

A Pretty pass: when is there a right to die?

Dame Brenda Hale

The Rt Hon Lady Justice Hale MA LLD(Hon), Court of Appeal, Royal Courts of Justice, London

This paper is based on the Fison Memorial Lecture, given by the author to Guy's, King's College and St Thomas' Medical and Dental School on 24 October 2002. The lecture is also published in the *Common Law World Review*, 2003;32:1

Clin Med 2003;3:142-8

ABSTRACT – This paper discusses the present extent and limits of a persons right to choose when and how to die, in the light of the contrasting decisions in the cases of Mrs Pretty (who was not allowed the choice) and Ms B (who was), and of the European Convention of Human Rights. It also discusses whether the Convention might eventually develop a right to self determination which would include such a right.

KEY WORDS: assisting suicide, autonomy, capacity, human rights, living wills, refusing treatment

Things have come to a pretty pass when religion is allowed to invade the sphere of private life.

Those words are attributed to Queen Victoria's mentor, Viscount Melbourne. A 'pretty pass', according to Brewer's *Dictionary of phrase and fable*, is 'a difficult or deplorable state of affairs'. Lord Melbourne could not have predicted that one of the starkest examples of the conflict between religious values and respect for private life ever to come before the courts of this country would do so at the instance of a Mrs Pretty.

My interest in this topic stems from two recent decisions of our courts. These are not about euthanasia in the usual sense of mercy killing, but about assisting suicide or withdrawing treatment. Their contrasting results highlight the principles and dilemmas of the present law extremely well. Mine is

now a practitioner's rather than an academic's perspective: in Mrs Diane Pretty's case, I was a member of the Divisional Court which made the first decision, confirmed by the House of Lords and the European Court of Human Rights (ECHR) in Strasbourg (*R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening)*).¹

A right to choose?

Mrs Pretty was diagnosed as suffering from motor neurone disease in November 1999. Her condition deteriorated quickly. By late 2001, she was essentially paralysed from the neck down, had little decipherable speech and was fed by a tube. She had only a few weeks to live. She was frightened and distressed by the suffering and indignity she would have to bear if the disease were allowed to run its natural course. She wanted her husband to provide her with the means to end her suffering when she no longer felt able to bear it. The final act, however, would be hers. These were the facts with which we were presented: we were asked to decide the case without further exploration of what might be involved.

Section 1 of the Suicide Act 1961 abolished the common law crime of committing suicide, but section 2(1) made it a criminal offence, punishable with up to 14 years' imprisonment, to aid, abet, counsel or procure the suicide of another. The Prettys' solicitor wrote to the Director of Public Prosecutions (DPP) asking him to undertake not to prosecute Mr Pretty for this offence. The DPP said he could not do so. Mrs Pretty asked the court to quash this decision and order the DPP to give the undertaking. Very much as second best, she asked us to declare section 2(1) incompatible with her rights under the European Convention on Human Rights. This would not have affected the validity of the DPP's decision – merely put pressure on the Government to take steps to change the law.

The Divisional Court refused Mrs Pretty's application in October 2001. This refusal was upheld by the House of Lords in November. In April 2002, the ECHR ruled that there had been no violation of her Convention rights. She died very soon afterwards, aged 43, in the distressing and undignified way that she had most feared. Yet no-one ever suggested that she was not fully competent to make the choice to die at the time and in the manner of her own choosing.

Key Points

It is a crime to help someone to commit suicide but a civil wrong to treat someone against her/his will

The difference between killing and letting die is difficult to draw in law and in practice

The difference between capacity and incapacity to decide to refuse treatment is difficult to draw in law and in practice

The right to life and the prohibition of inhuman or degrading treatment under the European Convention on Human Rights do not include a right to die

The Convention does recognise a right to self determination within which a right to choose when and how to die might eventually be developed

No-one who had seen Mr and Mrs Pretty together in court could have doubted their devotion to one another, or failed to admire the tender loving care he gave her, the fighting spirit which had brought them there, and her bright brave smile in the face of it all.

