Houses of Parliament

Joint Committee on Human Rights

Oral evidence: Human rights and assisted dying, HC 1195

Wednesday 24 May 2023

Watch the meeting

3 pm

Members present: Joanna Cherry MP (Chair); Lord Alton of Liverpool; Lord Dholakia; Lord Henley; Baroness Lawrence of Clarendon; Baroness Meyer; David Simmonds MP.

Questions 1 - 11

Witnesses

I: Paul Bowen KC, Barrister at Brick Court Chambers; Dr Stevie Martin, Lecturer in Public Law at the University of Cambridge; Professor Richard Ekins, Professor of Law and Constitutional Government at the University of Oxford; James Strachan KC, Barrister at 39 Essex Chambers.

Examination of witnesses

Paul Bowen KC, Dr Stevie Martin, Professor Richard Ekins and James Strachan KC.

Q1 **Chair:** Good afternoon, everyone, and welcome to today's meeting of the Joint Committee on Human Rights. We are a cross-party committee of Lords and Commons Members. Today, we are holding a one-off session on the topic of assisted dying from the human rights aspect. We hope that the evidence we take today, looking at the human rights framework on assisted dying, will feed into a broader inquiry being undertaken by the Health and Social Care Committee.

I am delighted that we are joined this afternoon by four witnesses with expertise in this area. First, we have Dr Stevie Martin, a college lecturer in law at the University of Cambridge. Her research examines the ways in which public law impacts on and can provide protections for vulnerable sections of society. In 2021 she published a book entitled *Assisted Suicide and the European Convention on Human Rights*.

We are joined online by Professor Richard Ekins, professor of law and constitutional government in the University of Oxford. Professor Ekins works on questions in constitutional law and practice and in legal and political philosophy. He leads the Policy Exchange's Judicial Power Project, for which he published articles looking into the subject of assisted dying in the United Kingdom.

Next, we have Paul Bowen KC, a deputy High Court judge at the Administrative Court and Family Division, and barrister at Brick Court Chambers. He practises across the spectrum of public and administrative law, often with significant human rights, EU or other international law elements. He appeared for the appellants in the cases of Purdy and Nicklinson involving the United Kingdom's current ban on assisted dying.

Last, but most certainly not least, is James Strachan KC, a barrister at 39 Essex Chambers. He has a practice in administrative and public law, human rights and privacy. He appeared for the Secretary of State for Justice in the cases of Newby and Conway involving the UK ban on assisted dying.

Good afternoon, and thank you all for joining us. I am going to kick off by asking Professor Ekins the first question. How can assisted dying be defined and what is the connection between assisted dying and the concept of euthanasia and assisted suicide?

Professor Richard Ekins: For my part, I think that the term "assisted dying" is unhelpfully imprecise and somewhat euphemistic, so it is a good thing that the question is being posed. The term obscures effectively what is going on, which is the killing of a person. It is not simply helping them to die, which may arise from other causes. I think it is more precise to speak of assisted suicide, which is obviously an offence under our law and in many other jurisdictions, and euthanasia, distinguishing between

voluntary and involuntary euthanasia. I can understand that the term is used as a blanket term to gesture towards all three, or both, depending on whether one distinguishes voluntary from involuntary euthanasia. It is helpful to speak more precisely, partly because it is possible that some people may hear "assisted dying" and think it means making people comfortable when they are dying by the provision of palliative care, which is clearly something very different from what we are discussing today.

Chair: Dr Martin, do you agree or disagree with that? Do you want to add anything?

Dr Stevie Martin: It can be unhelpful if one does not appreciate the nuance, but as an umbrella term it is quite a useful one, especially in legislation, particularly where legislation covers both euthanasia and assisted suicide. As Professor Ekins acknowledged, there are different forms of euthanasia, and what we typically deal with in the context of assisted dying is voluntary active euthanasia—that is, euthanasia conducted at the request of an individual, as opposed to passive euthanasia, which covers withdrawal or refusal of life-sustaining treatment. It has the risk of being vague, but in the profession, both legal and medical, most people appreciate that assisted dying covers physician-assisted suicide and voluntary active euthanasia.

Chair: Mr Strachan, can I bring you in on this question?

James Strachan: My view is that the terminology is important. The label "assisted dying" has been used in the courts. The Supreme Court in the Nicklinson case referred to the term "assisted dying". It has also been used to describe proposed Bills in Parliament—for example, the Assisted Dying Bill—but my understanding is that, generally speaking, when it is used in that way it refers to the concept of assisted suicide rather than euthanasia or the intentional act of killing, which would form the offence of murder under our common law. I agree it is important that everyone understands how the term is being used, but my understanding is that it is more commonly understood to apply to assisted suicide rather than euthanasia.

Chair: I should apologise. I think I pronounced your name wrongly. Forgive me.

James Strachan: I answer to both.

Chair: I am sure I am not the first one and I will not be the last, but do accept my apologies.

Mr Bowen, is there anything you would like to add on the issue of terminology? My initial question was: how do we define assisted dying, and what is the connection between assisted dying in the concepts of euthanasia and assisted suicide?

Paul Bowen: I think it is a useful shorthand to describe three different things. One is assisted suicide, where the individual takes the final step that ends their life; another is voluntary euthanasia, where a third party,

such as a physician, takes the final step; the third is the voluntary withdrawal of life-saving or life-sustaining treatment. In my view, all three of those fall within that umbrella. It is a useful shorthand, but it is very important to understand that they are three very different things with three very different legal outcomes.

Chair: Moving on to the question of legal outcomes and legal status, I hand over to Baroness Meyer.

Q2 **Baroness Meyer:** My name is Catherine Meyer and I want to ask you: what is the legal status of assisted dying in the UK?

Paul Bowen: Dealing with those three headings, we start with the voluntary withdrawal of life-sustaining treatment. That is entirely legal; indeed, individuals have a right to insist that life-saving treatment be withdrawn, if they are competent to make that decision.

Assisted suicide is a criminal offence contrary to Section 2(1) of the Suicide Act 1961. There are some circumstances in which the CPS will not prosecute an individual who assists another person in their suicide if it falls within one of the criteria in the CPS guidance which was introduced after the Purdy decision, in particular if it is established that the individual made a competent decision to end their own life and the individual who assisted them was acting out of compassion.

As for voluntary euthanasia, that constitutes the offence of murder. It is irrelevant whether the individual consented and whether the perpetrator was acting out of compassion, although both those factors would be relevant at the sentencing stage.

Dr Stevie Martin: Under the euthanasia umbrella, there are two different forms of euthanasia, as we discussed. There is voluntary active euthanasia and passive euthanasia, which is the withdrawal of treatment. We have withdrawal of treatment of people who are capacitous. That is driven by a person’s informed decision to cease treatment; to continue to provide it in the face of that would be a tort at the very least. We also have law that governs the withdrawal of treatment from incapacitous people—individuals who are unconscious and otherwise incapable of providing informed consent. That is also permitted. Recent decisions and case law from the UK Supreme Court make clear that there is no requirement to obtain consent from the courts before doing so, as long as there is agreement between family and doctors that continued treatment is no longer in a patient’s best interests. That form of withdrawal is also permissible, but governed by similar but distinct requirements and principles.

Baroness Meyer: For instance, people in a coma.

Dr Stevie Martin: Yes.

Baroness Meyer: Does it apply also for mental illnesses, or not?

Dr Stevie Martin: If they are incapacitous and continued life-sustaining treatment would no longer be in their best interests. However, there is obviously a clear distinction between a person who is receiving life-sustaining treatment and an individual who is mentally unwell and receiving treatment for that mental illness. There is quite a wealth of case law that governs treatment of individuals with mental illness. That is governed by the Mental Health Act and principles in that respect.

Professor Richard Ekins: I agree with much of the summary. It is true and important that assisted suicide is still a serious offence under our law. It is also true that prosecutors have a discretion as to whether to prosecute, as they do for all offences. Not many likely offences under that Act are prosecuted, but none the less it remains a serious offence. For my part, I think it is a mistake to discuss withdrawal of treatment as though it is similar in kind to what is otherwise murder and assisted suicide. Withdrawal of treatment does not involve, on the part of the physician's withdrawal of treatment, an intention to bring about death. If it did, it would constitute the offence of assisted suicide or murder.

To come back to your original question about how to delimit the frame or the scope of the term "assisted dying", withdrawal of treatment is categorically different, as the legal consequences thus far confirm in our law.

