Neutral Citation Number: [2017] EWHC 2447 (Admin)

Case No: CO/6421/2016

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 05/10/2017

Before:

LORD JUSTICE SALES
MRS JUSTICE WHIPPLE
MR JUSTICE GARNHAM

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Between:

The Queen on the application of: **Noel Douglas Conway**	**Claimant**
- and -	
The Secretary of State for Justice	**Defendant**
(1) Humanists UK **(2) Care Not Killing** **(3) ND Yet UK**	**Intervenors**
(1) The Crown Prosecution Service **(2) Attorney General**	**Interested Parties**

Richard Gordon QC, Alexander Ruck Keene and Annabel Lee (instructed by **Irwin Mitchell**) for the **Claimant**
James Strachan QC and Benjamin Tankel (instructed by **Government Legal Department**) for the **Defendant**
Caoilfhionn Gallagher QC and Graeme L. Hall (instructed by **Hodge Jones & Allen**) for the **1st Intervenor**
David Lawson (instructed by **Barlow Robbins**) for the **2nd Intervenor**
Catherine Casserley (instructed by **Fry Law**) for the **3rd Intervenor**

Hearing dates: 17, 18, 19 and 20 July 2017

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Approved Judgment

Lord Justice Sales:

Introduction

1. This is the judgment of the court, to which all its members have contributed.

2. This case concerns the issue of provision of assistance to a person with a serious wasting disease who wishes to commit suicide, so as to be able to exercise control over the time of his death as the disease reaches its final stages. It follows a line of cases which have addressed that or similar issues, in particular *R (Pretty) v Director of Public Prosecutions* [2001] UKHL 61; [2002] 1 AC 800 ("*Pretty*"), *R (Purdy) v Director of Public Prosecutions* [2009] UKHL 54; [2010] 1 AC 345 ("*Purdy*") and *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38; [2015] AC 657 ("*Nicklinson*"). Permission to bring this judicial review was granted by the Court of Appeal (McFarlane and Beatson LJJ, see [2017] EWCA Civ 275), having earlier been refused by the Divisional Court (Burnett LJ, Charles and Jay JJ) at [2017] EWHC 640 (Admin).

3. Section 1 of the Suicide Act 1961 abrogated the rule of law whereby it was a crime for a person to commit suicide. This is a claim by Mr Conway for a declaration of incompatibility pursuant to section 4 of the Human Rights Act 1998 ("the HRA") in respect of the prohibition in the criminal law against provision of assistance for a person to commit suicide. That prohibition is contained in section 2 of the Suicide Act 1961, as amended by the Coroners and Justice Act 2009 ("section 2"). Section 2(1) provides:

> "A person ("D") commits an offence if –
>
> D does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and
>
> D's act was intended to encourage or assist suicide or an attempt at suicide."

4. Mr Conway is 67. He suffers from a form of Motor Neurone Disease ("MND") which he probably contracted in about 2012.

5. MND is a neurological disease which attacks the nerve cells responsible for controlling voluntary muscle movement. The nerve cells degenerate and die and stop sending messages to the muscles. The muscles gradually weaken and waste away. Eventually, the brain's ability to start and control voluntary movement is lost. Mr Conway has to use a wheelchair and requires ever increasing levels of assistance with daily life, eating and bodily functions. The muscles which allow Mr Conway to breathe are also wasting away. He increasingly finds it difficult to breathe without mechanical assistance in the form of non-invasive ventilation ("NIV"), which he requires for an increasing number of hours each day. The average life expectation of a person with MND is between two and five years. MND is a terrible affliction, and Mr Conway has our profound sympathy and our respect for the way in which he has been coping with it.

6. When Mr Conway has a prognosis of six months or less to live, he wishes to have the option of taking action to end his life at a time of his choosing. He explains:

> "I would like to be able to seek assistance from a medical professional so that I may be prescribed medication which I can self-ingest to end my life successfully, if I wish to do so. If I am unable to take the medication by drinking a prescribed medication, I would also be prepared to receive medication in a different format, by activating a switch for example. I do not believe that unsupervised alternative methods of suicide are humane or acceptable and would be additionally distressing for my loved ones.
>
> …
>
> I do not wish to get to a stage where my quality of life is so limited, in the last six months of life, that I am no longer able to find any enjoyment in it. This disease is a relentless and merciless process of progressive deterioration. At some point, my breathing will stop altogether or I will become so helpless that I will be effectively entombed in my own body. I would not like to live like this. I would find it a totally undignified state for me to live in. I find the prospect of this state for me to live quite unacceptable and I wish to end my life when I feel it is the right moment to do so, in a way that is swift and dignified. …"

7. Mr Gordon QC for Mr Conway submits that section 2 is a blanket ban on the provision of assistance for suicide which constitutes an interference with Mr Conway's right of respect for his private life under Article 8 of the European Convention on Human Rights ("ECHR"), as adopted as a Convention right for the purposes of the Human Rights Act 1998 ("HRA"), which is disproportionate and incompatible with that article. Accordingly, he submits that this court should grant a declaration of incompatibility in respect of section 2.

8. In the course of the hearing, Mr Gordon abandoned a distinct argument that section 2 is also incompatible with Article 14 of the ECHR.

9. Article 8 states:

> "(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."

10. Mr Strachan QC appears for the Secretary of State. He defends the compatibility of section 2 with Article 8. However, as Mr Strachan explained, the government does not promote its own policy in relation to the question of assisted suicide. When the issue is raised in Parliament, parliamentarians are given a free vote. Thus in a real sense Mr Strachan's submissions are made on behalf of Parliament itself, to defend the human rights compatibility of Parliament's choice in 1961 to enact section 2 and then to affirm it on successive occasions over the years and to maintain it in force now.

11. Mr Strachan accepts that the prohibition against assisting suicide set out in section 2 represents an interference with Mr Conway's right to respect for his private life in Article 8(1). This is now clearly established by authority: see *Pretty v United Kingdom* (2002) 35 EHRR 1, para. 67; *Hass v Switzerland* (2011) 53 EHRR 33, para. 51; *Purdy*; and *Nicklinson*. As stated in *Hass*:

> "… the right of an individual to decide how and when to end his life, provided the said individual is in a position to make up his own mind in that respect and to take the appropriate action, is one aspect of the right to respect for private life within the meaning of Article 8 of the Convention."

12. However, Mr Strachan submits that section 2 is compatible with Article 8 and not in violation of it because the interference with Mr Conway's right under Article 8(1) is justified under Article 8(2). The compatibility of section 2 with Article 8 was confirmed by the European Court of Human Rights ("ECtHR") in the case brought in Strasbourg after the domestic decision in *Nicklinson*: see *Nicklinson v United Kingdom* (2015) 61 EHRR SE7.

13. In particular, on Mr Strachan's submission, section 2 is a provision which meets the relevant standard of being "necessary in a democratic society" as a proportionate measure "for the protection of health", "for the protection of morals", and "for the protection of the rights of others." Although section 2 is a general or blanket prohibition, Parliament is entitled to regard it as necessary as a protection for the weak and vulnerable. It is also entitled to regard it as a measure which gives proper respect to the sanctity of life. Section 2 also reflects and gives reassurance to patients regarding the ethical standards which medical practitioners will apply in their cases and thereby promotes trust between doctors and patients and safeguards the provision of appropriate healthcare.

14. As part of his case, Mr Conway has put forward the outline of an alternative statutory scheme which he says would safeguard relevant competing legitimate interests and would sufficiently protect the weak and vulnerable in society and which therefore shows that the blanket prohibition in section 2 is an unnecessary and disproportionate interference with his rights under Article 8. The substantive criteria outlined by Mr Conway are that the prohibition on providing assistance for suicide should not apply where the individual is aged 18 or above; has been diagnosed with a terminal illness and given a clinically assessed prognosis of six months or less to live; has the mental capacity to decide whether to receive assistance or to die; has made a voluntary, clear, settled and informed decision to receive assistance to die; and retains the ability to undertake the final acts required to bring about his death having been provided with such assistance. In addition, he has outlined these procedural safeguards: the individual makes a written request for assistance to commit suicide, which is

witnessed; his treating doctor has consulted with an independent doctor who confirms that the substantive criteria are met, having examined the patient; assistance to commit suicide is provided with due medical care; and the assistance is reported to an appropriate body. As a further safeguard, Mr Conway also proposes that permission for provision of assistance should be authorised by a High Court judge, who should analyse the evidence and decide whether the substantive criteria are met in that individual's case.

15. The outline alternative statutory scheme proposed by Mr Conway is broadly equivalent to that in a Bill introduced in Parliament by Lord Falconer of Thoroton ("the Falconer Bill"). The Falconer Bill did not attract the support of Parliament and did not become law.

16. Mr Conway's case is that to accord proper respect to his Article 8 rights, the prohibition in section 2 ought to be modified to allow people in his position and within the category of individuals proposed by him to be provided with assistance in the form he describes so as to be enabled to commit suicide by their own action. He accepts that section 2 is clear in its meaning and effect, to prohibit the provision of assistance to someone to commit suicide, on pain of criminal sanction. There is no alternative interpretation which can be given to it pursuant to section 3 of the HRA.

Comparison with the Nicklinson *case*

17. Mr Conway's claim is that his rights under Article 8 require the prohibition in section 2 to be adjusted to permit others to provide him with assistance to enable him to commit suicide. He does not contend that compatibility with Article 8 would require the law to be changed to allow people to be killed by the action of another person, which is properly called euthanasia.

18. In this significant respect, the present case involves issues which are distinct from those which arose in two of the three cases under review in *Nicklinson*. There are also other material differences between Mr Conway's case and all three cases under review in *Nicklinson*.

19. *Nicklinson* involved appeals in relation to three claimants. Two of the claimants (Mr Nicklinson, who died in the course of the proceedings, and Mr Lamb) suffered from irreversible physical disabilities amounting to what was referred to as "locked in syndrome", as a result of which they were almost completely immobile, though they remained of sound mind and aware of their predicament. Mr Nicklinson had been placed in this condition as the result of a stroke; Mr Lamb as the result of a car accident. They were so disabled as to be unable to carry out any act themselves to commit suicide, even with assistance from others. The speculative possibility of construction of a special machine activated in some way by minimal blinking movement by them to inject them with a fatal dose of drugs was discounted by the Supreme Court. An important part of their case was that in order to respect their Article 8 rights the law ought to allow a third party to take action to end their lives. Amongst other relief, they sought a declaration of incompatibility with their rights under Article 8 in respect of the law which prohibits the deliberate killing of another human being or even the provision of assistance to a person who intends to commit suicide (i.e. the prohibition in section 2).

