The haunting case of Sophia, a 51-year-old Canadian woman, laid bare the unsettling reality of legalised assisted suicide.[1] Struggling with severe chemical sensitivities and unable to find safe housing, Sophia sought Medical Assistance in Dying (MAiD), not because of terminal illness, but because life's circumstances had become unbearable. Her death was not merely a personal tragedy but a stark indictment of a system that, in offering death as a service, risks eroding the very dignity it claims to uphold. As Britain contemplates the Terminally Ill Adults (End of Life) Bill ('The Bill'), Sophia's story demands we confront an uncomfortable truth: in offering death as a service, the state does not merely provide an option, it fundamentally reshapes what constitutes a life worth living.

The Bill sits at the intersection of competing human rights. Article 2 of the European Convention on Human Rights (ECHR), which guarantees the right to life, appears to preclude its own negation.[2] *Pretty* asserted that this right "*could not, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely the right to die*".[3] Yet, Article 8, protecting private life and autonomy, suggests that preventing an individual from avoiding an undignified death may violate personal autonomy.[4] It seems that, while death cannot be claimed as a right, the state retains

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[1] Leyland Cecco, 'Are Canadians being driven to assisted suicide by poverty or healthcare crisis', (*The Guardian*, May 2022) < https://www.theguardian.com/world/2022/may/11/canada-cases-right-to-die-laws> accessed 14 February 2025

[2] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention in Human Rights, as amended) (ECHR) art 2

[3] App no 2346/02 (ECHR, 29 April 2002)

[4] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention in Human Rights, as amended) (ECHR) art 8

the power to decide whether to extend its hand in facilitating it. In Britain, such a shift would represent a profound departure – a move towards a more interventionist, perhaps paternalistic, model of medicine, one that fractures the long-standing principle of negative rights to treatment, as affirmed in *Re B*.[5]

Comparative jurisprudence reinforces this complexity. In *Washington v Glucksberg,* the Supreme Court rejected assisted suicide as a fundamental right, deferring such decisions to individual states.[6] Similarly, in *Haas v Switzerland,* the European Court recognised the lack of consensus on end-of-life choices, granting States broad discretion.[7] Such deference should raise concern, as fundamental rights are subject to the highest level of scrutiny, whereas when death is framed as a state-sanctioned service, its regulation becomes subject to shifting political and administrative priorities. No country tells this story better than Canada. MAiD began as a narrow provision for the terminally ill.[8] It has since expanded to include those with non-terminal conditions, and soon, even 'mature minors'.[9] In Belgium and the Netherlands, psychiatric suffering alone can now justify assisted dying, with 1.4% of Belgian Physician-Assisted Suicides (PAS) falling under this category.[10] History is an unkind witness to legislative ambition and what is deemed the 'exception' always widens, not by conspiracy but by legal logic

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[5] Re B (Adult: Refusal of Medical Treatment) [2002] 2 All England Reports 449

[6] 521 U.S. 702 (1997)

[7] App no 31322/07 (ECHR, 20 January 2011)

[8] Carter v Canada (AG) [2015] SCC 5; Bill C-62 'An Act to amend the Criminal Code (medical assistance in dying)', No.2

[9] Sydney Campbell et al, 'Exploring assisted dying policies for mature minors: A cross-jurisdiction comparison of the Netherlands, Belgium & Canada', [2024] (Health Policy, 105172), Vol 149

[10] Marc De Hert, Kristof Van Assche, 'Euthanasia for unbearable suffering caused by a psychiatric disorder: improving the regulatory framework', [2024] (PubMed Central, 10785970)

– if one form of suffering warrants death, why not another? These expansions are driven by legal challenges, with courts repeatedly broadening eligibility criteria. This results in an inherently litigious issue, straining an already overwhelmed judicial system. As the courts become instruments of expansion, we must question, in a decade, who will The Bill serve? And who will it fail? It is our duty to question such consequences as Lord Sumption warned in *R (Nicklinson)* that the law's role extends beyond merely reflecting social attitudes but actively shaping them. [11]