Lord Henley: Mr Bowen, you mentioned that compassion and consent were irrelevant in a charge of murder at that stage but might be relevant at the sentencing stage. However, at that stage there is, in the end, only one sentence that the court can impose if an individual is convicted of murder. Is that not right?

Paul Bowen: Yes, but the court has a power to decide the minimum term that a person should serve.

Lord Henley: But the sentence will still be for life.

Paul Bowen: The sentence is a life sentence but the minimum term might be a very short period indeed. If they are not considered to be dangerous, at the expiry of that minimum term they would be released.

Chair: They would be released on licence because they are still on a life sentence.

Paul Bowen: They would be on licence for the rest of their lives.

Dr Stevie Martin: When you look at the prosecution statistics, you see that there have been just over 180 referrals under Section 2. I believe that the CPS did not proceed in about 160 of those or the police withdrew. Of those that remained, there have been several prosecutions, in particular under Section 2, but others have been dealt with by way of common-law murder and other offences. I would also add on mercy and compassion that it may have relevance in defences. It is not uncommon to see diminished responsibility in cases of loved ones who have been

prosecuted for murder offences in the context of what might otherwise be deemed euthanasia.

Chair: Are you able to give us an indication of what the conviction rate is in the cases that are proceeded with?

Dr Stevie Martin: I have the data, but I think it is comparatively quite low for those that have been proceeded with. Four have been successfully prosecuted under Section 2 since the collection of statistics was commenced in the early 2000s. They were very different fact scenarios, so there was not a high rate of prosecution or conviction under Section 2.

Chair: These will all be cases that are heard by a jury.

Dr Stevie Martin: Yes.

Chair: That is obvious, but it is perhaps important to bear that in mind.

Dr Stevie Martin: In the most recent one the individual was acquitted at jury trial.

Baroness Meyer: If one gives consent in writing to, say, one’s husband, that does not change anything.

Chair: Is it right that there are quite precise guidelines and considerations by the DPP now as to the circumstances in which a case should be proceeded with?

Paul Bowen: Certainly for assisted suicide, yes.

Baroness Lawrence of Clarendon: Baroness Meyer mentioned there being something in writing. If a person has already given consent before they get to the stage of being incapacitated and no longer able to make a decision, what would the charge be if the patient’s family or whoever carried out their wishes?

Dr Stevie Martin: I envisage two scenarios. If a patient has deteriorated and is now receiving medical treatment that is sustaining their existence, that evidence would be very weighty in deciding whether continued treatment is in their best interests. That requires some kind of medical intervention, and that would be permissible. But if we are talking about a scenario in which a loved one has carried out the wishes of the patient, who perhaps has entered into an advanced stage of Alzheimer’s or Parkinson’s, that would still be murder under our law.

Q3 **Lord Alton of Liverpool:** Our colleague in the House of Lords, Lord Carlile KC, often says that we have a tough law but with a kind face. I think that plays into the points that the panel has just made.

I should declare interests for the sake of the record. They are non-financial, but I am on the board of Living and Dying Well, and am a patron of Right To Life and several hospices.

My question is not so much about our jurisdiction but other jurisdictions.

There are 7.6 billion people in the world who live in jurisdictions where there are prohibitions or protections; 100 million live in jurisdictions where the law has changed incrementally. In over half of those, this does not involve just assisted dying; it involves euthanasia in the terms that you have just described.

Can you tell us what protections and safeguards are in place? I think you will know that one of the significant concerns raised in Parliament has been how we protect the vulnerable, not least disabled people and the groups who are so strongly opposed to any changes in the law?

Dr Stevie Martin: There are many facets to that. A significantly smaller number of the population have access to it, but that dictates an increasing body of empirical data on which we can draw. There are different models of protection. One way in which there is an offer of protection is through the eligibility criteria. What you will often see in the predominant number of permissive jurisdictions is that eligibility is limited to individuals with terminal illnesses and those with a life expectancy of six months or less. That is one way in which states have been able to try to balance the rights of individuals to choose the manner and timing of their death and protect individuals who may be compelled to die—those who are vulnerable—in circumstances where they would not otherwise choose to do so.

The other important protective mechanism is our existing medical system on which we rely to make these decisions and provide protections every day, as we have all said. We have a system that permits the withdrawal of treatment from both capacitous and incapacitous patients. Central to that process is doctors being able to distil whether patients are acting as a result of undue pressure. I think that is a very vital facet of any protective mechanism.

In the main, all systems, bar Switzerland, have involvement by doctors. Germany is a bit different because it was a constitutional court decision and there is no regulation, but the overwhelming majority of permissive jurisdictions have involvement by medical professionals who conduct these assessments every day, not just in the assisted dying context.

James Strachan: I do not know about every different system that is in place in those other jurisdictions. I do know that they are very varied and that the ways in which the protections work depend on eligibility, as has just been touched on. As noted, some of the proposals in this jurisdiction have been to limit it to people who are terminally ill, whereas the case of Nicklinson before the Supreme Court did not involve terminally ill persons. That was one of the difficulties.

When one thinks about other jurisdictions it is important to consider the eligibility criteria. Of relevance to that—at least in the context of human rights, for example—is that the protection under Article 2 of the convention, which is the right to life, has been construed as not giving a right to die, but that article can be engaged when a system allows for assisted suicide or euthanasia if the protections to its implementation are

not sufficient. There was a recent case in Belgium where the mechanisms were found procedurally not to have the requisite protection because of the involvement of a particular medical professional on one panel assisting in the decision.

Lord Alton of Liverpool: To push you further on that, Article 2 is clearly hugely important in this discussion, because the mandate of this committee is to look at ECHR provisions and how they affect our law. Is my understanding correct that we have not been found in breach of ECHR, and that there are exemptions in Article 2—for instance, for capital punishment or self-defence—but no exemption for euthanasia or assisted dying or assisted suicide?

James Strachan: You are absolutely right. This jurisdiction has not been found in breach of any of the convention rights, given the current state of the law, by the Strasbourg court or domestic courts, whether under Article 2 or any other article right. Equally, the Strasbourg court appears to have recognised that the limited jurisdictions that do have systems in place are not necessarily in breach of Article 2. However, if the systems that are in place in order to regulate the ways in which assisted dying might take place are not sufficient, they may engage or breach Article 2 because of the dangers of someone's life being taken under those systems. I hope that answers your question, but it might not entirely.

Lord Alton of Liverpool: It does, and I am grateful to you.

Paul Bowen: If I may, I will add two things to Mr Strachan's observations. The first thing to point out is that the House of Lords in the Debbie Purdy case did find that the law was incompatible with Article 8 at the time, in so far as there was no guidance as to the circumstances in which the CPS would bring a prosecution for assisted suicide.

As far as concerns the Article 2 issue, it is quite right that in the Pretty case the Strasbourg court said that the Article 2 right did not bring with it a corollary. There was a right to life but no right to choose not to live. Since then, the courts have recognised—indeed, Lord Neuberger's speech in the Nicklinson case explicitly says this—that where a system of law is prohibitive, such as here, it has the effect that some people will take their lives earlier than they would otherwise do because of the prohibition. They have to travel abroad, to Switzerland, at a time when they can still take their own lives, as was explicitly recognised by Madam Justice Smith in the Carter case in Canada. That itself can give rise to Article 2 considerations. As a committee, you will be well aware of the difference between so-called negative obligations and positive obligations under Article 2. There is a negative obligation on the state not to take life; that is absolute, other than in explicit circumstances.

Lord Alton of Liverpool: Is it fair to say that the Carter case is seen almost as a random case that is contrary to all the other decisions that have been made elsewhere? Article 2 clearly says, does it not, that no one shall be deprived of their life intentionally?

Dr Stevie Martin: I do not think it is an anomalous case; I think that it reflects a growing trend. The German, Austrian and Italian constitutional courts have all followed Carter in finding that similar prohibitions are incompatible with various rights.

To follow on from that point, an argument has not been made before or taken up by a domestic court, or before Strasbourg, that squarely confronts this issue, which is that our system pits two positive obligations: the positive obligation to put in place a system that does not compel people to suicide prematurely, which our system does, and a system that protects the right to life of vulnerable individuals. That is the reality.

Lord Alton of Liverpool: Dr Martin, I want to ask you something that arises out of your book, in which you say that autonomy basically trumps other considerations. Therefore, terminal illness is only the beginning; it is not the end of the argument. You would want to see it much wider and further extended.