20. As the result of a brainstem stroke the third claimant (Martin) was also in a state broadly equivalent to "locked in syndrome". He retained the capacity to make limited hand movements and could commit an act of suicide, but only with the assistance of a third party. He was interested in finding out about the Dignitas service in Zurich, Switzerland and possibly travelling there to make use of that service to assist him to die, but would require assistance from others to enable him to do so. His case was that the Director of Public Prosecutions ("the DPP") should clarify and modify his published policy guidance for prosecutors in respect of cases of encouraging or assisting suicide – issued as a result of the *Purdy* case – so that his carers and others could know that they could assist him in committing suicide through use of the Dignitas service without the risk of being prosecuted. The DPP's guidance necessarily reflected the underlying substantive criminal law as set out in section 2.

21. The medical condition of each claimant in *Nicklinson* was different from MND, the disease from which Mr Conway suffers. Unlike Mr Conway, none of the claimants in the *Nicklinson* case was terminally ill. They faced the prospect of living for many years in a helpless condition, completely dependent on others, which they found demeaning and monotonous and which they wished to end. Mr Lamb had also experienced a significant amount of pain every day since his accident, with the consequence that he was constantly on morphine.

22. Mr Nicklinson and Mr Lamb could only end their own lives if they refused food and water and starved and/or dehydrated themselves to death. The evidence was that this would involve "a painful and undignified process of dying" (so described by Lord Dyson MR and Elias LJ in their judgment in the Court of Appeal at [1]); it would be "a potentially protracted exercise, involving considerable pain and distress" (per Lord Neuberger of Abbotsbury PSC in the Supreme Court, at [4]). Mr Nicklinson embarked on "the very difficult and painful course of self-starvation" (Lord Neuberger, at [6]) during the proceedings and died of pneumonia after the hearing in the Divisional Court and before the hearing in the Court of Appeal. This was the reason why Mr Lamb was added as a claimant in the proceedings when the case reached the Court of Appeal.

23. Similarly, the only option for Martin if he was unable to obtain the assistance of others in relation to trying to use the Dignitas service in Switzerland would be to starve and/or dehydrate himself to death.

24. By contrast, the evidence in relation to Mr Conway is that if he wishes to die, including when his bodily functions have deteriorated and he approaches a "locked in" state himself, he could act upon that wish by asking, if necessary by communication through eye-blinking, for his NIV equipment to be removed. Since NIV is a treatment which involves physical intrusion by others of external matter (air) into Mr Conway's body and physical placing on his body of a face-mask, there is no doubt that he has an absolute right at common law to insist upon the cessation of NIV. This is common ground. Where NIV is stopped in a person with MND whose muscular deterioration is such that he cannot breathe without assistance, death follows shortly afterwards. Palliative care is available to manage this period, the aim of which is to allow the individual to feel calm and comfortable during the process of dying.

25. Expert evidence was filed on both sides about this. Neither party asked for permission to cross-examine any witnesses. In fact, there were no significant points of difference between them. The medical position is reasonably clear.

26. Where an individual suffering from MND is reliant on continuous assisted ventilation, the process of dying once NIV is withdrawn usually lasts only a few minutes, though in some cases it may take a few hours and in some very rare cases can take days. This was explained by the consultant respiratory physician with responsibility for Mr Conway, Dr Naveed Mustafa, and there was no dispute about it.

27. In our view, the best evidence about palliative care to manage the process was given in an expert report of Professor Christina Faull, a leading expert in the UK on palliative care in connection with withdrawal of assisted ventilation. She is the chair of the group that developed the Association for Palliative Medicine of Great Britain and Ireland 2015 guidance entitled "Withdrawal of assisted ventilation at the request of a patient with motor neurone disease: Guidance for Professionals". This guidance was published after consultation with a range of professional organisations and individuals. It has been endorsed by Hospice UK, the Motor Neurone Disease Association, the Royal College of Physicians, the Royal College of Nursing and the Royal College of General Practitioners. Professor Faull explains that the evidence from palliative practice supports her opinion that "effective symptom management can be given to prevent and manage breathlessness and distress for patients and that their families can be well supported."

28. Mr Gordon did not seek to mount any serious challenge to this assessment by Professor Faull in his submissions. The claimant filed an expert report from Emeritus Professor Sam Ahmedzai, who is also a specialist in palliative medicine. We were not taken to this in the course of the hearing. It does not give any significantly different perspective from that of Professor Faull on the ability of modern palliative medicine to provide options for managing the last period of life to cope with an individual's symptoms and distress arising from MND in an acceptable way. As Professor Ahmedzai explains in relation to the last days of life, "there is considerably increased scope for palliative care (both generalist and specialist levels) to enhance the care of the patient who is dying with MND."

29. Dr Claire Stockdale is the palliative medicine consultant who has responsibility for Mr Conway. She confirms that Mr Conway is receiving very good quality palliative care and related support. She also explains that when the time comes NIV could be withdrawn under circumstances where the patient is helped to be settled and comfortable: "Medication is used to ensure the patient is not aware of the NIV being withdrawn and does not become uncomfortable or distressed."

30. Mr Conway does not regard this option for ending his life as acceptable. Nor does he regard approaching the Dignitas service in Switzerland as an acceptable option. In any event, as with Martin in the *Nicklinson* case, he would need assistance from others to make use of it, in contravention of the prohibition in section 2, so that is not a viable alternative. For entirely understandable reasons, he wants respect for his dignity in the sense of being able to choose for himself the timing and manner of his death, by means of being provided with assistance in the form of advice from professionals and drugs at a fatal dose which he could administer himself.

31. As mentioned above, it is common ground that the operation of section 2 to prevent him having this option constitutes an interference with his right to respect for his private life as set out in Article 8(1), much as the non-availability of euthanasia in the cases of Mr Nicklinson and Mr Lamb and the non-availability of assistance to commit suicide in the case of Martin in the *Nicklinson* case constituted an interference with their right to respect for their private life under that provision. However, unlike Mr Conway, they wanted to be able to free themselves from years of what they regarded as a meaningless and undignified existence, and not to have as their only alternative the painful and undignified option of self-starvation or dehydration.

32. This means that the practical issues in relation to Mr Conway in balancing his individual interests against the public interest are materially different from those in relation to the three claimants in *Nicklinson*. Although each individual suffers or suffered from a terrible affliction and it is invidious to compare the cases, nonetheless the options available to Mr Conway are not so very bleak as those facing the claimants in *Nicklinson*.

33. Mr Gordon emphasised that the category of individual around which Mr Conway had fashioned his case in the present proceedings was narrowly confined, in particular because the alleged incompatibility is in relation to those who are terminally ill. This is a point of distinction from the position of the claimants in *Nicklinson*. It allows Mr Conway to argue that his proposals represent a more limited intrusion upon ideas related to the sanctity of life, if they have a relevant part to play in the assessment under Article 8 (see below). If someone is terminally ill and will die shortly anyway, it might be said that the sanctity of life as a value is harmed less if he is enabled to commit suicide than in a case where someone who has many years of life remaining is assisted to do so. But many people, and not just those with a religious outlook on life, would object to such an important principle as the sanctity of life being downplayed in this way.

34. Mr Gordon also emphasised that Mr Conway's case does not involve asking anyone else to commit the act of killing him. He wishes to be enabled to kill himself. To the extent that general moral considerations are relevant to the issue of compatibility with Article 8, Mr Gordon submits that this is less morally objectionable than might be the position if Mr Conway were contending that the law ought to allow another person to commit the act of killing him. That would involve a more extreme violation of a moral taboo or injunction not to kill another person. This again is a point of distinction from the position of Mr Nicklinson and Mr Lamb in *Nicklinson*, although not from the position of Martin. But if the principle of the sanctity of life is brought into account, the moral injunction against ending a human life may be taken by many to extend with broadly equivalent force to a case of providing assistance to commit suicide as to a case of euthanasia.

Medical treatment and the common law

35. The common law confers rights on individuals to insist upon preservation and protection of their physical integrity. The effect of this is that an individual has an absolute right to refuse medical treatment. Even if medical treatment is necessary to keep a person alive, he has an absolute right to refuse it and to choose to die. As explained by Lord Keith of Kinkel in *Airedale NHS Trust v Bland* [1993] AC 789 at 857C, "… it is unlawful, so as to constitute both a tort and the crime of battery, to

administer medical treatment to an adult, who is conscious and of sound mind, without his consent: *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1"; see also, for example, p. 864G per Lord Goff of Chieveley.

36. This principle was applied by Dame Elizabeth Butler-Sloss P in *In Re B (Adult: Refusal of Medical Treatment)* [2002] EWHC 429 (Fam); [2002] 2 All ER 449. In that case, as a result of a haemorrhage of the spinal column in her neck and later complications, the claimant had become completely paralysed from the neck down and was dependent on artificial ventilation. She instructed the hospital to stop the ventilation, even though that would result in her death. The judge found that the claimant had capacity to take this decision and that the hospital would be bound to comply with her instructions: [94]-[95].

37. Issues arise where a person is unconscious or otherwise lacks capacity to make the relevant choice about whether to receive or continue to receive life-sustaining medical treatment. The leading authority is the *Bland* case. The House of Lords decided that life sustaining treatment for a patient in a persistent vegetative state could be terminated, with the result that he would die. Although the law "forbids the taking of active measures to cut short the life of a terminally ill patient", to terminate the treatment would not violate that prohibition. In the circumstances of that case the treatment involved invasive manipulation of the patient's body to which he had not consented and which conferred no benefit upon him and so could be withdrawn: p. 859B-D per Lord Keith. This did not involve crossing the Rubicon between care of the living patient and euthanasia – "actively causing [the patient's] death to avoid or to end his suffering" – which is not lawful at common law: p. 865B-F per Lord Goff.

The Pretty *case*

38. Diane Pretty suffered from MND. She was mentally alert and wished to control the time and manner of her dying, but her physical disabilities prevented her from taking her life without assistance. Save for the prohibition against such assistance in section 2 and the threat of criminal sanction, her husband was willing to provide that assistance. It was accepted in Mrs Pretty's case that she faced "the prospect of a humiliating and distressing death": see *R (Pretty) v Director of Public Prosecutions* [2001] UKHL 61; [2002] 1 AC 800 at [1] per Lord Bingham of Cornhill. It does not appear that evidence regarding the availability and effectiveness of palliative care equivalent to that before us was before the courts in her case. Mrs Pretty sought an assurance from the DPP that her husband would not be prosecuted if he assisted her to commit suicide and other relief, including a declaration that section 2 was incompatible with her rights under Article 8.