Ms B was also aged 43 when she died earlier this year. She too fell ill in 1999, when a cavernous haemangioma was diagnosed after a haemorrhage in the spinal column at her neck. She recovered then, but the angioma recurred in February 2001. She became tetraplegic, paralysed from the neck down. She was transferred to the hospital intensive care unit and placed on a ventilator, on which she had been dependent ever since.

She had already executed a living will, stating that should the time come when she was unable to give instructions, she wished for treatment to be withdrawn if she was suffering from a life-threatening condition, permanent mental impairment or permanent unconsciousness. After surgery to remove the angioma had made only a small improvement in her condition, she asked for the ventilator to be switched off. The hospital took legal advice and arranged for her to be assessed by two psychiatrists. In April 2001, they assessed that she did not have the capacity to decide for herself. She was referred to several spinal units with a view to attempting some rehabilitation.

However, an independent psychiatric assessment in August 2001 concluded that she did have the capacity to decide. She made another living will, made it clear that she did not want to go to a spinal rehabilitation unit, and rejected a proposal for 'one-way weaning' off the ventilator. The hospital was prepared to agree to this but not to simply turning it off. The normal weaning procedure is designed for patients who can or may be able to breathe again for themselves. The breaths supplied by the ventilator are gradually reduced, but if it turns out that the patient cannot manage on her own the ventilation is increased. In one-way weaning, the ventilation is not increased even if the patient is unable to breathe alone. Ms B declined this because it did not include pain control and would take several weeks. She wanted a quick and painless death rather than a slow and painful one in which she would 'feel robbed of a certain amount of dignity'.

She applied to the High Court for a declaration that she had the capacity to choose whether to accept or refuse medical treatment, that she had had such capacity since August 2001, and that the hospital had been treating her unlawfully since then. In March 2002, Dame Elizabeth Butler-Sloss, President of the Family Division, granted these declarations, thus leaving the choice of whether or not to continue the ventilation entirely to Ms B (*Re B (Adult: Refusal of Medical Treatment)*).²

She also awarded Ms B a small sum in damages for trespass to the person. This marked her disapproval of the hospital's conduct in not taking action to resolve the situation: they regarded Ms B as competent to choose, she had clearly chosen not to have the treatment, but they had forgotten the legal advice they had earlier been given and were continuing to treat her against her will. The clinicians and nurses had become emotionally involved after caring for this remarkable woman for over a year. This was understandable, but the trust should not have left it to them.

The President, Dame Butler-Sloss, also did her best to persuade Ms B to change her mind:

She is not bound by her past decision and when she goes to the hospital prepared to accept her, she has the right to reflect on what she may wish to do with her life. I would like to add how impressed I am with her as a person, with the great courage, strength of will and determination she has shown in the last year, with her sense of humour, and her understanding of the dilemma she has posed to the hospital. She is clearly a splendid person and it is tragic that someone of her ability has been struck down so cruelly. I hope she will forgive me for saying, diffidently, that if she did reconsider her decision, she would have a lot to offer the community at large.

Ms B did not reconsider and shortly afterwards she was transferred to another hospital where the ventilator was switched off.

The legal limits of autonomy

Counsel who was successful for Ms B was the same Counsel who was unsuccessful for Mrs Pretty. Counsel are not allowed to voice their own personal opinions in court; they say 'I submit' rather than 'I think'. This is because it is their professional duty to make the best case they properly can for their clients, irrespective of their personal views of the client or of the law. My guess is that Counsel knew very well what the result would be in each case. But did he wonder, as many others will wonder, whether such different results in such similar cases can be justified? Why was Ms B allowed to die a quick and dignified death at the time of her choosing, while Mrs Pretty had to suffer a slow and much less dignified death not at the time of her own choosing?