You also attack the idea that there is a slippery slope. I put it to you that last year, in Holland, there was a 13% increase in the number of euthanasias, which totalled some 8,720. It began with just recognising terminal illness as a reason for these laws to be passed, and this is where we have ended. Does that not imply at least a slippery slope, as you have said there is not one?

Dr Stevie Martin: I do not necessarily suggest that autonomy must always trump other considerations. It is a vital consideration, but sanctity of life is also important. One of those factors is the reality that people are being compelled to take their lives prematurely.

As for the slippery slope, it depends on how one defines it. The Dutch process has evolved out of a democratic evolution that has had contributions from the citizenry. I would challenge the suggestion that there has been a slide into something not envisaged and supported by a democratic process, as the Dutch process has been.

Lord Alton of Liverpool: You want to see that yourself.

Dr Stevie Martin: What part?

Lord Alton of Liverpool: Dutch-style laws here.

Dr Stevie Martin: I would not suggest that that is what I am agitating for. I tend to concentrate more on the necessary aspects of rights compliance. I think the system as it currently stands is not right-compliant. Whether it requires extension beyond that which we see in other countries would be a matter for a democratic process by which there is a contribution from representatives in Parliament.

Professor Richard Ekins: I want to go back to the original question about safeguards. Dr Martin quite rightly mentioned eligibility criteria and medical oversight. It is worth noting that the eligibility criteria introduced

at a certain point in time do not remain static. One sees that very clearly in Canada. Initial legislation was quite narrowly targeted to comply with the Supreme Court's judgment in Carter, focusing on reasonable foreseeability of death, and was further expanded—partly under judicial pressure and partly by political choice—quite rapidly, all in a very short space of time. To me, this suggests that this is not a stable state of affairs. One's hope that one can limit the practice to a narrow set of persons for whom there are compelling considerations is ungrounded, and the practice in Canada in recent years strongly confirms that risk.

Chair: Professor Ekins, can I make sure I properly understand what has happened in Canada? Is it correct that initially there was a statute quite narrowly drawn?

Professor Richard Ekins: In response to a decision, as I understand it.

Chair: That was in response to a decision of the constitutional court, but in what way has it been expanded? Is it by the legislature or by the courts?

Professor Richard Ekins: By the legislature, but under judicial pressure. The limitation to reasonable foreseeability of death was held, I believe, to be discriminatory against those who were in a long-term condition of suffering and disability but not within reasonable foresight of death, however so defined. It is a combination.

For my part, I think there is a slippery slope. There is clear evidence here that, in Carter, the Supreme Court's lack of concern about that has proved to be unfounded, by which I mean that the problem has manifested itself quite clearly. It is still a slippery slope in my view if there is support along the way. If one's concern is that we are crossing a major moral and legal threshold by allowing intentional killing and assistance of intentional killing, the fact that people get quite keen on this and expand the range of it, as they have in the Netherlands and Belgium, is not a reason to think there is no problem because people are perfectly happy. It might be there is a problem precisely because they are getting used to this more expansive jurisdiction or practice.

I know the conversation has moved on to Article 2. If you permit me, I will say one or two things about that. My view is that the practice one sees in the Netherlands and Belgium, and a law that made provision for assisted suicide, would breach the requirements of Article 2. It is true that the Strasbourg court clearly has not held that. The Mortier case at the end of last year, to which my colleague referred, involved a partial but not frontal challenge to the lawfulness in convention terms of Belgium's practice of euthanasia. It seems to me that there is a very strong argument that the state should be making provision to protect people from being killed.

Dr Martin referred to Canadian jurisprudence that takes up the argument that, if we do not make provision for assisted suicide, the state is forcing people to kill themselves prematurely. That line of thought may be aired,

but it certainly was not approved by a majority of the court. With respect, it is an unpersuasive argument. The state is not forcing people to commit suicide by proscribing the assistance of suicide. On the contrary, it is discouraging the act in question and attempting to avoid further instances of suicide. I think there is a self-refuting character to the argument. We have to make it lawful for suicide to be assisted in order to discourage or minimise it, but we are required by our duty under the convention and basic morality to protect everyone's right to life in law to prevent those suicides as well. I think the argument is uncompelling. It did find favour in the Supreme Court in Canada, in Carter, which is important and warrants serious consideration, but to my mind the argument does not make sense and should not be taken further by courts in Europe—which as I understand it, have not taken it further—and certainly not by the Parliament of the United Kingdom.

Paul Bowen: Responding to the suggestion that the Carter decision is a random decision, I point out that it was upheld by the Canadian Supreme Court, so I would not call that a random decision.

Lord Alton of Liverpool: What other examples can you give of courts, random or otherwise, that have said the same thing as the Canadian Supreme Court in the case of Carter?

Dr Stevie Martin: The German and Italian constitutional courts.

Lord Alton of Liverpool: They said the same thing.

Dr Stevie Martin: All three European courts have said that self-determination requires that there is access to assistance in dying in certain circumstances. Other jurisdictions—South Africa, for example—have found favour with it, although ultimately its constitutional court overturned it, but only because it determined that there probably was not a prohibition on assisted dying. New Zealand's High Court did not find favour with it, but its Parliament has engaged in a democratic process and through a consultation has introduced legislation.

Chair: What right are the courts that you have listed drawing on? You mentioned self-determination. Is that an Article 8-style right?

Dr Stevie Martin: It would be equivalent to Article 8, the right to liberty. In response to the point that Professor Ekins just made on Article 2, it is disingenuous to suggest that it is unpersuasive, given that the empirical evidence and the statistics demonstrate that people are committing suicide prematurely. We have anecdotal evidence from Members of Parliament, and we have cases such as that of Omid T, that clearly demonstrate that people are prematurely taking their lives as a result of the ban in Section 2 of the Suicide Act. I think Tom Mortier was a full frontal attack on the compatibility of the Belgian system with Article 2. It was run by an individual son on behalf of his mother, who had access to assistance in dying, and it squarely challenged whether the system in Belgium was compliant with her Article 2 rights, not his.

Chair: What was the outcome of that?

Dr Stevie Martin: That a system that permits assisted dying has sufficient a priori controls; if doctors are able to ensure that patients have capacity, meet the eligibility criteria and are not acting under undue pressure, there is compliance with that regulatory system in a specific case. The key is that there is compliance with an ex post facto system of review. That is where Belgium came up against difficulty. Those are the requirements for there to be an Article 2-compliant system, but Strasbourg has never confronted it. In the Newby case, the court, very dismissively I think, dealt with the Article 2 challenge, but it has never considered that potential.

James Strachan: To come back to the Article 2 question, observations were made by Lord Neuberger in the Nicklinson case about that article, but those were not the conclusions of the Supreme Court generally. Nicklinson went to the Strasbourg court, which rejected the application. I am not expressing any view about the state of the law; I am just trying to draw the attention of the committee to the law as dealt with in this jurisdiction. Subsequent to the Nicklinson case, the argument about an acceleration in the number of people taking their lives, constituting in that case a breach of Article 8, was advanced but rejected as a basis for upholding the challenge to the state of the law after it had been considered again by Parliament.

All I am pointing out is that the debate about Article 2 and the protection of life, and the concept that without such a system of assisted suicide people may take their lives earlier, was considered domestically by the Divisional Court and the Court of Appeal. An appeal to the Supreme Court against that decision was rejected in the Conway case, all of which post-date Nicklinson. Within that case, the courts considered the Carter case in Canada and distinguished it on the basis that there is a different constitutional arrangement in Canada as compared with the system in this country and the way in which the constitutional systems and the rights in question are arranged.

Chair: I want to make sure I understand properly the position on Article 2. In a minute we will move on to Article 3. Under Article 2 the state of the law is that it is possible to have a system of assisted dying that is Article 2-compliant.

Dr Stevie Martin: Yes.

Chair: Strong safeguards have to be built into it.

Dr Stevie Martin: Yes.

Chair: But the state of the law, as it applies to those of us who are signatories to the Council of Europe and therefore bound by the convention, is that it is possible to have an Article 2-compliant system of assisted dying but that would be very fact-specific to the type of safeguards, which I am sure we will come on to later in this session. The

Supreme Court of the United Kingdom has said that whether we should draw up a system like that is a matter for Parliament to decide; it is not for the courts. That is it in a nutshell on Article 2.

James Strachan: That must be right, save that I do not think the courts here have specifically considered whether Article 2 would be breached by a particular system. The inference is that it would be acceptable, but I do not think anyone has specifically considered that.