39. Her claims were dismissed by the House of Lords. The DPP had no power to undertake that a crime yet to be committed should be immune from prosecution. Section 2 was not incompatible with rights under Article 8. Mrs Pretty's rights under Article 8 were not engaged: [26] (Lord Bingham); [61] (Lord Steyn); [99]-[101] (Lord Hope of Craighead); [112] (Lord Hobhouse of Woodborough); [124] (Lord Scott of Foscote). But even if they were, any interference with them by reason of section 2 was proportionate and justified under Article 8(2), in particular because of the need to protect the vulnerable and prevent abuse: [26]-[30] (Lord Bingham); [62] (Lord Steyn); [102] (Lord Steyn); [112] (Lord Hobhouse); [124] (Lord Scott). This was so

even though Mrs Pretty was mentally alert, had formed her wishes freely and was not herself in the category of vulnerable people.

40. Mrs Pretty brought a claim against the United Kingdom before the ECtHR relying on a number of Convention rights: *Pretty v United Kingdom* (2002) 35 EHRR 1. The ECtHR held that there had been no violation of any of her rights.

41. However, the ECtHR differed from the House of Lords in part of its analysis in relation to Article 8, in that it held that Mrs Pretty's rights under Article 8(1) were engaged in the circumstances of her case:

> "The applicant in this case is prevented by law from exercising her choice to avoid what she considers will be an undignified and distressing end to her life. The Court is not prepared to exclude that this constitutes an interference with her right to respect for private life as guaranteed under Article 8(1) of the Convention. …" ([67]).

42. The ECtHR agreed with the later part of the reasoning of the House of Lords in reliance on Article 8(2), to the effect that section 2 was a proportionate and justified interference with Mrs Pretty's rights under Article 8(1): [68]-[78]. In particular, the ECtHR said this at [74] (omitting footnote):

> "… the Court finds, in agreement with the House of Lords and the majority of the Canadian Supreme Court in the *Rodriguez* case [*Rodriguez v Attorney General of Canada* [1994] 2 LRC 136], that States are entitled to regulate through the operation of the general criminal law activities which are detrimental to the life and safety of other individuals. The more serious the harm involved the more heavily will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy. The law in issue in this case, section 2 of the 1961 Act, was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to taken informed decisions against acts intended to end life or to assist in ending life. Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of the class which provides the rationale for the law in question. It is primarily for States to assess the risk and the likely incidence of abuse if the general prohibition on assisted suicides were relaxed or if exceptions were to be created. Clear risks of abuse do exist, notwithstanding arguments as to the possibility of safeguards and protective procedures."

43. Four points arising out of the *Pretty* litigation should be mentioned at this stage. First, as noted above, the ECtHR's ruling that a person's decision as to the manner and timing of his death engages his rights under Article 8(1) has been endorsed in later Strasbourg case-law (see *Hass v Switzerland* (2011) 53 EHRR 33 and *Koch v Germany* (2013] 56 EHRR 6) and domestic law, in particular in *Nicklinson*. In light of those cases, it is common ground in these proceedings that Article 8(1) is engaged.

44. Secondly, it was accepted by the Supreme Court in *Nicklinson* and is accepted by Mr Gordon here that the ECtHR would find that the blanket prohibition against assisting someone to commit suicide contained in section 2 involves no violation of Article 8, as the ECtHR had held in the *Pretty* case. The ECtHR's position in this regard was confirmed in *Nicklinson v United Kingdom.*

45. Thirdly, therefore, the declaration of incompatibility which Mr Conway seeks in these proceedings is not a declaration of incompatibility with Convention rights as contained in the ECHR itself, to indicate that the United Kingdom is in breach of its obligations under that Convention as a matter of international law. Rather, Mr Conway seeks a declaration of incompatibility with the Convention rights as set out as distinct provisions in domestic law under the HRA. That a distinct claim of incompatibility with such rights can be maintained even where there is no breach of the ECHR itself was indicated by the House of Lords in *Re G (Adoption: Unmarried Couple)* [2008] UKHL 38; [2009] 1 AC 173 and was confirmed by the Supreme Court in *Nicklinson*. Mr Strachan accepts this, as he is bound to do. These decisions show that the interpretation of the domestic version of the Convention rights in the HRA does not simply mirror the Convention rights in the ECHR, as some earlier authorities suggested might be the case and as the House of Lords in *Pretty* appears to have assumed. We will refer to the distinct domestic interpretation of Convention rights as "the *Re G* interpretation". It is relevant that *Re G* and *Nicklinson* post-date the House of Lords decision in *Pretty*: see the discussion below.

46. Fourthly, Mr Gordon emphasises that in the submissions in the *Pretty* case in Strasbourg the British government appears to have contended that the rationale for section 2 was the need to protect the weak and vulnerable, as reflected in the ECtHR's judgment at [74] (see above at paragraph [42]). Mr Gordon's submission in the present case is that, on the footing that this and this alone is the rationale for section 2, the legislative reform he outlines would satisfactorily fulfil that objective, so the blanket prohibition in section 2 should be regarded as a disproportionate and unjustified interference with Mr Conway's admitted rights under Article 8(1).

47. As noted above, in these proceedings the Secretary of State relies on a number of objectives which he says are promoted by section 2, including but not limited to protection of the weak and vulnerable. The other objectives relied upon are respect for the sanctity of life ("protection of morals": see Article 8(2)) and promotion of trust between patient and doctor in the care relationship, by reinforcing the ethical standards applied by doctors, so that patients get and have the confidence to make use of the best advice and treatment available ("protection of morals", "protection of health" and "protection of the rights and freedoms of others": see Article 8(2)). Mr Gordon does not say that the Secretary of State is estopped from seeking to rely on these objectives as well, but he says that it is revealing that they were not relied on by the British government or the ECtHR in the *Pretty* case and maintains they do not carry much weight.

48. Mr Strachan says that the British government did in fact rely on a range of aims in its submissions to the ECtHR in *Pretty,* whilst accepting that the Court only refers to one of them, the protection of the weak and the vulnerable, at [74] of its judgment. But, he says, the point leads nowhere. The British government is not limited by what might have been argued in the past; and in any event, even if the rationale for section 2 is taken to be limited to protection of the weak and vulnerable, it is clearly

compatible with Article 8 as a proportionate measure "for the protection of the rights and freedoms of others" which is justified under Article 8(2). He further submits that when the additional objectives are brought into account, it is still more obvious that section 2 is a measure which is justified under Article 8(2) and which is not incompatible with Article 8. These rival submissions are assessed in the discussion below.

Engagement by Parliament in relation to section 2 and questions of assisted dying

49. Since it is relevant to our discussion of the effect of the Supreme Court's decision in *Nicklinson* on the present proceedings, we next set out the background of consideration in Parliament of section 2 and wider questions whether to legalise measures of assisted dying, including by active intervention to end a person's life.

50. Since its enactment in 1961, the prohibition on assisted suicide in section 2 has been discussed a number of times in Parliament. The following list of occasions when Parliament has considered the issue, in the period before the Supreme Court decided *Nicklinson,* is taken from the Secretary of State's Detailed Grounds at para. 37, with some amendment:

i) In 1994, the House of Lords Committee on Medical Ethics, after receiving evidence, reported that "[a]s far as assisted suicide is concerned", they saw "no reason to recommend any change in the law" (see HL Paper 21-I, 1994, para 26). This was primarily based on "the message which society sends to vulnerable and disadvantaged people", which "should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life" (*ibid*, para 239). The Government in its response agreed, on the grounds that a change in the law "would be open to abuse and put the lives of the weak and vulnerable at risk" – (1994) Cm 2553, page 5.

ii) After the ECtHR gave judgment in *Pretty v United Kingdom* on 29 April 2002, Lord Joffe attempted unsuccessfully to persuade Parliament to pass legislation in the form of the Assisted Dying for the Terminally Ill Bill between 2003 and 2006 (the "Joffe Bill"). This was framed to provide assistance for people who were subject to illnesses involving unbearable suffering and who were unable to kill themselves without assistance to do so.

iii) A House of Lords Select Committee examined the Joffe Bill and the issues surrounding it, received evidence and published its report on 4 April 2005 (HL Paper 86-I, 2005) (the "Select Committee Report").

iv) There was an adjournment debate on assisted dying in the House of Commons on 11 November 2008.

v) In July 2009, during the debate on the Bill which became the Coroners and Justice Act 2009, which amended section 2 of the 1961 Act in certain respects, Lord Falconer of Thoroton moved an amendment that would have removed the threat of prosecution from those who assist terminally ill people to travel to countries where assisted dying is legal. During the July 2009 debate on that Bill the amendment was defeated in the House of Lords. The House of Lords instead approved the clause which became the provision in the 2009 Act

(section 59) which preserved the effect of section 2 and re-enacted section 2(1) in clearer terms.

vi) The House of Commons also approved the relevant clause which became section 59 of the 2009 Act in a brief debate during which the purpose of that provision to preserve the effect of section 2 was explained.

vii) The Appellate Committee of the House of Lords handed down judgment in *Purdy* on 30 July 2009. The decision dealt with the policy of the DPP in relation to bringing prosecutions in cases of provision of assistance to someone wishing to die. The DPP reformulated his policy in 2010 in light of that decision. In March 2012, there was a debate on the DPP's reformulated policy in the House of Commons. Changes in the law were mooted, but in the event the reformulated policy was approved on a motion put to a vote. On 5 December 2013, a question for short debate on assisted dying was put before the House of Lords.

viii) On 12 December 2013 there was a debate in the House of Lords about end of life care which included debate about section 2(1) of the 1961 Act.

ix) On 5 March 2014 there was a debate in the House of Lords about prosecution policy which again included debate about section 2(1) of the 1961 Act.