The lawyer has clear answers to these questions. They all start from the fundamental commitment to equal freedom. We all have the right to decide what to do with our own money, property, time, faculties and bodies. This is the liberal ideal of autonomy:

*Autonomy makes a person the sovereign authority over her life. She must choose and develop her own preferences, principles and commitments, live faithfully according to her choices and be responsible for the life she makes for herself. . . . people should be free to choose, follow and revise their own life projects, to have the opportunity to develop their talents, and to be given the chance of living out a good and fulfilling life The liberal values the opportunity to choose because this is an essential component of a person's goals, projects and achievements being authentically her own.*³

But of course this does not mean that everyone may do exactly as they please. There have to be limits. There are three main legal limits, although there are a good many other practical ones.

The first legal limit is that you cannot choose to infringe the equal rights of other people, including their own right to be free from harm. That is ultimately why the hospital was wrong to continue treating Ms B: the doctors and nurses wanted to do so because of their personal commitment to saving and prolonging life whenever they could, coupled no doubt with their personal liking and admiration for a remarkable woman. But for them to

exercise that choice was an infringement of her right to choose what would be done with her body. She did not owe them or anyone else a duty to stay alive.

The second legal limit is that only those who have the legal capacity to exercise choice are free to do so themselves. Those who do not have that capacity may have other people, usually their parents, carers or the courts, decide what is best for them. Everyone is assumed to have capacity until the contrary is shown. But what do we mean by capacity? As the President said, the law is

clear and easily to be understood by lawyers [but] its application to individual cases in the context of a general practitioner's surgery, a hospital ward and especially in an intensive care unit is infinitely more difficult to achieve.

She herself had said in *Re MB (Medical Treatment)*:

A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent or to refuse treatment. That inability to make a decision will occur when:

(a) the person is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question;

(b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at a decision.⁴

That test came from *Re C (Refusal of Medical Treatment)*,⁵ and bears a remarkable resemblance to the test recommended by the Law Commission in its report on Mental Incapacity.⁶

The crucial components of capacity are the ability to understand the relevant information, to have it in mind at the relevant time when the choice has to be made, and to use that information to make a choice. It assumes a proper explanation of the relevant information and focuses on the cognitive ability to understand its salient features. But it also requires the mental capacity to exercise choice. So if the choice is constrained, for example, by compulsion or delusion, the person will lack capacity. But that must be carefully distinguished from a choice which is informed by the subjective values and preferences of the person concerned. We must not interfere just because we disagree with her choice, or even because we do not think her choice is a sensible or prudent one.

The doctor instructed by the Official Solicitor to advise the court in the case of Ms B was struck that the clinicians had started not from an assessment of her competence but from the decision she had made, which they found unacceptable because it was contrary to their own views and advice. But it is fundamental to the whole idea of freedom that one has to start from the point of view of the person making the decision, their competence and their values. The weight which an individual chooses to give to competing factors is an essential part of the decision-making process. The President quoted Dr Kim Atkins:

If we accept that the subjective character of experience is irreducible and that it is grounded in the particularity of our points of view, then we are bound to realise that our respect for each other's differences and

autonomy embodies a respect for the particularity of each other's points of view. Respect for autonomy is at the same time recognition of the irreducible differences that separate us as subjects.

... While we can imagine, we cannot know objectively 'what it is like to be' another person, no matter how many facts we are in possession of...

Insisting that a decision be made from a fully objective perspective can only produce a decision that is further from the patient's own point of view, not closer to it.⁷

The President had no difficulty in finding that Ms B was fully capable of making up her own mind about her own situation: 'She appears to me to demonstrate a very high standard of mental competence, intelligence and ability'. The psychiatrists agreed. But they had all had the luxury of time to think about and assess the situation. Ms B had been thinking about it and considering the options for more than a year. The psychiatrists had had time to do a full psychological and psychiatric assessment. The President had heard the evidence over several days, including a visit to Ms B's hospital bed.

