

### A socio-legal perspective on changes to assisted dying laws in the UK

During the last decade there has been a significant liberalisation of the laws concerning assisted suicide in the global North. Since Canada's decriminalisation of voluntary active euthanasia (VAE) and assisted suicide (Medical Assistance in Dying) in 2016, a number of other jurisdictions have followed suit: some states in Australia (Victoria and Western Australia, 2019; Tasmania, 2022; and Queensland, 2023 – South Australia and New South Wales are set to follow later in 2023) and Germany (2020) have legalised practices of assisted suicide, while others like New Zealand (2020) and Spain (2022) have also subsequently decriminalised euthanasia.

Case law appeals (e.g., Nicklinson, 2014), Parliamentary Bills (Baroness Meacher's 2021 Assisted Dying Bill), and the current Inquiry into assisted dying, reveal the direction of travel in the UK. Poll-based evidence suggests that the majority of UK residents support some forms of assisted suicide with caveats around eligibility.<sup>i</sup> Furthermore, the Royal College of Physician's position which recently changed from 'against' to 'neutral'<sup>ii</sup> gives further momentum to the prospect of legal reform.

However, debates on assisted suicide are often polarised, either around legalisation *or* criminalisation, the right to choose assisted suicide *or* the protection of vulnerable persons. Such polarisations continue into regulation: typically solutions resort to either medicalisation *or* continued criminalisation. I do not wish to recite these binary debates or regulatory solutions here, but only want to suggest that while significant, they are generally siloed and more importantly they blinker us to other possible ways of thinking through the problem of assisted suicide and possible regulatory solutions.

Social sciences can offer much to the debate and importantly can draw the Committee's attention to the social context that shapes how changes in the law are considered. Although we may have an *idea* about the societal values we would like to share, empirical evidence shows us that society is deeply stratified along axes of inequality according to gender, ethnicity, age, disability and sexuality. Consequently, society places more value on some people's worth than others. It is important then to explore which people are central to the assisted suicide debate. We find that they are often marginalised— both in terms of experiences of poverty and social deprivation, as well as experiences of stigma and social exclusion.<sup>iii</sup> I ask the Committee to consider a more holistic view of the question of assisted suicide, and before asking the questions that the Committee poses<sup>iv</sup>, which are clearly important, to pose some broader but more foundational questions:

- What societal values do we *want* to share concerning whose life is regarded as significant, worthwhile, and 'good'?
- What does the empirical evidence suggest regarding the values that British society currently holds about whose life is regarded as significant, worthwhile and 'good,' and whose is not?
- What is the wider social, economic and political context in which we are debating euthanasia/assisted suicide?

We can learn a lot from sociological/ social science research that gives sophisticated and nuanced insight into these questions, particularly from disability studies that question the assumptions that some lives are more 'livable' than others.

Framing the problem differently also enables us to consider *alternative* modes of regulation beyond these binary polarised solutions. One might propose a holistic approach that would necessitate greater attention to social and economic policy changes at the level of social support for socially vulnerable persons, at the same time as allowing choice and care for those who request assistance in their death. This is an important consideration as the data shows it is marginalised groups that are more likely to seek end of life solutions. It is also important to question dominant societal values that stigmatise vulnerability and dependency that may, unintentionally, support discourses that see disability and infirmity as a burden to family and society. Moreover, a solution must be found which has greater respect for medical practitioners who often do not want to carry the burden of assisted suicide and who are often left unprotected by legal reforms.<sup>v</sup>

The aim here is not to protract the debate but to take greater cognisance of the underpinning context which requires consideration, and of the different perspectives that are far more nuanced. There is nothing to prevent the consideration of a case-by-case approach to assisted suicide requests. This could be managed or regulated outside of medicine and criminal law and could share responsibility between different professionals (including medics, but also social care practitioners, welfare officers, and family members) who might act as panelists, for example, in deciding on cases brought before them, in a more holistic manner. While more time consuming and difficult to implement, such a solution would potentially be more considered, protective and safe, for all parties involved, not only those seeking death and those who are vulnerable, but also those professionals tasked with performing interventions. While there will inevitably be a central role of the medical profession and police officers in any mode of regulation, this responsibility must be supported and shared to protect both the professionals and those contemplating ending their lives.

I would be happy to supply all the research evidence that I use to support these proposals and discuss further case law and comparative examples that I use in my own research and publications:

Book:

\*Harden, J. (2016). *Law, Immunization and the Right to Die*. London: Routledge.

Articles:

Harden-Dvorak, J. (forthcoming) Decriminalising End of Life Interventions. Invited submission to journal special issue on 'decriminalisation' for *Social & Legal Studies*.

Harden, J. (2017) Biopolitics and the Enemy: On Law, Rights and Proper Subjects, *Law, Culture and the Humanities*, 13(3), 383-403.

Harden, J. (2013). Fear, Sovereignty and the Right to Die. *Societies*, 3(1), 66-79.

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<sup>i</sup> <https://docs.cdn.yougov.com/9zj99qnof/YouGov%20-%20Doctor-assisted%20suicide.pdf>

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<sup>ii</sup> <https://www.rcplondon.ac.uk/news/rcp-clarifies-its-position-assisted-dying>

<sup>iii</sup> Statistics on disability in the UK reveal that significantly higher percentages of disabled persons experience unemployment and poverty than non-disabled persons. Loneliness also disproportionately impacts people with limiting long term illness or disability (15% compared to 4% stating they often/.always felt lonely) and those living in the most deprived areas. See <https://www.gov.uk/government/statistics/community-life-survey-202021-wellbeing-and-loneliness/wellbeing-and-loneliness-community-life-survey-202021>

<sup>iv</sup> For instance: What protections could be put in place to protect people from coercion and how effective would these be?; What information, advice and guidance would people need in order to be able to make an informed decision about whether to access assisted dying/assisted suicide services?; What capabilities would a person need to be able to consent to assisted dying/assisted suicide?

<sup>v</sup> Evidence from the Netherlands suggests that two-thirds of cases requested by patients are either rejected outright or are not pursued by physicians (e.g., by way of procrastination). Many physicians begin their careers with the aims of healing and saving lives, and therefore the prospect of being responsible for bringing about death may weigh heavily on their personal and professional emotions as well as ethics. Even by expanding to a MAiD model like Canada that enables nurse practitioners to assist suicide, the Canadian model has seen delays in MAiD for reasons of conscientious objection. Those we would likely most entrust to assist in suicide - palliative care practitioners and specialists in geriatrics – are the most against it, as the 2019 RCP survey highlights. Since any Bill is likely to account for conscientious objection, in practice requests to death would likely stagnate as they have done in the Netherlands and in Canada.

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