51. The Supreme Court handed down judgment in *Nicklinson* on 25 June 2014. After that, Parliament considered the issue of assisted dying on the following occasions (again, this is taken substantially from the Detailed Grounds):

i) On 5 June 2014, Lord Falconer introduced his Assisted Dying Bill in the House of Lords. It had been prepared following research and analysis by a body referred to as the Falconer Commission. The Falconer Bill received its second reading on 18 July 2014, after 10 hours of debate but without a vote. The Falconer Bill was debated for two days in committee in November 2014 and January 2015. However, Parliament was prorogued before the Bill made any further progress in the 2014-2015 session.

ii) In June 2015, Rob Marris MP tabled a Private Members' Bill, the Assisted Dying (No 2) Bill, in the House of Commons. It was in materially similar terms to the Falconer Bill. It was debated in the House of Commons on 11 September 2015 for 4 hours and 18 minutes. It was rejected by 330 votes to 118.

iii) On 3 June 2015, Lord Falconer introduced an Assisted Dying Bill in the House of Lords in materially similar terms to his earlier Bill. It was not given time for debate due to its position on the ballot for private Bills.

iv) On 9 June 2016, Lord Hayward introduced an Assisted Dying Bill in the House of Lords in materially similar terms to the Falconer Bill. Parliament was dissolved before it got its second reading.

v) On 16 January 2017 there was a brief debate following a question in the House of Lords about whether the Government had any plans to legalise assisted dying for terminally ill adults with capacity, with appropriate safeguards.

vi) On 6 March 2017, there was a Short Debate in the House of Lords on the question of what assessment the Government had made of recent legislation on assisted dying in North America and whether such laws might provide an appropriate basis for legislation in England and Wales.

52. As can be seen, both Houses of Parliament have had the opportunity to consider the question of assisted dying on numerous occasions both before and since *Nicklinson* was decided. The prohibition on assisted dying has remained in place.

The Select Committee Report

53. As noted above, in 2005 the House of Lords Select Committee reported on the Joffe Bill. That bill sought to legalise medical assistance with suicide for people who were terminally ill, mentally competent and suffering unbearably and would have legalised euthanasia for those who were physically incapable of carrying out the final action to end their lives by way of suicide. The Select Committee called for evidence from a large number of organisations and invited contributions from individuals. Transcripts of the extensive oral evidence are publicly available. The abstract of evidence annexed to the Select Committee's Report touches on the areas of evidence taken by the Committee and the areas of controversy on which it reported.

54. The Select Committee recognised the principle of personal autonomy and noted that the supporters of the Joffe Bill believed that persons should have the right, subject to prescribed safeguards, to have medical assistance to die in the same way as patients already have the right to refuse life-prolonging treatment. It also noted that opponents argued that the two situations were not comparable, that it would be impossible to ensure that any safeguards were not abused and that in any event the law should not permit intentional killing, whatever the motive.

55. The Committee recorded conflicting views about the likely effect of the Joffe Bill in giving benefit to some and risking harm to others and about the risk of a change in the law leading to a "slippery slope" of assisted suicide or euthanasia in unsuitable cases, which some argued could be mitigated by effective safeguards. The Select Committee also noted a division of views about whether the Joffe Bill would improve or undermine the trust which underpins doctor-patient relationships and about whether medical practitioners would be prepared to implement such a Bill were it to become law. The Select Committee recorded the suggestion that the Joffe Bill would put some vulnerable groups of people, such as the disabled and the elderly, at greater risk, while noting opinion polls which suggested that the majority of people in these groups supported legislative change.

56. The Select Committee members visited three foreign jurisdictions which had enacted laws to permit assisted suicide, namely the State of Oregon in the USA, the Netherlands and Switzerland. The Select Committee noted that recent opinion polls in these places had suggested a high level of support for these laws, that such polls had generally taken the form of yes/no questions and that the attitude of medical professionals was ambivalent but more generally hostile.

57. The Select Committee's post-bag suggested a narrow majority in favour of the Joffe Bill. The Committee issued its report with recommendations, acknowledging that the Joffe Bill would not progress due to shortage of time in Parliament. It invited Parliament to debate its report and suggested that a further committee of the whole House of Lords should consider any further Bill seeking to change the law.

58. Mr Strachan submitted that little had changed since the Select Committee Report on the Joffe Bill. There is merit in that submission. Mr Conway's claim in these proceedings raises many of the same issues and controversies as were examined in detail and reported upon as long ago as 2005. It should be noted that the range of evidence received and considered by the Select Committee was very wide, extending well beyond that relied on before us.

The Falconer Bill

59. The Falconer Bill (and in turn, the bills introduced by Rob Marris MP and Lord Hayward) provided for procedures similar to those proposed by Mr Conway in these proceedings as sufficient safeguards to meet any risk to the weak and vulnerable from a change in the law in respect of section 2. The procedure suggested by Mr Conway is summarised at paragraph [14] above. The Falconer Bill would have legalised assisted dying for those who have a voluntary, clear, settled and informed wish to end their own life; are aged 18 or over; have capacity to make the decision to end their own life; have made and signed a declaration to that effect in the presence of an independent witness, where the declaration is also signed by the witness and two suitably qualified medical practitioners; have been ordinarily resident in England and Wales for not less than a year; have been diagnosed by a registered medical practitioner as having an inevitably progressive condition which could not be reversed by treatment and as a consequence of which they are reasonably expected to die within six months; and where the consent of the High Court has been obtained. Both the Falconer Bill and Mr Conway's proposals had features which are different from the Joffe Bill, in particular the requirement that there be a prognosis of death within six months, the absence of a requirement that the individual be subject to unbearable suffering and the addition of a requirement to obtain the consent of the High Court in each case.

Foreign jurisdictions

60. We were assisted in understanding the comparative legal position by the expert report of Professor Penney Lewis, Professor of Law at the Dickson Poon School of Law, King's College London, dated 15 December 2016, relied on by Mr Conway. It is not necessary for us to set out the comparative position in detail. We note, however, that at present only five of the forty-seven member states of the Council of Europe permit any form of assisted suicide. Of those, three permit euthanasia, i.e. termination of life by others on request by the individual, as well as assisted suicide (the Netherlands, Belgium, Luxembourg); the others permit assisted suicide but not euthanasia (Switzerland and Germany). The US States which have legislation have adopted a model for assisted suicide only, not euthanasia, e.g. in Oregon, Washington, Vermont and California. Canada also permits assisted suicide, not euthanasia. Comparison of the various schemes which operate in foreign jurisdictions reveal differences in the eligibility criteria adopted, the approach taken to how the assistance is delivered, how risk to others is prevented or minimised, and how the process is overseen and

regulated by the relevant authorities. We are not aware of any foreign jurisdiction which has adopted a scheme containing all the same safeguards as are now suggested by Mr Conway.

Medical Associations, Scope and Not Dead Yet UK

61. Medical associations have also examined the ethical and practical issues in relation to end-of-life care and physician assisted dying.

62. The British Medical Association ("BMA") produced a very full report on these issues in 2015, which also set out the results of its research with doctors and the public. Whilst recognising that there were strong views on both sides of the debate, the BMA did not recommend a change in the law. The research found that the majority of doctors thought there would be professional and emotional impacts on doctors if physician-assisted dying were legalised and the majority of the impacts identified by them were negative; many doctors did not see being involved with physician-assisted dying as compatible with their understanding of their fundamental role and remit as a doctor (see in particular vol. 2 of the 2015 report, pp. 71-72).

63. The BMA's review of the position in the Netherlands found that there were distressing complications with physician-assisted suicide in a significant number of cases, such that Dutch doctors preferred to be involved in euthanasia procedures rather than assisted suicide (vol. 1, p. 103). Its review of data from Oregon also identified that complications arose in a significant number of cases of physician-assisted suicide (vol. 1, p.117). It referred to a study of over 1,000 assisted suicides in Switzerland across a five year period which found that "although assisted suicide was associated with people with higher educational attainment and higher socio-economic status, it was also more likely amongst women and amongst groups with particular vulnerabilities, such as those who live alone, and perhaps experiencing social isolation and loneliness" (vol. 1, p. 124).

64. The BMA's research identified considerable concern amongst doctors regarding the possibility for detrimental effects on doctor-patient relationships if physician-assisted dying were legalised, including that this would increase fear and suspicion of doctors (particularly for the disabled, frail, elderly and those who feel they are a burden) which could affect what information patients are willing to share with their doctors (vol. 2, pp. 62ff and 74-75).

65. The Royal College of General Practitioners carried out an extensive consultation in 2013 with its members and membership bodies with a view to establishing its position on the law on assisted dying. The results were reported in January 2014. Most consultees indicated that the College should maintain its position of opposition to a change in the law on assisted dying and the College confirmed its position accordingly.

66. A survey of the fellows and members of the Royal College of Physicians in 2014 showed that a majority of respondents did not support a change in the law on assisted dying. The College confirmed its position accordingly, including in a briefing issued by it in advance of the second reading of Rob Marris MP's private member's Assisted Dying (No. 2) Bill.

67. In January 2011 the Council of the Association of British Neurologists approved by a substantial majority the conclusions of a working group, which also had the broad, but not unanimous, support of the Association's wider membership, that in the context of severe disability and a neurological condition likely to prove fatal, "Administering medication with the intention of providing symptomatic relief even if this has the secondary effect of shortening life is consistent with good medical practice" but that "Interventions should not be given with the primary purpose of causing death".

68. In our view, these concerns expressed by responsible professionals dealing with patients on the front line of clinical practice cannot be regarded as unreasonable or without foundation. There plainly is a real risk that a change in the law to legalise provision of assistance for suicide could have a serious detrimental effect on trust between doctors and patients.

69. On 10 July 2015 the British Geriatrics Society ("BGS"), which represents physicians who are geriatricians, issued a paper setting out its position in relation to physician assisted suicide. It also was opposed to a change in the law on assisted dying. Since the paper encapsulates in a carefully considered and succinct form a number of themes which emerge generally from the evidence before us, it merits quotation here:

> "1. The BGS accepts individuals' rights to determine the choice of treatment and care they receive provided they have the capacity to do so. We further accept that sometimes, some symptoms are difficult to control and that even if they are controlled people may still find their life unbearable. However a policy which allows physicians to assist patients to die is not acceptable to us. We believe instead that the most vulnerable should be enabled to access the services and care they need to lead as independent and symptom free a life as is possible and, when the time comes, to die in the setting of their choice with dignity.
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> 2. Members of the BGS look after many older people with frailty, disability and those who are dying. We accept life has a natural end and that our job is not to prolong life at all costs but to improve quality of life whilst accepting that death is inevitable. Our members have long experience of conversations with patients about ending their life. Often these are phrased as 'Can't you just let me go?' However our experience shows us these are more often a cry for help than a genuine desire for death. Often, listening to our patients' wishes, concerns and fears, and taking time to address their needs significantly diminishes their wish for death. We also believe older people may feel despair as a direct result of the reaction of others to their frailty and the care and treatment they are afforded. The BGS considers the best way for physicians to help these vulnerable people is to maximise their independence and health, rather than assisting with their expressed wish to die.
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> 3. We know that older people are often strongly influenced by their families and carers - the vast majority, but not all, will

have their well-being at heart. Even so, many requests to end life - made either directly or indirectly to us as geriatricians - come from the patients' families and not the older person themselves. Often such requests are then forgotten if such degrading symptoms as urinary and faecal incontinence, depression and unremitting pain are relieved.