It was all very different in cases involving pregnant women. The law is just the same. The courts have acknowledged that a pregnant woman 'is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends upon it' (*St George's Healthcare NHS Trust v S*;⁸ *Re MB (Medical Treatment)*;⁹ cf *Re S (Adult: Refusal of Treatment)*).¹⁰ She has the right to refuse a blood transfusion or a Caesarean if she chooses to do so. But, curiously, those women who did put at risk their babies' lives by refusing medical intervention were found at the time to lack the capacity to make that choice.

In *Re T (Adult: Refusal of Treatment)*,¹¹ the courts held that a pregnant young woman who had been injured in a car crash was not competent to refuse a blood transfusion (Lord Donaldson) because she was not in a physical or mental condition to reach a decision binding on the medical authorities or, if she was, because she was under the undue influence of her mother; (Butler Sloss LJ) because her decision was vitiated by undue influence.

How many courts, and how many doctors, would find that a woman did have capacity to refuse emergency treatment which would save her own and her baby's life? One has to question whether the concept of capacity is yet strong enough to bear the weight that the law lays upon it. Might we be better off saying that there was always legal justification in imposing life-saving treatment in an emergency where death was imminent and then letting the debate take place in a calmer and more structured way – as arguably took place with Ms B? But if that were the law, it might validate enforced Caesareans in every case where there was a credible risk to the mother's life.

Even that would not help salve our consciences in the advance refusal cases: the case law is again quite clear that a person who has the capacity to do so may refuse treatment in advance of the time when they become incapable of making the choice (see *Airedale NHS Trust v Bland*).¹² The doctors in Ms B's case may not have known about her living will before they decided to ventilate her, or may have had their doubts about its applicability.

The third constraint on our freedom is even more problematic. There are some things that we are specifically not allowed to agree to do or to have done to us, because they are thought too harmful either to us as individuals or to society at large. Autonomy gives way either to:

- (a) paternalism – the idea that people do not always know what is good for them and others who know better are entitled to intervene for their own good; or
- (b) moralism – the idea that certain things are wrong even if they do not do harm or wrong to other people, although sometimes on closer examination the argument is that they are wrong because they are damaging, if not to individuals then to society or the community.

In its Consultation Paper on Consent, the Law Commission took the view that recent indications of Parliamentary opinion were ‘redolent of a paternalism that is softened at the edges when Parliament is confident that there is an effective system of regulatory control’ (eg licensing, professional ethics or self-regulation).

Thus it was a crime to take one’s own life until 1961. It is still a crime to take another person’s life even with their active consent and encouragement. It is still a crime to inflict actual bodily harm upon someone, except in some defined and regulated circumstances, even with their consent, for example in the course of sexual gratification (see *R v Brown*).¹³ This was found by the European Court of Human Rights not to be an unjustified interference with the right to respect for private life protected under Article 8 (see *Laskey, Jaggard and Brown v UK*).¹⁴ And it is still a crime to help someone to take their own life. Yet it is not a crime to let someone die if they want to do so.

So there is another crucial distinction: between killing and letting die. The hospital was allowed, indeed obliged, to let Ms B die. But no-one was allowed help Mrs Pretty die, whether by her own hand or theirs. The evidence to the House of Lords Select Committee on Medical Ethics (Report, 1994) was divided on this: between those (including many doctors) who saw it as necessary and common sense, and those (including many nurses) who saw it as ‘nothing short of hypocritical’ or ‘philosophically disingenuous’. The Committee must have approved of it, as they did not recommend any change in the law.

It is another distinction which people may find difficult to draw at the time. The doctors looking after Ms B saw turning off the ventilator as killing her: a deliberate act which would have the effect of bringing about her death. Yet they seemed prepared to contemplate gradually withdrawing the ventilation, equally deliberately and to the same effect. The law saw the first as withdrawing invasive treatment to which she no longer gave her consent. The second did not therefore arise.