Chair: Theoretically, it would be possible for this Parliament to pass an assisted dying law and for someone to challenge it as not being Article 2-compliant.

James Strachan: Absolutely.

Chair: Professor Ekins, is that what we call a legacy hand up or did you want to come back in there?

Professor Richard Ekins: I have a very quick point, which is to direct the committee's attention to Fleming v Ireland from 10 or 11 years ago. It was a High Court decision and then Supreme Court of Ireland decision upholding the consistency of its ban on assisted suicide with the Irish constitution but also with relevant convention rights, maintaining that the ban on assisted suicide was certainly not a breach of Article 2, Article 3 or Article 8. It was decided after the first instance Carter decision, but I believe it was before the Supreme Court of Canada Carter decision.

Chair: What is the name of the Irish case?

Professor Richard Ekins: Fleming v Ireland.

Q4 **Baroness Lawrence of Clarendon:** I have a question on Article 2. Could you say a little more about what has happened within our domestic laws on Article 2 and assisted dying? We have heard about the European position.

Dr Stevie Martin: Do you mean the challenges to our laws?

Baroness Lawrence of Clarendon: Yes.

Paul Bowen: Article 2 has been part of the armoury, if I may put it that way, in some of the challenges. I explained how it was included as a full frontal assault in the Pretty case, where it was argued that in Article 2 there was a corollary to the right to life, in that there was a right to end life or end one's own life as well. That was rejected. That has not really resurfaced.

James made the point a moment ago on the more subtle Article 2 argument: that the state has a duty to protect people from the consequences of a system that forces them to kill themselves earlier than they otherwise would, which can raise Article 2 considerations. That was the point that Lord Neuberger accepted in principle in the Nicklinson case. It was one of the arguments accepted on evidence in the Carter case. After Nicklinson, those arguments were included in the Conway case.

James has explained how they were unsuccessful, but it is fair to say that all the post-Nicklinson challenges have failed, in my view primarily because the courts considered that this is essentially an issue for elected representatives rather than for the courts to decide.

To some extent, the question of which of the articles are engaged is the less important one. In the context of Article 2 and, when we get to it, Article 3, we are talking only about the positive obligations under those provisions. They are all qualified rights rather than absolute rights; they are to be balanced against the state's other duties, which include the duty under Article 2 to protect vulnerable people from their lives being ended prematurely. Where there is a balance to be struck between competing rights or competing positive duties on the state, the Strasbourg court has said that there is a wide margin of appreciation given to states as to how they strike that balance. Essentially, the courts will not get involved and it is up to individual states to choose, but they can choose one or the other without breaching the convention. A state can introduce a system that permits assisted dying and, at present anyway, it can choose a system that prohibits it.

Chair: This committee is not deciding whether Parliament should have a law on assisted dying. Thankfully, that is somebody else's responsibility, although ultimately all parliamentarians will have to engage with this if it recommends that we should have one. Ultimately, interesting as all these debates about the human rights engaged are, they will not give us the answer as to whether the United Kingdom should have a law on assisted dying, because it is possible to have a law on assisted dying that is ECHR-compliant—but obviously there are wider issues than that.

Dr Stevie Martin: I would say that normatively, though, it is important. The debate thus far has pitted an Article 8 right, which we very much characterise as a private right, such as the right to a private life, the right to autonomy and self-determination of individuals such as Tony Nicklinson and Noel Conway, against the sanctity of life in Article 2, which invariably is an impossible balance; it has typically resulted in Article 2 being favoured. It is important to acknowledge that, at least arguably, there is scope for an argument that there are two Article 2 rights engaged when it comes to a system such as Section 2. We look at whether the state has a regulatory framework in place, which is one of its obligations under Article 2, that provides adequate protection for life. That is an Article 2 right for those looking for access and an Article 2 right for those who do not want to be forced, as opposed to it being Article 8 versus Article 2.

Baroness Lawrence of Clarendon: A while ago there was a case involving a child, where the medical team wanted to withdraw treatment. The court was on its side, but then the parents argued their child's right to life. That is the balance, is it not?

Lord Alton of Liverpool: The Charlie Gard case.

Baroness Lawrence of Clarendon: Yes. It is about the balance. The

parents said they would go to whatever court it is to insist that treatment is not withdrawn, but the medical team said, "That's it. We've gone as far as we can go". How does that balance out between the parents who want to keep their child alive and the medical decision?

Dr Stevie Martin: The best interests of the child are paramount. We have had Gard, Evans, Hafeez and a number of cases involving children subsequently. The central factor is whether continued treatment is in a child's best interests. That is the standard for any person who is incapacitous. Is it in the best interests of this individual to continue to treat them? In our law generally, we do not protect life for life's sake; we protect a form of life that has quality for the individual who holds the right to life, so best interests is the central determinant.

Chair: David, could you direct your questions in the first instance to Professor Ekins, because I think he wants to come back on the general discussion about Articles 2, 3 and 8?

Q5 **David Simmonds MP:** It is my pleasure, Chair. I am happy to accept the steer. My question goes to the point about quality of life. Article 3 contains a prohibition on torture and degrading treatment. Starting with you, Professor Ekins, as you have steered, what is your view on the extent to which assisted dying and the legal framework around it engage Article 3 of the European Convention on Human Rights?

Professor Richard Ekins: In company with the court and the House of Lords in Pretty and the European Court of Human Rights as well, I do not think it engages it. It does not engage it because the state is not forcing a person to undergo torture or inhuman or degrading treatment. For some people the position can be terrible, but it is not as a result of state action. That is significant because the structure of the same argument applies for Article 2, as I think both those relevant courts concluded in relation to that article.

Just to circle back to that earlier discussion, if I may, with your invitation, the structured litigation we have had in our courts has of course been an attempt to persuade the courts to declare the legislation in question incompatible with Article 2. Our courts have not, at least directly, had to confront the question of whether a law authorising assisted suicide or euthanasia would be compatible with Article 2. It is entirely foreseeable, or conceivable, that if Parliament were to change the law there would be such a challenge.

For my part, I do not agree that it is straightforward, as it has been suggested, that legislation authorising assisted suicide or euthanasia is in fact compatible with the Article 2 right to life. It is certainly true that Strasbourg has not concluded it is incompatible. I do not think it follows that it is in fact compatible with Article 2, as properly understood. I do not think the Mortier judgment confronts that question in terms. It takes it partly for granted that it is in place, and then looks to see if the procedure it provides is sufficient to protect a chamber judgment by majority. The question remains live.

I do not anticipate that the Strasbourg court would any time soon declare the practices of the Netherlands and Belgium—or ours, if we follow—to be incompatible with Article 2, but there is a good argument around the shape of the detailed text of the article and the interests it protects that such a regime would be incompatible. It is an intriguing argument. There is a kind of internal incompatibility in Article 2. As I say, I am not persuaded. I think Article 2 provides clear affirmation to the protection of the right to life in law, which does not entail trying to avoid somehow people being provoked into committing suicide earlier than they otherwise would. The state is not forcing them to end their lives.

David Simmonds MP: Can I ask the other panellists to expand a little on that point? Relevant in some of the work the committee has done in other areas of inquiry is the balance between where, as you described, the state is not forcing someone to undergo torture or inhuman or degrading treatment versus a situation where the state is failing to protect someone from inhuman or degrading treatment. In the context of asylum, that has been a very relevant factor, where it has been argued that someone had a right to asylum in the UK because the Government in their country, although not subjecting them to it, was failing to protect them from it by a third party in the country in question. I would be interested in whether, given that context, this is confined solely to a state actor proactively doing something to someone versus failing to ensure somebody's rights by omission, in effect.

Professor Richard Ekins: Certainly, the state should be taking measures to ensure that acts of torture are not taking place on the part of private persons carrying them out and so on. It would be a failure of our law to not have such a provision, as of course we do. The position taken by the court—the House of Lords and the European Court of Human Rights in Pretty—is that the terrible state of affairs in which some persons find themselves because of disease and illness does not involve them being subjected to inhuman or degrading treatment. In particular, there is a problem of compatibility between Article 3 and Article 2 if you prescribe that in order to comply with Article 2 one must facilitate or carry out intentional killing, which is prohibited by Article 2, and the law requires the right to life to be protected by law.

James Strachan: There is a discussion of that in the Pretty case, where of course there were very distressing circumstances for the applicant, which are explained in the domestic court and recognised by Strasbourg. They also specifically considered that as not requiring interpretation of Article 3 as a procedural obligation to have a system of sanctioning assisted suicide or euthanasia. So they tackled that.