4. Much of the public demand for assisted dying seems to stem from the fear of a prolonged death with increasing disability sometimes associated with unwanted burdensome medical care. This suffering at the end of life can be prevented by a change in the focus of care - from prolonging life to addressing the individuals' own priorities and symptoms, and by the involvement of medical professionals skilled in palliative care and end of life care.

5. The BGS does not accept that legalising physician assisted suicide is in the broader interests of society. We recognise that some people feel their life is unbearable; however, law makers should consider not only the rights of individuals in society but also society itself and the impact the legislation will have on all members of our communities. The BGS is concerned with protecting the interests of vulnerable older and disabled people who already feel pressure to give up their lives to reduce the burden they feel they cause to others.

6. Campaigners for physician assisted dying argue that curing disease and bringing about death are not mutually exclusive roles, the intention in both cases being the relief of suffering. It is further argued that the primary role of the physician is to care for his/her patient, which must therefore entail respecting their autonomous wish to die. However, the BGS believes that crossing the boundary between acknowledging that death is inevitable and taking active steps to assist the patient to die changes fundamentally the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society. Once quality of life becomes the yardstick by which the value of human life is judged, the protection offered to the most vulnerable members of society is weakened.

7. The right of any individual, whether terminally ill or not, to have their symptoms controlled is undisputed. In our opinion it is crucial to distinguish in clinical practice between actions primarily intended to control symptoms and actions primarily intended to assist the patient to die. In the same vein, the BGS would emphasise that the right of a patient to choose or decline treatment and/or intervention whatever the consequences, supersedes all other guidance and wishes. This equally applies to those who express their wishes regarding their future care using an appropriately constituted advance directive who can be assured that such wishes will be respected.

> 8. The BGS is concerned that 'assisted dying', while it does not apply directly and solely to older people, will lead to a change in attitude to death in society and also within the medical profession. The prohibition on intentional killing is the cornerstone of society and it is worth preserving the notion that all lives are precious. The BGS accepts that this denies a very small number of persons the right to have their life ended by their physician if it is their autonomous wish. However it must be noted that every society puts some limits on respect for autonomy, which must be balanced against the greater good of society. The BGS urges improvement in the medical and social care of older people, placing them back in the centre of a society which respects their wisdom and experience.
>
> …"

70. We consider that the paper by the BGS, which draws upon the experience of doctors dealing with a population of people in old age who face similar difficult situations to Mr Conway, is helpful as an indication of the effect of section 2 in practice and what would be likely to happen if it were amended.

71. Scope, the charity for disabled people, issued a public statement to oppose the Falconer Bill and express its opposition to a change in the law on assisted dying for reasons similar to those given by the BGS. It referred to recent polling which showed that 65% of the disabled people polled said that people assume disabled people do not have a good quality of life and expressed concern that changing the law would take away the protection disabled people have against such attitudes, leading to disabled people coming under pressure from others in society to end their lives. It referred to feelings of depression and despair that people can experience when first diagnosed with a terminal illness or disability, but noted that such feelings can change over time and stated Scope's view that "People need support to come to terms with these feelings, rather than help to end their lives." Scope was not persuaded that the protections in the Falconer Bill were adequate and quoted a statement from Baroness Jane Campbell, who herself has a progressive disability, in that regard.

72. Baroness Campbell filed a witness statement in these proceedings on behalf of an organisation called Not Dead Yet UK, a group of terminally ill and disabled people who oppose all moves to change the existing laws on assisted dying, to elaborate upon these points. She explained in particular the concern of those people that society sees disabled people as a burden and the impact that relaxation of the prohibition against assisted suicide in section 2 would be likely to have upon them.

73. On 17 July 2014 Scope published the results of its poll, which showed substantial concern amongst disabled people about moves to legalise assisted suicide on the grounds that they feared that it would lead to pressure being placed on disabled people to end their lives prematurely, something from which they felt the present law in section 2 protects them.

Medical expert evidence

74. We were assisted by a range of medical expert reports filed on both sides. For Mr Conway, we had expert evidence from Professor Tom Sensky (a professor in the field of psychological medicine) regarding assessment of decision-making capacity, including for people wishing to die; Professor Michael Barnes in relation to life expectancy issues in cases of MND; Professor Robin Jacoby (a professor of old age psychiatry) to confirm Mr Conway's mental capacity; Professor Ganzini, the Director of Geriatric Psychiatry Fellowship Progam at Oregon Health and Science University, dealing with experience with physician assisted suicide in Oregon; Dr C.M. Danbury, a consultant in intensive care, dealing with issues relating to treatment and withdrawal of treatment at the end of life; Professor Justin Stebbing (a professor in the field of cancer medicine and medical oncology) in relation to prognostication of time of death; and Professor Ahmedzai in relation to palliative medicine.

75. The Secretary of State adduced in evidence an expert report by Professor the Baroness Finlay of Llandaff, a consultant physician and professor of palliative medicine. She served on the House of Lords Select Committee on the Joffe Bill in 2004-5 and has long experience of reviewing evidence in relation to physician assisted suicide and physician administered euthanasia, including data from Oregon. Amongst other matters, Baroness Finlay referred to a survey of 1,000 GPs in 2015 which revealed that only 14% of respondents would be prepared to assess an individual who wished to have assistance from a doctor to commit suicide. She also referred to experience in Oregon of a pattern of "doctor shopping" to find doctors willing to prescribe fatal doses of drugs. She relied upon these materials to support her view that a similar pattern would be likely to develop in this country if the prohibition in section 2 were relaxed. She describes the importance of trust in the patient-doctor relationship and the impact upon that relationship which relaxation of the prohibition in section 2 could have. She also called attention to difficulties of prognosis of likely time of death, concluding that "Even with the best modelling data available, it is not possible to predict with any reasonable accuracy whether a person with MND will live less than six months". She also gave evidence about a sense of coercion patients may feel, as experience shows, from a range of sources, including a desire not to be a burden on their families. The Secretary of State also adduced in evidence the expert report from Professor Faull on the subject of palliative medicine and a report from Dr Annabel Price, an expert in the field of liaison psychiatry, dealing with assessment of mental capacity and mental states of people seeking assistance to commit suicide.

76. This is not a trial of an issue of clinical negligence or the like. The resolution of the claim for a declaration of incompatibility did not require there to be cross-examination of any of the expert or other witnesses. The question at issue is whether Parliament has a proper basis for maintaining in place the prohibition against provision of assistance for suicide contained in section 2. This does not require us to set out and analyse in full detail the expert and other evidence placed before us. We refer to the evidence to the extent that it is necessary to do so to determine Mr Conway's claim for a declaration of incompatibility.

Discussion

77. As explained above, it is common ground that the prohibition in section 2 against provision of assistance for suicide involves an interference with Mr Conway's right to

respect for his private life under Article 8(1). Therefore the question of compatibility of section 2 with Article 8 turns on whether section 2 can be justified under Article 8(2) as a measure to promote one or more of the objectives set out in Article 8(2) which is proportionate to such an objective or objectives.

78. The questions which therefore arise are "(a) is the legislative objective sufficiently important to justify limiting a fundamental right?; (b) are the measures which have been designed to meet it rationally connected to it?; (c) are they no more than are necessary to accomplish it?; and (d) do they strike a fair balance between the rights of the individual and the interests of the community?" (see *R (Aguilar Quila) v Secretary of State for the Home Department* [2011] UKSC 45; [2012] 1 AC 621, at [45] per Lord Wilson JSC).

The effect of precedent: Pretty *and* Nicklinson

79. The first, and boldest, submission of Mr Strachan is that this court is bound by existing domestic authority in the form of the decision of the House of Lords in the *Pretty* case to hold that section 2 is compatible with Article 8, having regard to the alternative finding in that case that if Article 8(1) was engaged, section 2 was objectively justified under Article 8(2). Mr Gordon disputed that this was part of the *ratio decidendi* of the case, given the prior ruling by the House (which is no longer sustainable) that Article 8(1) was not engaged at all. However, it seems to us at least arguable that the House's view about Article 8(2) is an alternative *ratio* of the decision and it seems to have been regarded as such by both the Divisional Court and the Court of Appeal in the *Nicklinson* case. Accordingly we address Mr Strachan's submission on that basis.

80. Mr Strachan submitted that both the Divisional Court and the Court of Appeal in the *Nicklinson* case regarded themselves as bound by the House of Lords decision in *Pretty* on the Article 8(2) part of the analysis: see [121] in the judgment of Toulson LJ in the Divisional Court and [105] in the judgment of Lord Dyson MR and Elias LJ in the Court of Appeal. There has been no significant change in the moral, ethical and pragmatic considerations relevant to the compatibility of section 2 with Article 8 in the period since the *Pretty* decision. Therefore, Mr Strachan says, this court is likewise bound by the decision of the House of Lords in *Pretty* to reject Mr Conway's claim.

81. We do not accept this submission. It is striking that no justice in the Supreme Court suggested that the decision in *Pretty* had binding precedential effect, subject only to the Supreme Court's inherent power to depart from previous decisions of itself and the House of Lords in circumstances analogous to those set out in the 1966 Practice Direction. In our view, the reason for this is that the Supreme Court in *Nicklinson* accepted that section 2 is compatible with Article 8 of the ECHR as interpreted by the ECtHR (as Mr Gordon also accepts in the present case), but reviewed the position separately for the purposes of applying Article 8 pursuant to the distinct domestic *Re G* interpretation of that Convention right in the HRA: see in particular the issues identified by Lord Neuberger at [58(b)-(e)]. The House of Lords in *Pretty* did not address that question, because the decision in *Re G* came later. The Court of Appeal in *Nicklinson* referred to *Re G*, but regarded the approach set out in it as "wholly exceptional" ([110]), with the result that "it would be improper for the court to find a blanket prohibition to be disproportionate where this is not dictated by Strasbourg

jurisprudence" ([111]). On that approach, the courts would be bound by the decision of the House of Lords in *Pretty* which did follow the Strasbourg jurisprudence.

82. However, the Supreme Court in *Nicklinson* did not regard the scope for a distinct domestic *Re G* interpretation of Article 8 as so narrowly confined as did the Court of Appeal. The Supreme Court treated the domestic *Re G* interpretation of Article 8 as a matter generally at large for the court, in relation to which the decision of the House of Lords in *Pretty* clearly did not constitute binding authority. Following *Nicklinson*, therefore, we do not consider that *Pretty* is binding authority in relation to the issues which we have to determine, which as in *Nicklinson* revolve again around application of Article 8 according to its domestic *Re G* interpretation.