Not all lawyers find the distinction easy either. Cory J, in the Irish Supreme Court case of *Re a Ward of Court (Withholding Medical Treatment)*¹⁵ (I am grateful to Barbara Hewson for this reference), saw withdrawing gastrostomy tube-feeding as killing (whereas all the other judges saw it as withdrawing invasive medical treatment). The trial judge in the case of the conjoined twins (*Re A (Children)(Conjoined Twins)*)¹⁶ was prepared to say

that the operation to separate them would not be killing the weaker twin, merely withdrawing the life support system provided for her by her stronger sister. The Court of Appeal did not agree. They had therefore to find other justifications for authorising it. (Thus raising the question of when deliberate killing is murder, which is beyond the scope of this paper.)

Help to die with dignity

So in English law there is a right to die by one’s own hand or by refusing life-saving or life-preserving intervention by others. But there is no right to be helped to die either by one’s own hand or the intervention of others. (There is, of course, only a very limited right to be helped to live, through the provision of care from people who have or have assumed responsibility for you: but you cannot insist on being provided with treatment which the doctors consider futile or which has been rationed according to rational criteria which you fail.) The question for the courts in the *Pretty* case was whether the European Convention on Human Rights made a difference.

Article 2 of the Convention reads like this:

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

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

(a) *in defence of any person from unlawful violence;*

(b) *in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;*

(c) *in action lawfully taken for the purpose of quelling a riot or insurrection.*

The State has an obligation not to take life except in the circumstances allowed by the Article. But the State also has an obligation to take positive steps to safeguard people’s lives from attack (see *Osman v United Kingdom*).¹⁷ This might include prohibiting killing even with consent: certainly it was not incompatible for the State to do so. (If Article 8 permits the State to prohibit consensual causing of actual bodily harm *a fortiori* Article 2 must permit the State to prohibit consensual taking of life.) But we agreed that this did not require the State to take positive steps to force life upon the unwilling. It might support a distinction between taking life and taking steps to enable another person to take her own life: it might therefore be permissible to relax the absolute rule against assisting suicide without offending against Article 2.

However, that did not mean that the State was obliged to do so. We rejected the argument that the right to life includes the right to die and the right to choose when and how to die. In *Re a Ward of Court*,¹⁵ the Irish Supreme Court pointed out that for the religious, death is not an end but a beginning. Denman J put the point in a more secular way (p. 161):

In respecting a person's death we are also respecting their life – giving it sanctity ... A view that life must be preserved at all costs does not sanctify life ... To care for the dying, to love and cherish them, and to free them from suffering rather than simply to postpone death is to have fundamental respect for the sanctity of life and its end.

Hence, as Hamilton CJ put it (p 124):

As the process of dying is part, and an ultimate, inevitable consequence, of life, the right to life necessarily implies the right to have nature take its course and to die a natural death and, unless the individual concerned so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means, which have no curative effect and which is intended merely to prolong life.

But this was in the context of a situation like Ms B's, except that the ward lacked capacity so others had to make the decision for her. I doubt whether the court would have held that an artificially induced death, even in a case like Mrs Pretty's, was part of life.

We accepted the contrary argument that death is the antithesis of life: a right to life cannot possibly include a right to die. To hold otherwise would mean that no member state could prohibit suicide. It would also mean that would-be suicides could not be rescued: we at least expressed the view that it was lawful to rescue suicides and then consider the rights and wrongs later. We pointed out that the ECHR recognised the State's duty to protect prisoners from self harm, albeit subject to other provisions in the ECHR.

The ECHR in Mrs Pretty's case was also not convinced that the 'right to life' had a negative aspect. Article 2 is not phrased in terms of a freedom: it is unconcerned with issues to do with the quality of living or what a person chooses to do with his or her life (which may be protected by other articles):

Article 2 cannot without distortion of language be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the right to choose death rather than life. (para 39)

The ECHR declined to express a view on whether permitting assisted suicide would be in breach of the ECHR (para 41). Perhaps this is just as well, given that there are now two member states which have gone even further and legalised 'mercy killing'.