It was also revisited in the courts in this country in the Conway case, particularly in the context of evidence presented in that case on medical palliative care. Evidence was presented of developments in relation to palliative care for those suffering from whatever illness it may be, which was presented as part of the balance of arguments in relation to how one deals with suffering. It is recognised obviously as a significant issue but

not one that then translates into a requirement to do something under Article 3 itself.

Dr Stevie Martin: It is really important that we delineate between the various obligations that we are discussing, because there are many under each of the articles that we have canvassed. On Article 3, absolutely the narrative in both Pretty and subsequently has concentrated on the positive obligation. I think there is scope for an argument that a system that prohibits and criminalises a form of conduct is direct treatment by the state.

We have one case reference in Pretty, D v UK, which involved an extradition case, and we have seen a proliferation of cases that concerned states sending individuals back to jurisdictions where there is a real risk that they are going to be exposed to ill treatment there. It is not the sending state that is doing it, but the sending state is held to be in violation of its negative obligation not to treat somebody. So it is not the positive; it is where you are sending somebody to experience that treatment somewhere else. There is an argument there that, when you criminalise conduct, there is a potential that you are treating a person, but there is also scope based on obiter from the Northern Ireland abortion case from Lord Kerr and Lord Wilson, with support garnered from Hale and Mance as well, that the ban on abortion in cases of rape, incest and fatal fetal abnormality, including the criminalisation of conduct by doctors, was treatment for the purposes of Article 3. As I say, it is obiter, but there is an argument that the state here is not just failing to protect individuals; it is actively treating individuals by criminalising conduct. To use the terminology employed by Lady Hale in the Northern Ireland abortion case, you are exposing individuals to an agonising dilemma. You need to pick how you proceed. That is what the state is doing.

Paul Bowen: I agree with that. It is important to determine, first, what the law is, and, secondly, what the law may be and how it is going to develop. We are probably all agreed about what the law is. The differences between us perhaps are the directions in which the law will develop. It is helpful to look at other parallel situations to see how the courts have developed their attitude towards an issue over which, at the first bite of the cherry they have considered it is not appropriate to change the law, but subsequently, as society has changed, and as the consensus and the calculus has changed, they have reached different conclusions.

There are two good examples. One is in relation to corporal punishment. When the Strasbourg court first looked at that question, it refused to find that a law that permitted corporal punishment amounted to a breach of Article 3. There was the case of Costello-Roberts and the earlier case of Cosans. When it came back to the case in 1999, it reached a different conclusion and decided that it was a breach, because societies had changed and the consensus about whether that was acceptable behaviour had changed.

The other good example is in relation to gender recognition. The Strasbourg court in Goodwin in 2002 accepted that a refusal to recognise a change of gender in official documentation was a breach of Article 8, overturning the conclusions that it had reached in previous cases that had come before it. Our own courts have recognised that the laws need to be brought up to date to reflect the change in societal attitudes. Another good example is the Fitzpatrick v Sterling Housing Association case in 2001 where the House of Lords reinterpreted the word "spouse" to include somebody in a same sex partnership so that they were entitled to the benefit of the lease after their partner had died.

That is what you need to do. You need to look in your crystal ball and say, "In which direction is the mood music moving?" Is it moving towards the view that perhaps Professor Ekins represents of a tightening and that there should be no permissive regimes, or is it moving in the other direction? Are societies becoming more permissive on this issue? That is probably not something that we can help you with, certainly not a barrister.

Chair: That is very interesting.

Baroness Meyer: It is a question of morality at the end more than the law, really.

James Strachan: In contrast to all those other areas, this is an area where the courts have made it clear that they think it is the function of Parliament rather than the development of the law to shift the legal picture. In slight disagreement today, it is highly ambitious to think that the law will change in this area, because the courts have very clearly stated that it is a matter for Parliament if the law were to change, rather than an evolution of the common law or the convention rights. The courts have made it clear that they do not regard this as a breach of these convention rights.

Paul Bowen: The very point I was making is that the first time the courts considered the issue in relation to those other issues they decided it was not a matter for the courts; it was essentially a matter for Parliament. That changed.

Dr Stevie Martin: Our Supreme Court has not definitively ruled on compatibility. It did not in Nicklinson and in the appeal in respect of Conway it did not. So I do not think that we can definitively say what the law is in this country in terms of rights compliance with Section 2 without knowing what our Supreme Court would say if it were to squarely confront the issue.

Chair: In a sense, our Supreme Court is waiting for Parliament to devise a law, and I have no doubt it will be asked to rule on it at some point.

Paul Bowen: It is fair to say that if this question came back before the Supreme Court now it would give the same answer: it is for Parliament.

Chair: You think it would give the same answer.

Paul Bowen: At the moment.

Q6 **Chair:** Yes, at the moment. I know Professor Ekins has his hand up, but because of the time pressure I want us to talk a little more about Article 8. I know we have covered it already, but can we try to encapsulate our understanding? Article 8 covers the right to a private and family life. Could you give us your understanding of the extent to which Article 8 is engaged by assisted dying and the way that is dealt with in our domestic law so far? Forgive me if we are going over ground that we have touched on slightly, but I just want to make sure we are clear on that before we move on to Article 14.

Professor Richard Ekins: Our House of Lords position in Pretty was that Article 8 is not engaged. I think it was the right decision and it made sense. When the Pretty case went to the Strasbourg court, although the Strasbourg court upheld the compatibility of our Suicide Act with the convention, including with Article 8, it took the view that Article 8 was engaged. Then the question turned under Article 8(2) to whether the interference was justified. It concluded that it was, and it accepted the UK's arguments that there were good reasons for the interference.

With respect to the court, I think it was a mistake that the court did not squarely confront Article 8. It had good reason for rejecting the position taken by the House of Lords. Its conclusion that Article 8 is interfered with is almost offhand. The court is not willing to exclude the conclusion that Article 8 was engaged. It is a matter of European human rights law that Article 8 is engaged, so the question turns, as our courts have made clear in the Purdy case, where they consider it, and in Nicklinson and Conway, on the fact that one has to determine whether there is good justification for the interference. Our courts, certainly in Conway, concluded that yes, there is.

In Purdy, as has been mentioned before, the challenge succeeds in part, which is that the interference with Article 8 was not justified in so far as it was not in accordance with law, because the DPP's prosecutorial guidelines were insufficient to help someone to know where they stood. That is a decision that was very seriously open to challenge. It is politely questioned in Nicklinson by a number of the Supreme Court justices. The position is that our Government have to keep defending the lawfulness or the compatibility of the Suicide Act with convention rights—namely, Article 8—although it has done so successfully, at least after Purdy.

Dr Stevie Martin: It is important not to segment out assisted dying, however we define it, from the wider end-of-life context and medical treatment sphere. In Pretty, the court characterised the issue as a right to avoid an undignified death, and they looked at it through the prism of Article 8. In a number of cases following Pretty, not just in terms of assisted suicide but withdrawal of treatment, the court has reiterated that questions of quality of life come under Article 8. Most people would agree that, if we are deciding as an individual whether we would like to continue to receive life-sustaining treatment, that very much goes to our

intimate right to private life in the sense of autonomy and qualitative concerns protected by Article 8.

In respectful disagreement with Professor Ekins, I think there is a long line of case law, not just in the context of assisted suicide, from Strasbourg and our domestic cases, including recently in the case of B and Black, which examined this issue at length and whether a system of law that allows withdrawal of treatment from incapacitous patients without High Court approval is compliant with convention rights. That centred not just on Article 2 but on Article 8, and that is where best interests come into play. Normatively as well as jurisprudentially, it makes sense that Article 8 would be engaged when we discuss a person's decisions with respect to their treatment, medical or otherwise, and the way in which they determine to end their life.

Lord Alton of Liverpool: I have seen data that suggests that in countries that have changed the law the palliative care movement starts to collapse and that hospices close, so people do not then get the kind of dignified death that all of us would want people to have the opportunity to get. Does that engage these articles? What about children? We have seen the extension of the law now in Holland, and there are attempts in Canada to extend the law to children. What are the rights of children?

Lord Alton of Liverpool: There is one other thing, and that is the position of disabled people. I referenced it earlier. They have rights in this too. You will have seen the widespread concerns, not least those voiced in the House of Lords by people like Baroness Campbell of Surbiton and Baroness Tanni Grey-Thompson, who speak with great passion on this subject because of what they see as the discriminatory provisions against disabled people that make them more vulnerable. Surely, their family rights are brought into scope here as well.