83. The next question to arise is whether we are bound by the decision of the Supreme Court in *Nicklinson* to decide the present case in a particular way. Although all the judgments in that case contain very valuable discussions of the issues, we do not consider that we are formally bound to decide the present case in a particular way by that decision.

84. The Supreme Court reached its decision in *Nicklinson* in a particular context, where it was known that Parliament was itself due to debate the issues arising in the context of consideration of the Falconer Bill, which had been introduced and in relation to which it could also be expected that persons in the distinct position of Mr Nicklinson and Mr Lamb (who were not terminally ill and hence would not be covered by the Falconer Bill proposals) would also be debated: see [118] (Lord Neuberger). A constitutional issue therefore arose, whether the court should defer expressing any final view of its own regarding the compatibility of section 2 with Article 8 on its *Re G* interpretation until after Parliament had first debated the Falconer Bill.

85. The nine justices in the Supreme Court were divided in their views about this along a spectrum. As we read their judgments, and subject to certain differences in nuance between them, (a) Lord Sumption JSC (see in particular [233]-[234]), Lord Hughes JSC (in particular at [267]) and Lord Reed JSC (in particular at [196]-[298]) considered that no incompatibility of section 2 with Article 8 could be found as a matter of substance; (b) Lord Neuberger PSC (in particular at [113]-[118]), Lord Mance JSC (in particular at [188] and [190]-[191], Lord Wilson JSC (in particular at [196]-[197]) and Lord Clarke of Stone-cum-Ebony JSC (in particular at [293]) took the view that given that Parliament was on the point of debating the Falconer Bill it would be premature for the court to consider making a declaration of incompatibility until Parliament had had the opportunity to consider the issues for itself in that debate (at [293] Lord Clarke gave a stronger indication of the ultimate outcome of any application for a declaration of incompatibility if Parliament did so – in line with the justices in group (a) - than did Lord Neuberger, Lord Mance and Lord Wilson, who were at pains to emphasise that the question of incompatibility would be at large and would have to be considered afresh after any parliamentary debate: see [118], [191] and [197(f)] respectively); and (c) Baroness Hale of Richmond DPSC (at [299]-[321]) and Lord Kerr of Tonaghmore JSC (at [326]-[361]), who were satisfied at that stage of the proceedings that there was an incompatibility between section 2 and the Article 8 rights of those in the position of the claimants and were prepared to grant a declaration of incompatibility then and there. Lord Kerr considered that, among other reasons for finding an incompatibility, there was no rational connection between the aim of the legislation, taken as the protection of the vulnerable, and the interference

with the Article 8 right constituted by section 2: [349]-[351] and [361]. But no other justice concurred in that view.

86. The views of the justices in group (a) reflected what they regarded as the importance of and respect due to Parliament's legislative choice in light of the controversial social and moral dimensions of the question whether section 2 should be amended, what procedures might be put in place to mitigate the indirect consequences of legalising assisted suicide and whether any remaining risks were acceptable: see in particular [233]-[234] (Lord Sumption). Other justices also accepted that these considerations were relevant to any determination regarding the compatibility of section 2 with Article 8: see in particular Lord Mance at [164], [166]-[170] and [189]-[190] ("Parliament is certainly the preferable forum in which any decision should be made, after full investigation and consideration, in a manner which will command popular acceptance"); [115] per Lord Neuberger; [201] per Lord Wilson (the area is one "in which the community would expect its unelected judiciary to tread with the utmost caution"); and [300] per Baroness Hale ("Like everyone else, I consider that Parliament is much the preferable forum in which the issue should be decided").

87. The views of the justices in group (b), in deciding to defer the question of compatibility until after further debate in Parliament, reflected the importance of Parliament as a decision-maker in this morally and socially sensitive area but also their hopes that Parliament would take into account the points raised in the judgments in the Supreme Court when deciding what to do about section 2: see [113] (Lord Neuberger), [190] (Lord Mance), and [197], [202] and [204]-[205] (Lord Wilson). Fortunately, the decision in *Nicklinson* is recognised as the leading domestic authority in this area and there can be no doubt that subsequently parliamentarians have addressed the issues arising in relation to possible amendment of section 2 with the judgments in that case in mind. Therefore, it is unnecessary to grapple with issues which would have arisen in relation to Article 9 of the Bill of Rights had it been suggested that Parliament had ignored the decision in *Nicklinson* or not taken it properly into account. No-one has suggested that this might have been the case.

88. Mr Strachan submitted that we should dismiss Mr Conway's claim in these proceedings on the same basis as the claim by Mr Nicklinson and Mr Lamb for a declaration of incompatibility in relation to section 2 was dismissed in the *Nicklinson* case, by a combination of the reasoning of the justices in group (a) and group (b). Mr Strachan says that although the Falconer Bill and other Bills on assisted dying have been debated and defeated in Parliament, there remains the possibility of the introduction of Private Member Bills or promotion of further debates in future to address the issue again. That being so, he says, there is no material difference between the position now and that which the Supreme Court had to address in its decision in *Nicklinson*. It remains institutionally inappropriate for the court to consider granting a declaration of incompatibility. The question of the proper approach to assisted dying and provision of assistance to a person who wishes to commit suicide should be left for consideration by Parliament alone in due course.

89. We do not accept this submission. In our view, the judgments of the justices in group (b) in *Nicklinson* were based on the fact that it was known that a specific Bill was before Parliament so that the issues arising were due to be debated there in the near future. In those circumstances the justices in group (b) were prepared to postpone proceeding to a final determination of the issue of compatibility themselves. That was

an unusual course to take, since normally a court will proceed to determine a properly arguable claim which is presented to it. The proper role of the court is to protect the rule of law and this means determining legal claims which are brought. The unusual course of postponement of dealing with the question of compatibility which the justices in group (b) in *Nicklinson* favoured was justified by the special and unusual circumstances pertaining at the time of the decision.

90. But that is all now water under the bridge. Parliament has been presented with the opportunity to amend section 2 but has clearly chosen to maintain it in full force and effect without change. In practice, Parliament has arrived at a settled position on this. There is no further clear, concrete proposal for that issue to be revisited in Parliament again as a substantive matter within any short timescale ("in the near future": [116] per Lord Neuberger). Of course, in theory Parliament can always choose to consider anything at any time, but such chance as there is of further substantive consideration by Parliament of the issues in relation to section 2 is speculative and cannot be regarded as being in immediate prospect. We therefore consider that the current situation is very different from that at the time of the *Nicklinson* decision and we are not bound to reject Mr Conway's claim by virtue of a combination of the judgments of the justices in group (a) and group (b). On the contrary, in the absence of any equivalent special circumstances, since there is before the court an arguable claim for a declaration of incompatibility, permission for which has been granted by the Court of Appeal, we consider that it is the court's duty to consider it on the merits at this stage.

Legitimate aim

91. As mentioned above, there is an issue between the parties regarding the aim or aims which section 2 seeks to pursue. Mr Gordon submits that the only aim of any significance is the protection of the weak and vulnerable. Mr Strachan submits that even if that is correct, section 2 is still objectively justified under Article 8(2); but in fact the legitimate aims of the provision are wider than that, encompassing protection of the weak and vulnerable but also protection of the sanctity of life and promotion of trust and confidence between doctor and patient, which encourages patients to seek and then act upon medical advice. We accept below the first of these submissions, so our decision does not ultimately depend upon resolution of this issue regarding identification of the legitimate aim or aims pursued by section 2. However, as the issue of legitimate aim has been raised we should deal with Mr Strachan's wider submission. In our view, Mr Strachan has properly identified wider aims which section 2 seeks to promote and this serves to reinforce his submission that it is a provision which is objectively justified under Article 8(2).

92. First, we consider that it is appropriate to identify protection of the sanctity of life as a moral view regarding the importance of human life as one of the aims promoted by section 2. Leaving aside the decision of the Supreme Court in *Nicklinson*, many of the judgments which have addressed the question whether the blanket prohibition in section 2 against assisting suicide is justified have recognised that the question involves profound moral and ethical issues in a democracy: see e.g. *Nicklinson* in the Divisional Court at [1] and [89]; in the Court of Appeal at [3]-[4] and [54] in the judgment of Lord Dyson MR and Elias LJ; *Nicklinson v United Kingdom* paras. [84]-[85] (referring to "the sensitive issues, notably ethical, philosophical and social, which arise"); the decision of the House of Lords in *Pretty* at [2] (Lord Bingham); [54]

(Lord Steyn); [85] (Lord Hope); [109] (Lord Hobhouse). The judgments in the *Bland* case also recognised that moral issues were engaged in relation to medical treatment at the end of life: p. 797A per Stephen Brown P at first instance; p. 808B per Sir Thomas Bingham MR, p. 819C-G per Butler-Sloss LJ and pp. 825E-827G and 831A-832G per Hoffmann LJ in the Court of Appeal; and in the House of Lords, at pp. 863H-864A per Lord Goff, pp. 878H-880D per Lord Browne-Wilkinson and p. 899A-F per Lord Mustill. In the Supreme Court in *Nicklinson*, the argument focused on the objective of protection of the weak and vulnerable and less weight was given by some justices to the broader moral consideration of protection of the sanctity of life: see in particular [90]-[98] (Lord Neuberger); but even in that decision we bear in mind Lord Sumption's discussion of the position at [207], [209], [213]-[215] and [229], referring to the significance of the moral issues at stake. Moral views regarding the sanctity of life undoubtedly carry weight for many people as considerations which are relevant in this area. In a judgment which Lord Wilson in *Nicklinson* described as "classic" at [199], Hoffmann LJ in the Court of Appeal in the *Bland* case, at [1993] AC 789, 831C-D, said:

> "the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation. That is why although suicide is not a crime, assisting someone to commit suicide is …"

93. Therefore, to the extent that it may be necessary for Mr Strachan to rely on the protection of morals in the form of views regarding the importance of the sanctity of life as a relevant legitimate aim in this area for the purposes of Article 8(2), we consider that he is entitled to do so. Many people would regard considerations of the sanctity of life to be at the heart of the issues in this case. It seems unreal to discount this as a relevant consideration.

94. We also consider that Mr Strachan is entitled to refer to the promotion of trust between doctor and patient as a further legitimate aim for the blanket prohibition in section 2. The evidence before us shows that there is a real concern amongst doctors and a real risk that if the prohibition against assistance for suicide were relaxed, patients (particularly vulnerable and elderly patients) would have less confidence in their doctors and the advice they might give. This could well have deleterious consequences on the extent to which patients are willing to share information about their conditions freely with their doctors and the extent to which patients would be willing to accept and act upon medical advice given to them. Both these things would tend to undermine the quality and efficacy of medical treatment made available to them.

