue for arguments which have failed to convince Parliament".[294] This counter-majoritarian remark instils concerns as to when HRA challenges to primary legislation could ever succeed.

Precedence and legal change in lower courts [B heading; 12 bold]

Assisted-dying claims, challenging established norms, raised the question of whether the impetus for reform can start in the lower courts, given the *stare decisis* principle presumptively applicable in both Canada and the UK. As Loveland notes in his chapter in this book, Canada's lower courts "played fast and loose"[295] with this principle in respect of Canadian libel law. Provincial courts produced judgments prima facie irreconcilable with supposedly binding Supreme Court authority. The effect was not to trigger a normative crisis in the Constitution's judicial hierarchy but to prompt the Supreme Court significantly to alter its own views.[296]

A similar trend is evident in assisted-dying cases. In *Carter*, the Supreme Court restored the trial judge's decision that the prohibition against MAiD infringed s.7 rights of competent adults suffering intolerably due to a grievous and irremediable medical condition and was not justified under s.1 of the Charter. That decision had been reversed on appeal, on the ground that the trial judge was bound by the Supreme Court's *Rodriguez* judgment, upholding the blanket ban.[297] The Supreme Court accepted that trial courts can reconsider settled rulings of higher courts where a new legal issue is raised or where there is a "change in the circumstances or the evidence" that "fundamentally shifts the parameters of the debate"; it found that both conditions were met in *Carter*: the legal conception

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[293] [2018] EWHC 2615 (Admin) at [3].

[294] [2019] EWHC 3118 (Admin) at [40].

[295] P --- below.

[296] See especially pp ---- below.

[297] [1993] 3 SCR 519.

of s.7 had advanced since *Rodriguez* (the law on overbreadth and gross disproportionality) and the legislative and social facts differed from the evidence before that court.[298]

The language of *Carter* on the rule of precedence is broad. It suggests that lower courts have significant discretion in ascertaining fundamental changes in legal culture, social opinion or medical evidence and disregarding precedent. This flexible view of precedence means that legal progress is not reined in by judicial hierarchy, and a case need not reach the Supreme Court if substantial changes in circumstances require a change in the law. However, this approach has not been universally welcomed. According to Newman, this departure from the rule against anticipatory overruling is unexplained and shows a "striking disdain for precedent".[299] One could argue that, in respect of new rights claimed under the Charter, a relaxation of *stare decisis* is desirable given the parties' inequality of arms; the respondent public authority will always have the resources to take the case to the final stage, whereas the financial burden on individual litigants means that the Supreme Court may never hear the case and have an opportunity to revisit its position.

In contrast with these developments in Canada, British courts have consistently supported a strict view of precedence. In *Conway*, the High Court found that it was not bound by *Nicklinson* only because of its peculiar context: an assisted-dying bill was before Parliament, which prompted the majority to defer the assessment of HRA-compatibility.[300] The Court of Appeal drew two further distinctions: *Nicklinson* regarded patients in long-term suffering rather than terminally-ill patients within six months of death, and the appellant had put forward a specific legislative model that could replace the blanket prohibition.[301] The High Court in *Newby* found itself bound by the Court of Appeal decision in *Conway* even in the presence of a new claim under Art 2 ECHR.[302] Absent special circumstances, lower courts appear unwilling to provide a fresh reappraisal of arguments based on new evidence, intervening experience in other jurisdictions, or changes in social opinion.

Parliaments' ambivalent view of courts as constitutional interpreters

Mullock suggested that, despite the dismissal of the *Nicklinson* appeal, the judgment "has almost had as much impact as a verdict in favour of Nicklinson, Lamb and Martin",[303] and that the warning that a s.4 declaration might be issued in the future had the same influence as an actual declaration.[304] This proved to be overoptimistic. Ironically, the refusal of British judges to issue a s.4 declaration was a hindrance to parliamentary debates. Martin noted the confusion that *Nicklinson* generated as to what is expected of Parliament during the House of Commons' consideration of the 2015 bill; this included the interpretation by MPs that the law did not need changing, insofar as only two judges found it incompatible with the ECHR, or that Parliament acted within the margin of appreciation.[305] Given

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[298] [2015] 1 SCR 331 at [44]-[47].

[299] Newman, op cit fn 266 at p218. For further criticism of *Carter*'s impact on precedence see Bateman – LeBlanc (2018) 'Dialogue on death: Parliament and the courts on medically-assisted dying' p387 in Ross, op cit fn 85.