Dr Stevie Martin: Yes. On the point about hospices, I would highlight the fact that the data from those permissive jurisdictions consistently demonstrates that the overwhelming majority—we are talking 85% or above—of people who access assistance in dying are terminally unwell with cancer and receiving palliative and hospice-based care, and that includes in Canada.

A very recent study conducted by a professor at Galway University looking at all the data concerning palliative treatment in permissive jurisdictions actually found the inverse, which is that palliative care systems are bolstered in jurisdictions that have permissive regimes because there is an impetus and a push towards ensuring that the system functions appropriately.

As to children, the Netherlands is considering whether to permit assistance in dying for those under 12. Belgium does, but it is very narrowly constrained. Whereas the Dutch and Belgian systems are open to adults who do not have terminal conditions, that is not the case for children. Depending on the age of the child, the degree of involvement by parents also differs. For children who are effectively emancipated, they

will have greater decision-making, but that is entirely consistent with what we have in our system when it comes to Gillick-competent children who are making decisions about life-sustaining treatment.

Lord Alton of Liverpool: Clearly, there cannot be consent if there is a young child involved in this. They are not in a position to.

Dr Stevie Martin: Parents will. It depends on the age of capacity. Parents in Belgium have an increasing role with respect to young children when it comes to euthanasia. I would point out that the rates are extraordinarily low. No minor in Belgium in the last reporting year had a certificate with respect to assisted dying. The rates are exceedingly low.

Finally, this is obviously an extraordinarily important issue for disabled people and one dealt with primarily through eligibility criteria. In very few jurisdictions—indeed, very limited jurisdictions—would disability alone enable you to access assistance in dying. In those where it is open to those who are suffering intolerably, you have the same protection mechanisms that concern undue influence and the distilling of why a person is accessing assistance in dying in the first place. Those would be my responses.

Lord Alton of Liverpool: On suicide, which you have also mentioned, the evidence is that suicide increases in countries where there is a promotion of legalised assisted suicide. How do you deal with that, given that we saw figures this week showing that young people in larger numbers than ever before have been committing suicide in this country?

Dr Stevie Martin: I do not know that there is actually a correlation. There is often greater reporting in jurisdictions that permit assistance in dying. There is no data that demonstrates that there is an overall increase in suicide as opposed to assisted suicide in jurisdictions that permit it.

Chair: I just want to pull this back to the human rights considerations. Those are extremely important issues, David, and they must be properly explored elsewhere. That will be the function of the Health and Social Care Committee. I want to pull us back to the human rights aspects. In relation to disabled people, there may be an engagement of Article 14 and anti-discrimination provisions. We will come to Article 14 in a minute.

Q7 **Dr Caroline Johnson MP:** I want to go back to terminal illness, which you talked about earlier. I should say that I am a consultant paediatrician and on the Health and Social Care Committee.

Doctors are not generally very good at deciding how long people’s life expectancy is. We heard evidence on the Health and Social Care Committee that the Americans have defined terminal illness as part of their dying policy. They have defined it in such a way that were someone to be diabetic, for example, and say that they were going to stop treatment, they would of course be terminally ill because you cannot survive without your treatment, particularly if you have type 1 diabetes. That is not what I think the general public consider to be terminally ill. Do

you think that that is a failure of their legislators to provide good legislation, or do you think it is a difficulty of developing legislation at all?

James Strachan: I would just point out that that issue was considered in the Conway case. One of the measures proposed by the applicant in that case was a form of legislation that depended on having six months to live. There was evidence produced by other doctors as to the difficulty in deciding precisely that point: how do you know when someone has six months or less to live? I forget who it was who gave evidence. It is referred to in the judgment as to the ambiguity that comes into the criteria and how you apply it. Those points do not relate to the particular example you have just given, where I can see a dilemma, but they were put in the context of ordinarily diagnosing someone even with a terminal illness where there may be quite a lot of experience judging that point. There was indeed evidence from Baroness Campbell in that case on precisely that issue.

I do not have an answer to how one addresses it. It directly relates to this: if you were to come up with an assisted dying Bill and you were to put in a six months' criterion, how would one then ascertain when that criterion is met and what level of consensus is required in order for it to be met for the mechanisms to be in play?

Dr Caroline Johnson MP: And whether treatment that would prevent that death is relevant.

James Strachan: Indeed. It could then make it more than six months, as you put it.

Paul Bowen: The difficulty with any time limit of six months or 12 months of terminal illness is looking at it through a human rights prism. The human right not to suffer inhuman and degrading treatment or the human right to make choices over how and when we end our lives are not dependent on whether we have six or 12 months left to live. They are more likely to be determined by how unbearable our situation is, which is why I think it is asking for an answer to the wrong question, or using the wrong tools to answer the right question. The question is: does having unbearable suffering give you certain rights that you should be able to enforce? The answer is yes, and it should not depend on whether you have six months left to live or not.

Dr Stevie Martin: That is why states that permit assisted dying often include suffering criteria that refer to treatment that is unacceptable to the patient. You have that assessment of whether an individual perhaps does not want to be taking insulin on a daily basis, treatment that we may consider perfectly fine, like colostomy bags, and other forms of treatment that patients do not consider acceptable to them. That is not uncommon to see in jurisdictions. Australia has introduced a foreseeability cut-off of six months in all its states as well as a suffering criterion that looks at whether the treatment is acceptable to the patient.

Professor Richard Ekins: This discussion confirms how difficult it is to legislate responsibly. You must be right that, where one has the time-bound limits, that comes under a lot of pressure in practice. It also comes under pressure morally, as my colleagues have just shown. The argument for making provision for assisted suicide or euthanasia does not stop at those limits. It spills over quite quickly into the particular person's assessment of whether their life is still worth living and thus whether the law should facilitate their desire to be dead, whether by enabling others to assist them in suicide or making it lawful for someone to do what would otherwise be murder and kill them.

It is highly relevant when one thinks through whether one could make a partial exception to our current categorical prohibition; whether it could be neatly cabined, in short. Further, I am highly doubtful whether that is possible. Those doubts are reinforced by looking at the other jurisdictions—Canada in particular, but also the Netherlands and Belgium, which have a lot of experience.

Dr Stevie Martin: Following on from that point by Professor Ekins, nomenclature is important. For most people, it is not a preference to be dead; it is a preference to live without the conditions they have or the refractory symptoms they are experiencing. That is important from a rights perspective, because it brings us back to Article 3 and inhuman and degrading treatment, and the right to autonomy and self-determination as protected by Article 8, and perhaps out of that mire of whether one has a right to choose not to live.

Paul Bowen: That is really important as well. The consistent message I used to get from Debbie Purdy who I represented in her case was that it was not that she wanted to die; it was that she wanted to have the confidence to know that when the time came she would be able to die with dignity, which meant that once she had that confidence she could live the rest of her life joyfully, and that really is what it is about. It is not about giving somebody the right to die there and then; it is about giving them the confidence that, when it is time, they can die with dignity so they can enjoy the rest of the life that they do have.

Q8 **Dr Caroline Johnson MP:** This is a slightly provocative or awkward question perhaps. We have been talking about this in the Health and Social Care Committee. I want to ask you about children. You mentioned children, Professor Ekins, and the slippery slope. We have seen in a number of jurisdictions around the world that laws are brought in for adults and extended later to children, and progressively younger children in some jurisdictions as compared with others. Do the human rights laws apply differently to children than to adults?

Dr Stevie Martin: I do not think it is a number. It is limited to Belgium, the Netherlands and Colombia.

Dr Caroline Johnson MP: Canada?

Dr Stevie Martin: Canada is considering it. It is in the process of potentially expanding it to a certain number of minors, but it depends again on who we are talking about. Are we talking about infants, who are obviously governed by different considerations such as best interests, which, as you are far more well versed in, will cover medical decision-making in the main anyway, as in Gard, Evans and Hafeez.

Dr Caroline Johnson: This would not be medical decision-making. This would be parent decision-making.

Dr Stevie Martin: With professionals, because if there is a conflict, that is when you end up before the High Court exercising its parens patriae jurisdiction with respect to best interests.

Paul Bowen: With the final decision made by a judge.