Article 3 provides that:

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

As with Article 2, to which it is closely linked, this not only requires the State to refrain from torture, inhuman or degrading treatment or punishment. It also requires the State to take measures to ensure that people are not subjected to such treatment by others (such as parents or stepparents). The argument was that the right to be protected from inhuman or degrading treatment conferred the right to die with dignity. We agreed that it conferred a right to human dignity, but a right to live with as much dignity as could possibly be afforded until that life reached its natural end. We hoped that this would encompass

the right to proper medical treatment to prevent or alleviate the sufferings of people with terminal illnesses (although that might be controversial in member states without an NHS). It did not confer the right to be helped to die with dignity.

The ECHR pointed out that there was no complaint that the State was inflicting any ill treatment upon Mrs Pretty or that she was not receiving adequate care from the medical authorities. This was not the same as the case in which an AIDS sufferer was to be deported by the State to a place where no treatment would be provided. There was no ill treatment by anyone else. Articles 2 and 3 had to be construed in basically same way. They did not require the State to permit or facilitate a person's own death.

Thus far everyone was agreed. But was there somewhere else to look? The Irish Supreme Court had seen the right to self-determination as part of the right to privacy. This is recognised by Article 8 of the ECHR:

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

In the Divisional Court we thought that Article 8 could be engaged. We said:

The advantage of Article 8 in this, as in many other contexts, is that it contains within it the mechanism for balancing the various interests engaged. Article 8.1 protects the moral and physical integrity of the individual: see X and Y v The Netherlands (1985) 8 EHRR 235. It is possible to spell out of the right to bodily integrity the right of a competent person to refuse life prolonging or even life sustaining treatment, unless there is a good reason to interfere with that right under Article 8.2. We are even prepared to assume, for the purpose of this argument, that it could include the right to be allowed to take one's own life, again unless there is good reason to interfere with it under Article 8.2.

The House of Lords disagreed: they thought that the right to respect for private and family life was a right to respect for the way one lived one's life rather than a right to respect for the way one wished to die.

The right to human dignity and human freedom

The ECHR, however, pointed out that the concept of 'private life' is a broad term, not susceptible to exhaustive definition. Although no previous case had established as such any right to self-determination as being contained in Article 8, the Court considered that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees (para 61). The ability to conduct one's own life in the manner of one's own choosing may include the opportunity to pursue activities perceived to be physically or morally harmful or dangerous to the person concerned. Convention case law had

regarded compulsory measures impinging upon private life as requiring justification (eg in the sado-masochism case of *Laskey, Jaggard and Brown v United Kingdom*).¹⁴ Also:

The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of the sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.

This is an important statement. Human dignity goes beyond mere freedom, not least because it respects the value of those who are unable to exercise the right to equal freedom. It opens the door to that balancing exercise between the dignity and freedom of the individual and the interests of society which we in the Divisional Court had envisaged might one day take place.

So could the blanket ban in section 2(1) could be justified under Article 8(2)? There are three components in such justification:

- (1) it must be 'in accordance with the law', which this is;
- (2) it must be for a legitimate aim, which this is – it was accepted that the preservation and protection of human life in general and vulnerable people in particular was a legitimate aim; but
- (3) it must be 'necessary in a democratic society' – this means that it must correspond to a pressing social need and be proportionate to the legitimate aim pursued.

A considerable 'margin of appreciation' is left to member states in judging what fulfils these criteria in their own countries. In our view, this meant that we had to judge section 2(1) against conditions in our own country rather than by reference to the conditions in every member state. On the other hand, there was still a great deal of common ground on this subject amongst member states and indeed elsewhere in the world.

The ECHR agreed that states were entitled to prevent people doing harm to themselves. The more serious the harm the more heavily will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy. The vulnerability of the class of terminally ill people constitutes a rationale for the law. A blanket ban was not disproportionate, given the flexibility involved in the discretion to prosecute and the variable sentences for any offence other than murder. In the *Pretty* case, we were being asked to approve a husband helping his wife to commit suicide at a time and in a way which we knew nothing at all about.