Rational connection

95. Mr Gordon made no positive submission that there was no rational connection between the prohibition in section 2 and the legitimate aims on which Mr Strachan relied, in particular the protection of the weak and vulnerable. He referred to the judgment of Lord Kerr in *Nicklinson* on this point, but simply left the question of rational connection at large for us to consider.

96. In our view, there clearly is a rational connection between the prohibition in section 2 and the protection of the weak and vulnerable. We agree in that regard with [183]-[185] in the judgment of Lord Mance in *Nicklinson*. The further evidence from Baroness Finlay, the BGS, Scope and Baroness Campbell in the present proceedings strongly supports Lord Mance's analysis.

97. We also consider that there is a rational connection between the prohibition in section 2 and the other legitimate aims identified by Mr Strachan as referred to above. The prohibition serves to reinforce a moral view regarding the sanctity of life, as explained by Hoffmann LJ in the *Bland* case. The prohibition also serves to promote relations of full trust and confidence between doctors and their patients, and hence to promote the provision and acceptance of high quality medical advice to patients, particularly those who might be in a vulnerable position.

Necessity

98. Mr Gordon submits that the proposed legislative regime which Mr Conway has outlined would be adequate to address concerns regarding the protection of the weak and vulnerable. In particular, the involvement of the High Court to review any application for permission to provide assistance to a person wishing to commit suicide would ensure that he or she was free of any pressure and had full capacity to make the decision to die, as can already happen when a person wishes to have life sustaining support switched off: see *In re B (Adult: Refusal of Medical Treatment)*. Therefore the blanket prohibition against assistance for suicide in section 2 cannot be regarded as necessary to meet the legitimate aim in issue.

99. As mentioned above, Mr Strachan makes two submissions in response. First, he says that even if the legitimate aim promoted by section 2 is confined to protection of the weak and vulnerable, there is nonetheless a clear and proper case that the provision is necessary to promote that aim. Secondly, he submits that the justification of the prohibition in section 2 is clearer still when the other legitimate aims referred to above are taken into account.

100. We agree with both these submissions. As to the first, the involvement of the High Court to check capacity and absence of pressure or duress does not meet the real gravamen of the case regarding protection of the weak and vulnerable. Persons with serious debilitating terminal illnesses may be prone to feelings of despair and low self-esteem and consider themselves a burden to others, which make them wish for death. They may be isolated and lonely, particularly if they are old, and that may reinforce such feelings and undermine their resilience. All this may be true while they retain full legal capacity and are not subjected to improper pressure by others.

101. As Lord Sumption put it in *Nicklinson* at [228],

> "The vulnerability to pressure of the old or terminally ill is a … formidable problem. The problem is not that people may decide to kill themselves who are not fully competent mentally. I am prepared to accept that mental competence is capable of objective assessment by health professionals. The real difficulty is that even the mentally competent may have reasons for deciding to kill themselves which reflect either overt pressure

upon them by others or their own assumptions about what others may think or expect. The difficulty is particularly acute in the case of what the Commission on Assisted Dying called "indirect social pressure". This refers to the problems arising from the low self-esteem of many old or severely ill and dependent people, combined with the spontaneous and negative perceptions of patients about the views of those around them. The great majority of people contemplating suicide for health-related reasons, are likely to be acutely conscious that their disabilities make them dependent on others. These disabilities may arise from illness or injury, or indeed (a much larger category) from the advancing infirmity of old age. People in this position are vulnerable. They are often afraid that their lives have become a burden to those around them. The fear may be the result of overt pressure, but may equally arise from a spontaneous tendency to place a low value on their own lives and assume that others do so too. Their feelings of uselessness are likely to be accentuated in those who were once highly active and engaged with those around them, for whom the contrast between now and then must be particularly painful. These assumptions may be mistaken but are none the less powerful for that. The legalisation of assisted suicide would be followed by its progressive normalisation, at any rate among the very old or very ill. In a world where suicide was regarded as just another optional end-of-life choice, the pressures which I have described are likely to become more powerful. It is one thing to assess some one's mental ability to form a judgment, but another to discover their true reasons for the decision which they have made and to assess the quality of those reasons. I very much doubt whether it is possible in the generality of cases to distinguish between those who have spontaneously formed the desire to kill themselves and those who have done so in response to real or imagined pressure arising from the impact of their disabilities on other people. There is a good deal of evidence that this problem exists, that it is significant, and that it is aggravated by negative modern attitudes to old age and sickness-related disability. Those who are vulnerable in this sense are not always easy to identify (there seems to be a consensus that the factors that make them vulnerable are variable and personal, and not susceptible to simple categorisation). It may be, as Lord Neuberger of Abbotsbury PSC suggests, that these problems can to some extent be alleviated by applying to cases in which patients wish to be assisted in killing themselves a procedure for obtaining the sanction of a court, such as is currently available for the withdrawal of treatment from patients in a persistent vegetative state. But as he acknowledges, there has been no investigation of that possibility in these proceedings. It seems equally possible that a proper investigation of this possibility would show that the intervention of a court would simply interpose an

> expensive and time-consuming forensic procedure without addressing the fundamental difficulty, namely that the wishes expressed by a patient in the course of legal proceedings may be as much influenced by covert social pressures as the same wishes expressed to health professionals or family members. These are significant issues affecting many people who are not as intelligent, articulate or determined as Diane Pretty or Tony Nicklinson."

102. The House of Lords in the *Pretty* case agreed that there would be a real risk of vulnerable people seeking assistance to die if the prohibition in section 2 were relaxed: see in particular [29] (Lord Bingham) and [50] (Lord Steyn). The case in support of this view is still stronger on the evidence placed before the court in the present proceedings. We refer in particular to the position statement by the BGS quoted above, the Scope survey of disabled people and its position statement and the evidence of Baroness Campbell and Baroness Finlay.

103. Extrapolation from the experience in Oregon, where provision of assistance for suicide is legal, indicates that the numbers involved in seeking their own death if section 2 were modified may well be significant. In the witness statement adduced by Sarah Wootton, the chief executive of Dignity in Dying, to support Mr Conway's claim she refers to a range of estimates for cases in England and Wales made by different bodies based on such extrapolation, from about 900 to 1,934 (the figure her organisation uses is "around 1,500"). Baroness Finlay's own assessment is at the higher end of this range. It is likely that numbers of vulnerable people would indeed be included in such a cohort. The significant numbers seeking to use the new procedure would also be likely to have a tendency to normalise suicide with assistance, thereby further eroding the will of vulnerable people to resist the pressures, internal or external, upon them to end their lives.

104. Moreover, in relation to external pressure exerted by others on the person concerned, the process of seeking approval from the High Court would not be a complete safeguard. The court would have to proceed on the evidence placed before it. External pressures might be very subtle and not visible to the court. For example, it is not difficult to imagine cases of family discussions about money problems, not necessarily intended to place pressure on an elderly relative, in consequence of which they draw their own conclusions that they are a burden and would be better off dead. In any event, it might be difficult to disentangle factors of external pressure from the individual's own internal thought processes and difficult to tell when external pressure is illegitimate or such as to invalidate the individual's own choice to die. Data from surveys in Oregon of people seeking physician assisted suicide showed that of those responding 48.9% cited "Burden on family, friends/caregivers" as one reason for their decision. The risk that individuals will feel such pressures is clearly a real one. Also, the court would look at the position at a particular point in time and would not pick up cases where the individual concerned had doubts or their mood changed later on, but might come under pressure to proceed despite this.

105. The problems in relation to the court being able to pick up issues of improper external pressure would be compounded by the likelihood that in many cases the physicians to whom the individual turned to facilitate their death would not have long-term and intimate knowledge of them. It seems that any legislative regime would have to allow

doctors who had moral objections to assisting someone to die to decline to be involved and there are likely to be many, as the survey evidence referred to by Baroness Finlay indicates. So the individual might have to turn to doctors other than their usual, familiar GP to obtain assistance to die. This has been the experience in Oregon, as Baroness Finlay explains. No doubt those other doctors would seek properly to assess capacity and to check for an absence of improper pressure from others, but their ability to detect background pressures operating on a new patient whom they do not know well will be limited.

106. In relation to assessment of necessity for a measure like section 2 to protect the weak and vulnerable, the margin of appreciation and its domestic law analogue the "discretionary area of judgment" to be accorded to Parliament (see *Nicklinson* at [296]-[297] per Lord Reed) is an important factor. No-one knows for sure how people would behave and how society might be affected if section 2 were amended. An evaluative judgment is required in making that assessment and in deciding in light of it whether the blanket prohibition in section 2 is necessary to promote the legitimate aim of protecting the weak and vulnerable. Parliament has made the assessment that it is. The evidence we have reviewed shows that there is a serious objective foundation for that assessment.

107. Parliament has considered the matter with the benefit of the judgments of the Supreme Court in *Nicklinson* and has decided to maintain section 2 in place, after taking all relevant countervailing arguments into account.

108. In those circumstances, we consider that there are powerful constitutional reasons why Parliament's assessment of the necessity of maintaining section 2 in place should be respected by this court. These are the reasons referred to by the justices in group (a) and group (b) and by Baroness Hale in the *Nicklinson* case. For ease of exposition, it is sufficient to refer to the points made by Lord Sumption in this regard.

109. Parliament is the body composed of representatives of the community at large ([230]) with what can be called a democratic mandate to make the relevant assessment in a case where there is an important element of social policy and moral value-judgment involved with much to be said on both sides of the debate ([229] and [233]). There is not a single, clear, uniquely rational solution which can be identified; the decision cannot fail to be influenced by the decision-makers' opinions about the moral case for assisted suicide, including in deciding what level of risk to others is acceptable and whether any safeguards are sufficiently robust; and it is not appropriate for professional judges to impose their personal opinions on matters of this kind ([229]-[230] and [234]). In *Nicklinson* in the Court of Appeal, Lord Judge CJ aptly referred to Parliament as representing "the conscience of the nation" for decisions which raise "profoundly sensitive questions about the nature of our society, and its values and standards, on which passionate but contradictory opinions are held" (Court of Appeal, [155]). Parliament has made the relevant decision; opponents of section 2 have thus far failed to persuade Parliament to change the law despite active consideration given to the issue, in particular in relation to the Falconer Bill which contained essentially the same proposals as Mr Conway now puts before the court; and the democratic process would be liable to be subverted if, on a question of moral and political judgment, opponents of the legislation could achieve through the courts what they could not achieve in Parliament ([231] per Lord Sumption, referring to *R (Countryside Alliance) v Attorney General* [2008] AC 719, [45] per Lord Bingham

and *AXA General Insurance Ltd v HM Advocate* [2012] 1 AC 868, [49] per Lord Hope).