Dr Stevie Martin: Yes. It is not parents and doctors having the ultimate right. It is parents and doctors hopefully agreeing as to what course is in the best interests of the child, but courts ultimately deciding the rights of the child. There are jurisdictions that allow for assisted dying in various forms with respect to minors of various ages. The rights implications that arise under the convention depend entirely on the age of the child to some extent. If you have a Gillick-competent child as we understand it, a 16 year-old who is terminally unwell, the considerations that apply with respect to their rights, including their right to autonomy and freedom from inhuman and degrading treatment, will arguably have a different focus from a child that is incapacitous and is having decisions made for them by parents and doctors.

Dr Caroline Johnson MP: Does the right to life, for example, and the right to not have inhuman and degrading treatment differ whether you are seven or 17?

Dr Stevie Martin: No. The evidence will definitely be different, one might suggest, in terms of the interests of children being able to be communicated by them if they are capacitous and capable of providing that information. The fact is certainly to have consistency. The right to life is not absolute in the way that we suggest it could be under Article 2. We know that generally it does not prohibit withdrawal of treatment of people, either capacitous or incapacitous, or children either. Yes, it certainly has application. It is a more artificial exercise when you are dealing with incapacitous children who are very young and cannot express themselves, because you are asking people to make decisions about what would be in their best interests, including religious factors, which we have seen take quite heavy precedence in some recent cases.

Paul Bowen: These are the dreadfully difficult decisions that judges already have to make when it comes to the withdrawal of treatment.

Dr Caroline Johnson MP: I understand that. Would it be legal under the Human Rights Act to pass a law that provided for euthanasia but restricted it to adults?

James Strachan: Yes.

Dr Stevie Martin: It would be discriminatory, arguably.

Paul Bowen: It would not necessarily be unlawfully discriminatory.

Dr Stevie Martin: No, exactly. It would be justified.

Dr Caroline Johnson MP: It would not be discriminatory.

Professor Richard Ekins: I want to disagree with my colleagues, or at least some of them, to say that, as I view it, Article 2 is absolute, and withdrawal of treatment is not intentional killing. We are talking about acts of intentional killing and whether they are consistent with the convention or are required by the convention, which is the argument that is being developed.

Children are obviously persons, and so are entitled to protections under human rights law, and under basic morality too, of course. To the extent that their position is different, the relevant differences should be taken into account. In relation to Article 2, there is no difference because the right is absolute. In relation to Article 8 where the argument stresses autonomy, it may be that young children do not have an autonomy right that could be levered into a permission for someone to kill them.

There is more than one argument at play. It is not just autonomy but relief of suffering believed to be intolerable, and that is certainly an argument that will be deployed in order to wedge open the law and to make permission for killing children lawful. That will be the shape of the argument. Whether it is accepted by courts or by Parliament varies from time and place, but the logic does not stop with adults, certainly.

Q9 **Dr Caroline Johnson MP:** I have to say that the statement "to make … killing children lawful", sounds absolutely horrific.

I want to move on to Article 14, the right to protect against discrimination. In a case called Pretty, which I am sure you are familiar with, it was argued that Diane Pretty's Article 14 rights were violated because her husband was not allowed to take her life for her and that she was being essentially made to kill herself before she was unable to.

We also had some discussions in the Health and Social Care Committee about the fact that in America you have to be able to drink a liquid to kill yourself; it cannot be done actively by the other person. They can supply the liquid to you, and you have to syringe it into yourself through your nose or take it orally, effectively. Is that discriminatory? Does that infringe Article 14?

James Strachan: It certainly could, yes. Dealing with the Pretty case, an argument was run under Article 14 but rejected by the Strasbourg court. A similar argument has been run recently in the domestic courts to rely on Article 14 in conjunction with Article 8, and has again been rejected on the basis that seeking to challenge the prohibition on assisted suicide on the grounds that it is discriminatory does not add to the overall equation

of assessing the proportionality of the restriction under Article 8. It does not materially move the arguments. It is either a legitimate interference with the Article 8 rights, and consequently Article 14, or not. That is my understanding of the legal situation.

An interesting issue is that, if one were to introduce assisted suicide and to impose restrictive criteria as to when it can be invoked, be it terminal illness of six months, some definition of unbearable suffering, age restrictions, or anything of that kind, there is the potential for an Article 14 argument to say that that is a discriminatory application of the right to assisted suicide, and that is where what is described as the slippery slope argument has sometimes come into play. It is called "crossing the Rubicon" in some respects.

Once you cross the Rubicon or introduce a system, you have to have a system that is applied in a non-discriminatory fashion, and you have to think about what the basis is for restricting it to people who have six months to live versus seven, or people who do not have a terminal illness but are subject to unbearable suffering, or children, as you have indicated. In my view, that is a very difficult additional thing to think about when you are selecting your criteria.

Lord Alton of Liverpool: Mental illness now has been added to the list as well. It is being explored in Canada as an addition. If it is being denied in certain circumstances, people have the right to say that it should be extended in all circumstances.

Dr Stevie Martin: They have the right to say it but, under Article 14 of the European convention, discrimination can be justified if it is objective and in pursuit of a legitimate aim. That is where you see the Article 8 arguments come to the fore. It is perfectly possible to put in place a system that delineates between conditions, and that clearly discriminates in the technical sense, because you are separating individuals on the basis of health but which could nevertheless be justified by reference to arguments under Article 8 and otherwise by the need to protect vulnerable individuals, however paternalistic that may seem. That is indeed what we have seen elsewhere. Canada has a different system in some respects. There is a lot of overlap in the rights. Having accepted that there was no justification for a prohibition on assisted suicide, it was going to be a hard task to justify separating out categories of individual on the basis of a health condition, so that is where we would end up.

In this jurisdiction, we have Article 4. It is parasitic on other rights. You would need to engage a substantive right. Presumably, it would be Article 8. Then you would run the argument, depending which side you are on, that it is either objectively unjustifiable or objectively justifiable, and that requires a proportionality assessment. That is where you would have factors such as the need to protect vulnerable individuals; people with mental illnesses are frequently characterised as such.

These are not homogeneous groups. We need to be careful not to homogenise all disabled people, all children, all people with disabilities.

They have diverse and distinct interests, and have expressed them in many ways. I just do not want to be labelling entire groups and suggesting that they are either for or against permitting assisted dying.

Dr Caroline Johnson MP: The terms "assisted suicide" and "euthanasia" have been interchangeably used during this session. This is quite important. The American state that we spoke to took the view that because it had assisted suicide, which was where people have to consume a liquid via their mouth or a nasogastric tube themselves, it was effectively keeping the numbers down, as it put it, of people who were using it, whereas the Canadians had many more people take this route because that was an act of euthanasia, some with injection, which is potentially more effective in some respects as well and more tolerable. Would it be discriminatory to bring in a law like the American one, because people who did not have the capacity to take it would be discriminated against?

Dr Stevie Martin: That was the argument in Nicklinson and Conway, especially for people with motor neurone disease or ALS, who are incapable of doing the final act. That was Truchon, which was the successful Canadian challenge. It was based on an individual who had a condition that was going to result in their inability to take the medication themselves and not comply with the reasonable foreseeability requirement. Those two things are quite often bound together. It has been raised before our courts.

Dr Caroline Johnson MP: Was the case won?

Dr Stevie Martin: Not domestically; not in the UK or before Strasbourg. As has been pointed out, Diane Pretty unsuccessfully challenged Article 14.

James Strachan: It goes a little further than that. Yes, there would be an argument about discrimination, but as discussed in Nicklinson there is a further point about potential discrimination. If you are suffering from a terminal illness with six months or less to live, assuming one can adjudicate on that, clearly you may well be suffering and you have been diagnosed.

For those who are in the situation of a disease that does not necessarily give them a diagnosis of six months less to live but they have a longer period of enduring their suffering, if they are excluded from the terms of an Act that otherwise permitted assisted suicide, they might have a stronger argument to say, "That is a form of discrimination merely because I don't have a terminal illness. I have unbearable suffering". That dilemma is created as soon as one moves into the assisted suicide regime. You then have to balance very difficult judgments that involve issues of discrimination, in my view.

Q10 **Lord Henley:** We have been through Articles 2, 3, 8 and 14, and it seems fairly clear that, as we stand, we are currently compliant, or at least Strasbourg seems to think so. Strasbourg and our own courts also

seem to be quite clear that decisions on this matter should be matters for Parliament and not for the courts.

As a sweeping-up question, are there any other human rights issues, other than those particular four articles, that we should take into account when considering assisted dying and whether the law ought to be changed on that front? Do all four of you want to give a brief answer?