The Bill's attempt to contain this expansion through its six-month prognosis criterion reveals a fundamental flaw in treating suffering as a quantifiable matter. Medical literature consistently demonstrates the fallibility of prognoses, with studies from Christakis and Lamont showing that doctors frequently overestimate terminal diagnoses, meaning some will die prematurely under the mistaken belief that they had mere months left.[12] Others, enduring excruciating, but non-terminal conditions, remain ineligible. This uncertainty creates a dangerous gap between the law's need for precise criteria and the messy reality of human mortality. While Canada's criterion of an "*advanced state of irreversible decline'* offers more flexibility, it too struggles with the fundamental challenge of reducing existential decisions to clinical metrics.[13] If suffering defies simple quantifications, can any legal framework capture its complexity without

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[11] R (on the application of Nicklinson and another) (AP) (Appellants) v Ministry of Justice [2013] UKSC 0235

[12] N A Christakis and E B Lamont, 'Extent and determinants of error in doctor's prognoses in terminally ill patients: prospective cohort study', BMJ (Clinical Research ed), vol. 320, 7233 (2000) 469-72

[13] Bill C-7, 'An Act to amend the Criminal Code (medical assistance in dying) No. 43-1

authorising premature death while simultaneously denying relief for those in profound distress?

The administration of the Bill presents an even sharper dilemma. A ‘service; must be delivered with ‘reasonable care and skill’, a duty that feels deeply paradoxical when the intended outcome is death. Unlike other medical treatments, assisted dying leaves behind a regulatory void: the deceased cannot seek redress for an incorrect dosage or a flawed capacity assessment. This concern is far from hypothetical. A study in the Netherlands found that 40% of patients initially deemed competent were later determined to lack the necessary capacity upon specialised review.[14] Given the inevitability of human error, this accountability gap places immense administrative and emotional strain on the judiciary, casting judges as arbiters not only of the law but of life itself. Establishing a specialised capacity committee that blends medical and legal expertise could offer a more consistent reliable framework for eligibility decisions, alleviating some of the pressure on the courts.

Beyond the letter of the law lies the unspoken reality: coercion is rarely overt. The Bill’s safeguards against coercion, while well-intentioned, cannot address the subtle pressures created by offering death as a service. Economic precarity, inadequate healthcare resources, and societal stigma create invisible coercion that no legal

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[14] Mark D Sullivan, Linda Ganzini, and Stuart J Younger, ‘Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide?’, The Hastings Centre Report 28, no.4 (1998), pp.24-31, JSTOR, https://doi.org/10.2307/352610, Accessed 4 February 2025

framework can fully address. That is why the greatest sin of The Bill lies in its emphasis on death without a commensurate investment in palliative care. With the Oregon Public Health Division finding that depression significantly correlates with MAiD requests[15] and Global News reporting that how poverty becomes a driving force for disabled Canadians to seek MAiD, we must question whether we've created an implicit duty for society's most vulnerable.[16]

Proponents argue that assisted dying grants dignity, but dignity is not dispensed in a vial of barbiturates. It is found in the quality of care, the absence of fear, and the assurance that suffering will be alleviated. The Bill offers a pathway to death, but does it ensure that life remains a viable and dignified alternative? If the state offers death, it must first ensure that it is not the only escape from suffering. Otherwise, this law does not provide freedom but its illusion.

[Word Count: 1000]

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[15] Oregon Public Health Division, 'Oregon's Death with Dignity Act 2014' (2015), < https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf> Accessed 13 February 2025

[16] Brennan Leffler and Marianne Dimain, 'How poverty, not pain, is driving Canadians with disabilities to consider medically-assisted death', (Global News, 2022) < https://globalnews.ca/news/9176485/poverty-canadians-disabilities-medically-assisted-death/> Accessed 13 February 2025