110. Parliament is also better placed than the court to make the relevant assessment regarding the likely impact of changing the law in the matter. The consideration given by Parliament through its processes (including Select Committee investigations and reports) to the issue of assisted dying over the years has been more thorough and extensive than could be achieved in a court hearing to determine issues of law. As Lord Sumption said at [232]:

> "… the parliamentary process is a better way of resolving issues involving controversial and complex questions of fact arising out of moral and social dilemmas. The legislature has access to a fuller range of expert judgment and experience than forensic litigation can possibly provide. It is better able to take account of the interests of groups not represented or not sufficiently represented before the court in resolving what is surely a classic "polycentric problem". But, perhaps critically in a case like this where firm factual conclusions are elusive, Parliament can legitimately act on an instinctive judgment about what the facts are likely to be in a case where the evidence is inconclusive or slight: see *R (Sinclair Collis Ltd) v Secretary of State for Health* [2012] QB 394, especially at para 239 (Lord Neuberger of Abbotsbury MR), and *Bank Mellat v HM Treasury (No. 2)* [2014] AC 700, 795-796, paras 93-94, per Lord Reed. Indeed, it can do so in a case where the truth is inherently unknowable, as Lord Bingham thought it was in *R (Countryside Alliance) v Attorney General* [2008] AC 719, para 42."

111. For these reasons, we conclude that Mr Strachan succeeds in his submission that the prohibition in section 2 is necessary to protect the weak and vulnerable.

112. We also agree that his case on necessity becomes still stronger when the other legitimate aims are brought into account. As the conscience of the nation, Parliament is entitled to maintain in place a clear bright-line rule which forbids people from providing assistance to an individual to commit suicide. Parliament was and is entitled to decide that the clarity of such a moral position could only be achieved by means of such a rule. Although views about this vary in society, we think that the legitimacy of Parliament deciding to maintain such a clear line that people should not seek to intervene to hasten the death of a human is not open to serious doubt. Parliament is entitled to make the assessment that it should protect moral standards in society by issuing clear and unambiguous laws which reflect and embody such standards.

113. Further, we consider that Parliament is entitled to maintain section 2 in place as a measure which promotes trust between doctors and patients. Again, there is a good evidential case which has been made available to Parliament, particularly in the form of the BMA's survey and report and the BGS's paper, which supports the need for a clear rule prohibiting provision of assistance for suicide in order to safeguard and reinforce that relationship of trust.

Fair balance

114. In our judgment, the prohibition in section 2 achieves a fair balance between the interests of the wider community and the interests of people in the position of Mr Conway. The issues here are similar to those which arise in relation to the question of the necessity of the interference with Mr Conway's rights under Article 8(1). In particular, the margin of appreciation and the discretionary area of judgment for Parliament have similar relevance in the context of this part of the analysis. Parliament is entitled to maintain section 2 in place with full force and effect in order to promote the legitimate aims identified above in the interests of the general community, even though that has an impact in terms of restricting the options available to Mr Conway about the timing and manner of his death.

115. Two points are of particular significance at this stage of the analysis. First, the proportionality of the blanket prohibition in section 2, particularly having regard to the aim of protecting the weak and vulnerable, has been confirmed in relation to a person suffering from MND by the House of Lords and also by the ECtHR in the *Pretty* case. In our view, nothing of significance has changed since those decisions other than that (a) Parliament has looked again at section 2 and has re-affirmed it repeatedly, by re-enacting it in 2009 and by declining to pass legislation since then to amend it; and (b) the evidence now before the court shows that effective palliative care is available which would make the process of dying for Mr Conway and any other person suffering from MND far less distressing than appears to have been assumed in the *Pretty* case. Both these developments strongly reinforce the conclusion arrived at in the *Pretty* case.

116. On any view, the protection of the right to life of weak and vulnerable people is a matter entitled to great weight in any assessment of fair balance. The absence of any consensus among Council of Europe states about the approach to be adopted in balancing the interests of individuals and the interest of the general community continues to exist. It is another factor which indicates that the balance struck by Parliament falls within the margin of appreciation and its discretionary area of judgment.

117. Secondly, as we have explained above, the fact that Mr Conway is expected to die soon and the evidence about the palliative care available to him indicates that his interests are less badly affected by the interference with his Article 8 rights arising from section 2 than was the case in relation to Mr Nicklinson, Mr Lamb and Martin in the *Nicklinson* decision. The same strong public interest in maintaining section 2 in place is present in this case, but the price to be imposed on Mr Conway and people in his position to secure that interest is lower. It seems to us that the options for him cannot fairly be characterised as amounting to a form of cruelty: contrast *Nicklinson* at [313] per Baroness Hale.

118. Mr Gordon's submission is that section 2 is incompatible with Mr Conway's Article 8 rights, and he does not maintain a distinct case regarding any incompatibility it might have with the Article 8 rights of people in a different position, such as those subject to "locked in syndrome" like Mr Nicklinson and Mr Lamb. It is in any event doubtful that Mr Conway would be entitled to maintain a case by reference to other people's rights, rather than his own. In our view, the balance struck by section 2 between the general interest of the community and Mr Conway's interests clearly satisfies the fair

balance test. (In the course of the hearing we were informed that a distinct challenge to section 2 has been commenced by a person in a position more akin to that of Mr Nicklinson and Mr Lamb: consideration of that challenge will have to take place in those separate proceedings, in which permission has been granted.)

Remaining arguments

119. It is convenient to deal shortly here with some of the additional points made by Mr Gordon. He relied on *In re B (Adult: Refusal of Medical Treatment)*, a decision referred to by Baroness Hale and Lord Neuberger in *Nicklinson*, in support of his argument that the prohibition in section 2 is disproportionate. In that case, the individual was entitled to bring about her own death by refusing treatment, in reliance on her absolute right to do so at common law. The question of striking a balance with the wider interests of the community simply did not arise in that context. In our view, this case does not indicate that Parliament has failed to strike a fair balance in section 2, where the question of balancing the general interest of the community and the interests of the individual is at the heart of the proportionality analysis under Article 8(2).

120. *In re B* provides a good illustration of the ability of a court to make an assessment of the capacity of a person who decides she wishes to have life-sustaining treatment withdrawn, with the result that she will die. But for the reasons given above that does not meet the case put forward why section 2 is necessary to meet the legitimate aim of protecting the weak and vulnerable.

121. Moreover, in our opinion it is clearly legitimate for parliamentarians to take the view that there is a crucial distinction between cases where medical treatment is withdrawn because it can no longer be justified, with the result that the patient dies, and the present case where Mr Conway seeks to have steps taken actively to assist him to end his life. It is a distinction which they are entitled to regard as similar to the "crucial distinction" referred to by Lord Goff in *Bland* at p. 865D between cases where medical treatment is being withdrawn and cases in which steps are taken actively to end a person's life. Parliamentarians are entitled to conclude that the cases on either side of this principled dividing line are and should be treated as legally and morally distinct. For this reason also, *In re B* does not provide an answer to Mr Strachan's submissions in this case.

122. Mr Gordon also referred to the decision of the Supreme Court of Canada in *Carter v Canada* [2015] SCC 5, in which the court held that the ban on assisted dying in Canada was invalid under the Canadian Charter of Rights and Freedoms. He relied in particular on [114]-[115], in which the court referred to concerns about decisional capacity and vulnerability and observed that these concerns already arise in all end-of-life medical decision-making, including in relation to refusal by an individual of life support treatment.

123. We did not find the decision in *Carter* to be of assistance. It turned critically on provisions of the Canadian Charter (section 1 and section 7) which are in different terms from Article 8 of the ECHR and which engage a different analysis: see in particular [76]-[78]. It also turned critically on findings by the trial judge in the proceedings on evidence before her in relation to the effectiveness of safeguards for vulnerable people which the Supreme Court held could not be challenged on appeal:

[108]-[121]. The evidence before us is different and we have made our own findings in the light of it. Our reasoning in relation to the comparison with cases where an individual refuses life support treatment, such as *In re B*, is set out above. Moreover, the decision in *Carter* was concerned with the category of people who face unbearable suffering, rather than the category which Mr Conway identifies of people who face death within six months.

124. Mr Gordon suggested that many doctors already actively assist their patients who wish to commit suicide to do so, so section 2 was not really promoting the legitimate aims which Mr Strachan asserted. On the evidence before us, we do not accept this. Baroness Finlay cited a 2009 research paper which found no instances of physician assisted suicide which had occurred in practice in this country and concluded that in Britain euthanasia and physician assisted suicide "are rare or non-existent". Since both practices are illegal under the criminal law and it is unlikely that professional people would simply ignore such a ban, we see no reason to doubt this conclusion.

125. Mr Strachan was critical of the criteria proposed by Mr Gordon for his suggested alternative statutory scheme. In particular, in reliance on the evidence of Baroness Finlay, Mr Strachan says that the criterion that assistance for suicide would only be available to individuals with less than six months to live would not be capable of being applied with any certainty. Medical science does not permit such an assessment to be made with any degree of accuracy.

126. There is force in this point. In response to it, Mr Gordon relied on the expert report from Professor Barnes. However, in our view Professor Barnes's evidence did not present a serious challenge to Baroness Finlay's assessment that time of death for a particular individual with MND cannot be predicted with any reasonable accuracy. Professor Barnes confirmed that it is not possible to find it out from testing simple biomarkers and that prognostication of time of death would be a very difficult matter of clinical judgment. Professor Stebbing also gave evidence that "a clinician's prediction is not a very reliable or robust method of predicting survival."

127. In our view, the difficulty of formulating a clear and reliable criterion for who is to qualify as terminally ill under the scheme proposed by Mr Gordon is a factor of some relevance as indicating again the difficult legislative nature of the choices to be made in fashioning any such scheme. It is a further indicator that the balance struck by Parliament under section 2 is a fair one. It is legitimate in this area for the legislature to seek to lay down clear and defensible standards in order to provide guidance for society, to avoid distressing and difficult disputes at the end of life and to avoid creating a slippery slope leading to incremental expansion over time of the categories of people to whom similar assistance for suicide might have to provided.

Conclusion

128. For the reasons given above, we find that section 2 is compatible with the Article 8 rights of Mr Conway. We dismiss his application for a declaration of incompatibility.