James Strachan: Article 9 was raised in the Pretty case and rejected. I can see that people might invoke it. Article 10 has been raised in terms of freedom of expression because, among other things, the restriction under Section 2(1) of the Suicide Act also covers prohibition of encouraging suicide. It is a criminal offence to write or disseminate information that would encourage suicide, and that is particularly pertinent bearing in mind issues relating to what is available to people on the internet.

Dr Stevie Martin: Strasbourg has found that compatible, though, in Lings.

James Strachan: Yes. I think it also found an element of the law that restricted dissemination of such information to be compatible. It recognised that it was legitimate for the state to prevent encouragement of suicide in that respect. That is a sort of sub-issue, but I thought I would mention Article 10 as well in that context.

Paul Bowen: As to the hierarchy of rights as they apply in this field, Article 8 has been seen as the primary right. Article 2 can be engaged, Article 3 possibly, Article 14 maybe, but it is really about Article 8 and about balancing. For my part, I have never really felt that those other rights add an awful lot to the Article 8 considerations.

Professor Richard Ekins: I do not want to add another provision to your consideration, but perhaps I will just reverse the order of priority that you have just been given. I think Article 2 is the most important consideration here. Article 8 is by all means where a lot of the action is in terms of the cases, but the primary question here is first and foremost one of morality and responsible legislating, to which by all means our position as a matter of international law and the insights to be gleaned from judgments is relevant. First and foremost, it is a question about what our law should be, how we treat people justly and what they should be entitled to expect and to be free from, which in our law for centuries has been intentional.

Lord Henley: Thank you very much. Dr Martin, do you want to add anything?

Dr Stevie Martin: I would just round off. Certainly, Professor Ekins is correct that the primary focus, even if Article 8 has been the right through which we examine these issues, has been on the concept of the sanctity of life. I would encourage people who consider this issue to look holistically at the concept of the sanctity of life and what it means to live. Lord Kerr acknowledged that in Nicklinson when he asked what it is to mean to live. I do not want to repeat myself, but we do not absolutely

protect life at all costs when it comes to medical treatment generally; we recognise that people have a right to decide what a life worth living looks like for them, and that is pertinent when you look at Article 2 in the context of assisted dying as well.

Paul Bowen: Yes, and Article 2 does not impose a duty on the state to protect everybody from all risks to life. It does impose a duty to prevent an individual from taking his or her own life if their decision has not been taken freely and with full understanding of what is involved. A system that allows for those questions to be answered will be compatible with Article 2.

Lord Henley: Thank you very much.

Q11 **Lord Dholakia:** I declare my interest as a member of the All-Party Parliamentary Group for Dying Well.

Professor Ekins, what are the constitutional roles of Parliament, UK courts and the European Court of Human Rights when dealing with matters of legislation on assisted dying?

Professor Richard Ekins: First and foremost, it is the responsibility of the United Kingdom Parliament to decide freely for itself what our law should be on this question. What does justice require in relation to the predicament of people who are seeking assisted dying, and what does it require given the sanctity of life and the importance of protecting the vulnerable? Those are considerations that I am sure parliamentarians are earnestly considering all the time.

Under the Human Rights Act, our domestic courts have the jurisdiction to consider the compatibility of legislation and other government action with convention rights. Under Nicklinson and Conway, they have taken the view that there is little they can add in relation to this particular controversy. It is one that Parliament needs to resolve itself. That is in relation to the challenge where the court is being invited to declare our existing Suicide Act incompatible with convention rights. The courts have not been willing to reach that conclusion per se. Whether other law should change is a question first and foremost for Parliament to undertake.

Our courts under the Human Rights Act have an important role to play in signalling to Parliament, government and the public if our legislation is likely to be found to be incompatible with the convention on the part of the European Court of Human Rights. In the recent decision of Elan-Cane, our Supreme Court overturned Nicklinson and said that the courts could not conclude that UK legislation was incompatible with convention rights unless it was clear that the Strasbourg court would take the same view.

For the time being, it is clear that the Strasbourg court thinks that the UK’s ban of assisted suicide, as with other member states, is compatible with the convention. I agree that could change, and then our courts would signal to Parliament, government and the public that that decision in the Strasbourg court had changed. It would still remain a question for

Parliament to decide whether to change the law, whether that was consistent with what we owe to one another, whether it was consistent with justice, with the sanctity of life, protection of the vulnerable, et cetera.

The role of the European Court of Human Rights is to uphold the convention in disputes not only between member states but between individuals in member states. It should be holding steady to the terms of the convention and not reading the mood music, as one of my colleagues put it before, in trying to decide what sort of future state we want to have. It should uphold commitments that are clearly there on the face of the convention, as I think is the case with Article 2.

Paul Bowen: The primary responsibility for making laws is with Parliament. There is no doubt about that. Parliament makes the laws, the Executive apply the laws, and the judiciary decides whether they have complied with the law.

When it comes to the Human Rights Act, the balance that has to be struck is that the courts must recognise the expertise and the particular democratic legitimacy of the decision-maker, particularly if they are considering the compatibility of primary legislation.

Both the Strasbourg court and the domestic courts will apply a wide margin of appreciation—the term that is used—which recognises that there is a space in all governmental decision-making, Executive or legislative, within which the courts will not interfere. As Professor Ekins pointed out earlier, the concept of margin of appreciation, which has a domestic analogue, which we call the discretionary area of judgment, is now essentially the same since the Supreme Court decision in Elan-Cane.

If the Strasbourg court says, "That falls within the margin of appreciation. We're not going to intervene", the domestic courts will do the same. The width of that margin of appreciation will be determined by a number of things: the importance of the right concerned, the degree of interference with the rights that it involves, the extent to which it involves the distribution of scarce community resources, and the extent to which there is a consensus among other Council of Europe states.

With this particular example of assisted dying, the Strasbourg court and the domestic courts consider that it falls within the margin of appreciation for Parliament to decide to have laws that allow assisted dying or not to have laws that allow assisted dying, and that will change only in terms of the courts. As happened with the examples I have given you—corporal punishment and gender recognition—if, over a period of time, a vast majority of Council of Europe states have changed the law and the United Kingdom gets left behind, we are the laggards, perhaps at that stage that calculus will change. For now, the margin of appreciation, which is the tool that the courts apply to recognise the legitimacy of the primary decision-maker in a constitutional democracy, is the calculus, and that is where we are now. It is squarely in your court whether there will be a change in the law.

Dr Stevie Martin: It is important to examine what we are asking the different branches to do. I do not think anybody would suggest that the courts are the appropriate forum and can articulate the system that should be put in place should assisted dying be found to be required in some form as a result of a human rights instrument. Indeed, that is not what happened in Carter. Certainly not in this jurisdiction with the limited rules of evidence and the ways in which judicial review are conducted would anybody suggest that it is through judicial review that we could propose a system of assisted dying.

However, the courts provide an invaluable and, indeed, central mechanism by which individuals can litigate and vindicate their rights. That is the primary mechanism. One of the motivating reasons for enacting the Human Rights Act was to "bring rights home" and to ensure that people can enforce their rights before our domestic courts. That is an often overlooked function in this context for individuals who would suggest and argue that the blanket prohibition in Section 2 of the Suicide Act violates European convention rights.

Absolutely, there is no debate I think that Parliament is the body that would need to articulate, consider, scrutinise and pass legislation, but the courts provide a vital mechanism by which individuals can have their rights issues litigated. This was again what Lady Hale and Lord Kerr said in Nicklinson. That exercise both in terms of individual litigants and a more general assessment of the compatibility of legislation with the rights is an important mechanism of dialogue, which I think most constitutional academics and lawyers in this jurisdiction appreciate is a role that is played by the courts.

James Strachan: I think we are all agreed that it is for Parliament. It has been described as an ancient social, moral and ethical issue that is really for Parliament to decide.

I would just point out that in the Conway case the courts concluded that Parliament had decided, post Nicklinson, by rejecting a change to the law, and that that state of the law remained compatible. It is not a case of the courts awaiting a decision, but, of course, Parliament is entitled and best placed to make any change if it so chooses.

Lord Dholakia: Thank you.

Chair: That seems a good point on which to end. I would like to thank all four of you very much indeed. It is quite a dense topic and a lot for us to think about. I cannot thank you enough for the very clear and precise way you have all presented it to us. We will go away and chew it over. Thank you very much indeed.