[300] [2017] EWHC 2447 (Admin) at [84].

[301] [2018] EWCA Civ 1431 at [134].

[302] [2019] EWHC 3118 (Admin) at [48]-[49].

[303] Mullock, op cit fn 175 at p18.

[304] Ibid at p24.

[305] Martin, op cit fn 198 at pp 216-217.

courts' s.4 power to alert Parliament to legislative solutions falling short of HRA standards, any *obiter* comments on the desirability of reviewing the law, without a formal finding of incompatibility, are likely to remain inconsequential. Declarations of incompatibility have been consistently followed by compliant legislative responses and the continuation of the ban cannot be seen as parliamentary defiance of the courts. Rather, courts have chosen not to place any constraints on Parliament as regards assisted-death legislation, notwithstanding their constitutional mandate under the HRA.

The unhelpfully ambiguous position of the UK Supreme Court in its dialogue with Parliament and Parliament's marginal focus on assisted-dying proposals contrast with the clear message sent by the Canadian judiciary in *Carter* and its legislative aftermath. As Stewart noted, while s.241.2 was a departure from *Carter*, overall the legislative response followed the judgment.[306] Bill C-14 confirmed the validity of the 'dialogue' thesis, showing that Parliament preserves its place in fine-tuning the law after the entrenchment of the Charter. Conversely, for Macfarlane, despite the significant policy change effected, the new law was a surprising departure from the tendency of legislatures to follow courts' guidance on constitutionally permissible action.[307] Given the restriction to terminally ill patients, Nicolaides and Hennigar went so far as to conclude that Parliament's response denied judicial supremacy over constitutional interpretation;[308] it "directly reject[ed] the Court's interpretation of what the rights set out in section 7 require regarding MAID eligibility".[309] These authors view the new law as an expression of "coordinate construction", a theory according to which neither branch of government holds the monopoly on constitutional interpretation and legislative responses to judgements can redefine the scope of rights.[310] There seems to be, however, scholarly disagreement on whether 'dialogue' includes legislative attempts to modify a judicial invalidation or solely responses consistent with the judgments.[311]

The explanation for the departure of Bill C-14 from a unanimous judgment apparently lies in political considerations. According to Snow and Puddister, the adoption of a narrow eligibility scheme was the result of mixed responses from polls gauging MAiD support; consequently, "the popular Trudeau government seemed averse to spending political capital on this controversial area".[312] *Truchon* was an important test case for the framework of constitutional interpretation in Canada.[313] Since the executive did not appeal the Quebec judge's decision that "reasonably foreseeable death" is an unlawful requirement, the Supreme Court's interpretation of s.7 rights will be restored. The federal government's choice to amend legislation following *Truchon* without waiting for a 'second look' case in the Supreme Court treats the latter as the final arbiter in matters of Charter interpretation.

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[306] Stewart, op cit fn 85 at pp 457-458.

[307] Macfarlane (2018) 'Conclusion: Policy influence and its limits – Assessing the power of courts and the Constitution' p397 in Macfarlane, op cit fn 97. See also Macfarlane (2013) 'Dialogue or compliance? Measuring legislatures' policy responses to court rulings on rights' *International PolScR* 39.

[308] Nicolaides and Hennigar, op cit fn 87 at p326.

[309] Ibid at p327.

[310] Ibid at p313. See also pp 314-317 on theories about the relationship between Parliament and judiciary in respect of Charter interpretation.

[311] See Macfarlane (2017-18) 'Dialogue, remedies, and positive rights: *Carter v Canada* as a microcosm for past and future issues under the *Charter of Rights and Freedoms*' *Ottawa LR* 107 at p127.

[312] Snow and Puddister, op cit fn 260 at p53.

[313] See section II.

VII. Conclusion [A heading: 14 bold]

This chapter has argued that the exceptional availability of physician-assisted dying in Canada after the intervention of the Supreme Court strikes a fairer balance between different interests than the absolute British ban. A number of commonalities have been nonetheless identified in these jurisdictions. Having established that the prohibition on assistance interferes with fundamental rights, and that subjective sanctity-of-life ideologies are unsatisfactory justifications, both countries' Supreme Courts have accepted that protecting the vulnerable constitutes a legitimate aim. Their conclusions mainly differed as regards the need for a blanket ban and the confidence in a scheme authorising assistance in limited circumstances. In the British debate, 'slippery slope' arguments drawing on fear of abusive or erroneous application of the law have so far prevailed. Conversely, the Canadian legal reform has permitted autonomous responses to catastrophic illness, subject to case-by-case medical assessment. It has been suggested here that a permissive MAiD regime including safeguards against abuse avoids the injustice of a bright-line rule that chooses between, as opposed to reconciling, competing rights.