The House of Lords pointed out that we could not have done it in any event, because this was a matter which had to be left to Parliament. All we could do was declare section 2(1) incompatible with Mrs *Pretty's* Convention rights. This leaves the law intact but requires Parliament to put it right. Had we thought the time was right to do this, we might also have expressed a view on the criteria and safeguards which might be appropriate if the ban were to be relaxed. No doubt Parliament would pay some attention to what the courts, confronted with the evidence in a particular case, had thought necessary.

It is almost inconceivable that these safeguards would not involve the medical profession both in assessing whether the criteria were met and in supervising what help was actually given. Again, that was not what was being suggested in the *Pretty* case. The sincerity of Mr *Pretty's* desire to help his wife and respect her wishes was never in question. But many people would be uncomfortable about allowing family members to help without any outside scrutiny or assessment.

But, as we said in the Divisional Court (para 59), this raises a more fundamental problem:

If a blanket ban on assisted suicide is an unacceptable interference with autonomy and self-determination, why should an exception be limited to the terminally ill? It is not for third parties to make judgments about the quality of anyone else's life. Only that person can know what is or is not intolerable for them. The reason why we might wish to respect their right to die is that we wish to respect their right to their own values and choices, provided always that these are freely made. Yet, while there is some public support for allowing doctors to end the life of a person with a painful incurable disease if that person has requested it, there has been very little for allowing this if the person was not incurably sick.

I still do not know the answer to this question. It looks as though we may be preparing ourselves to accept the right of a person to die with dignity at a time and a manner of their own choosing, but only if the circumstances are such that we ourselves can empathise with and approve of it. If the reason for this is the respect we owe to everyone's personal values and choices, why should our empathy with those values and choices make any difference? Leaving the more difficult case of pregnant women aside, it is not at present arguable that anyone owes anyone else a duty to stay alive. We are not allowed to force life upon other people whatever their reasons for refusing treatment. Might we one day be prepared to feel the same way about assisting suicide?

Somehow I think not. Perhaps this is an area in which we will always be reluctant to carry the notion of individual freedom to its logical conclusion, and will only accept those choices which conform to our own notions of what is required by respect for human dignity. Respect for human dignity is not in terms guaranteed in the ECHR although it has been articulated in the jurisprudence of the ECHR. I believe that it has much to offer in expanding our notions of human rights beyond those associated with the simple right to equal freedom. But we have not yet begun to import it into our laws of death and dying.

References and cases

- 1 *R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening)* [2001] UKHL 61, [2002] 1 AC 800; cf [2001] EWHC Admin 788, *Pretty v UK*, 2346/02.
- 2 *Re B (Adult: Refusal of Medical Treatment)* [2002] EWHC 429 (Fam), [2002] 2 All ER 449.
- 3 Roberts P. Appendix C to Law Commission Consultation Paper No 139, *Consent in the Criminal Law*.
- 4 *Re MB (Medical Treatment)* [1997] 2 FLR 426, 437.
- 5 *Re C (Refusal of Medical Treatment)* [1994] 1 FLR 31, 36.
- 6 Law Commission. *Mental Incapacity*. Law Commission Report No 231. London: Law Commission, 1995.

- 7 Atkins K. Autonomy and the subjective character of experience.
J Applied Philos 2000;17(1):71–9.
- 8 *St George's Healthcare NHS Trust v S* [1999] Fam 26, 50, CA.
- 9 *Re MB (Medical Treatment)* [1997] 2 FLR 426, CA.
- 10 *Re S (Adult: Refusal of Treatment)* [1993] Fam 123.
- 11 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.
- 12 *Airedale NHS Trust v Bland* [1993] AC 789.
- 13 *R v Brown* [1994] 1 AC 212.
- 14 *Laskey, Jaggard and Brown v UK* (1997) 24 EHRR 39.
- 15 *Re a Ward of Court (Withholding Medical Treatment) (No 2)* [1996] 2 IR 79.
- 16 *Re A (Children)(Conjoined Twins)* [2001] Fam 147.
- 17 *Osman v United Kingdom* (1998) 29 EHRR 245.