In the UK, the encroachment upon self-determination rights in the name of speculative threats to others remains a disproportionate response to vulnerability issues, despite the DPP's policy of non-prosecution of compassionate assistance. Rather, the incongruence between legislative bar and administrative toleration compromises the moral justification for the restriction and raises rule-of-law concerns. Nor could the blanket ban be successfully mitigated, as Huxtable suggested, by greater clarity on the factors used in prosecution or a specific statutory defence.[314] The DPP guidelines cannot be so prescriptive as to contradict the statute by reading an exemption into it; as Coggon noted, it would be improper for the DPP to legislate.[315] Parliament's intervention is essential to ensure a legitimate assisted-dying regime, and a statutory exception based on *ex ante* judicial dispensation or medical authorisation is preferable to a legal defence.

In fact, any *ex post facto* assessment of criminal liability offers less protection to the vulnerable than an exception allowing prior examination of the case, as less evidence is available to verify consent and medical circumstances. The prospect of criminal proceedings also deters patients and potential assisters, especially medical professionals, unlikely to risk prosecution for patients unrelated to them. Reliance on family members typically limits assisted-dying options to travelling abroad to permissive jurisdictions, and the high cost of travel and other arrangements raises equality issues.[316] In cases of extreme disability, for those unwilling or unable to summon assistance, the choice is between indefinite suffering and self-starvation as sole independent recourse. The law also prompts those approaching a stage where they would lose their independence to take their lives prematurely, often through a violent method. Several rights are compromised as a result: privacy, protection against inhuman treatment, right to life, non-discrimination.

A regulatory framework for assistance in dying would remove the inconsistencies within medical law, which subordinates provision of life-saving treatment to patients' consent and refers disputes on withdrawal of life support for children and incompetent adults to courts, guided by medical opinion. If sanctity-of-life and vulnerability considerations do not require the protection of competent adults against irrational refusal of life-preserving treatment or investigating whether such refusal was the product of undue influence, they should not be invoked to deny patients the choice to end intractable suffering and avoid a distressing death. The current ban affects severely disabled and/or impecunious

[314] Huxtable (2017) 'Judgment 1 – *R (on the Application of Nicklinson and Another) v Ministry of Justice* [2014] UKSC 38' p206 in Smith at al (eds), op cit fn 121.

[315] Coggon, op cit fn 121 at p213.

[316] See Mondal and Bhowmik (2018) 'Physician assisted suicide tourism – A future global business phenomenon' *The Business and Management Review* 35; Richards (2017) 'Assisted suicide as a remedy for suffering? The end-of-life preferences of British "suicide tourists"' *Medical Anthropology* 348.

patients who are not vulnerable, and hence not the intended target of the measure, whilst it fails to protect vulnerable individuals capable of travelling to Dignitas or ending their lives unaided, by disconnecting a life-support machine or otherwise. The interference with fundamental rights is therefore both ill-suited to meet its objective and overbroad.

Admittedly, removing the blanket ban presents difficulties over the justification of conditions and exclusions. Newman cautioned: "once one moves away from a bright-line rule, a law on assisted suicide becomes subject to continual questioning concerning the boundary temporarily established".[317] However, an unjust ban cannot be maintained solely to avoid addressing access issues and potential future challenges. The progressive fine-tuning of the law is inherent in the democratic process through which courts and Parliament update legislation, guided by social opinion and taking stock of experience.

It has also been submitted here that the Canadian Supreme Court's position in *Carter* better reflects the constitutional role of the judiciary in bringing about reform in sensitive policy areas. Democratic law-making relies on courts to place the cause of niche sections of the population on the legislative agenda and to advance human-rights protection in controversial, slow-changing aspects of the law. The comparative examination of assisted-dying laws in Canada and the UK reveals a profound problem of democracy when courts fail to act as a corrective to majoritarian deliberation or inertia-ridden legislatures.

[317] Newman, op cit fn 266 at p220.