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THE POLITICS OF ASSISTED DYING: EXPLAINING THE PUBLIC-PARLIAMENTARY GAP

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The politics of assisted dying: explaining the public-parliamentary gap[1]

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Abstract

This paper provides an overview of the politics of assisted dying in the UK, mapping key issues and debates in the field. It does not take a view on the moral issues involved but offers explanations for why assisted dying legislation has not been introduced in the UK, despite an increasing trend for legislation in other jurisdictions. In particular, it reflects on the large gap between public opinion and Parliamentary opinion on the issue of assisted dying. The paper prepares the ground for future research to highlight some of the less visible processes in shaping views on the issue.

Introduction

There has been a long history of engagement with the issue of assisted dying in the UK. The Voluntary Euthanasia Legislation Society (later Dignity in Dying[2]) was established in 1935 and the first attempt to change the law in the UK was the Voluntary Euthanasia (Legalisation) Bill in 1936. This was introduced by Labour Peer Lord Ponsonby in place of the late Lord Moynihan, who had helped to found the Society.[3] While the Bill had the support of notable individuals within the medical profession, clergy and beyond, it was rejected at the end of Second Reading in the House of Lords by 35 votes to 14. Ponsonby concluded his remarks in the Lords by stating:

> 'I am perfectly certain that a measure of this kind will in time be accepted, and that those who are opposing it now will in time to come feel that they look back, as we look back upon those who opposed the use of chloroform in childbirth, to a time when there was a less enlightened view taken on these crucial matters.'[4]

Yet in the decades that have since elapsed, Parliamentary opinion has remained firmly against legislation.

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[1] I would like to thank the CWiPP Working Paper Series editors, Alvaro Martinez-Perez and Aki Tsuchiya for their very helpful comments on this paper.

[2] At different times, the group has also been called the Euthanasia Society, Voluntary Euthanasia Society and Exit. It became Dignity in Dying in 2005.

[3] https://churchinparliament.org/2015/09/18/1936-archbishop-lang-and-the-voluntary-euthanasia-legalisation-bill/

[4] https://api.parliament.uk/historic-hansard/lords/1936/dec/01/voluntary-euthanasia-legalisation-bill-hl Hansard (HL Deb 01 December 1936 vol 103 cc465-505)

While the negative associations attached to the term 'euthanasia' that followed Nazi atrocities dampened the debate in the period after the Second World War[5], it found a resurgence in the UK and elsewhere as these associations faded. Since the 1980s UK public support for assisted dying by a doctor for people with a painful incurable disease has consistently hovered around the 80 per cent mark (BSA 2017, 26)[6] and more recent polling commissioned by pro-legislation groups has indicated support may have increased further.[7] Despite this consistently high level of public support, opposition expressed through Parliamentary votes is almost a mirror reversal of the scale of public opinion, with 74% of MPs voting against legislation in the most recent instance in 2015. The British Social Attitudes survey suggested that 'The most surprising aspect of this issue is, perhaps, how out of step UK law is with long-standing and significant majority public support' (BSA 2017, 8).[8] This divergence is the central puzzle that this paper seeks to address.

While this paper refers to legislative initiatives in the UK Parliament, it should be noted that this issue has been a devolved matter in Scotland since 1998 and, as such, the main focus of this paper is on legislation as it would apply to the rest of the UK.

The terrain of debate

Definitions and labelling of end-of-life practices vary widely and there is no consensus on terminology. This field is normatively charged, and 'partisans often champion their own preferred set of terms, labels and distinctions' (Magelssen et al 2016, 1). The default term used here is 'assisted dying', which follows the terminology of recent UK legislative debates, but other terms are used where they are preferred by other authors or provide more nuance. Where key actors or authors have a stated association with a campaign group on either side of the debate these are identified in the discussion.

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[5] In debating the Incurable Patients Bill in 1976, Lord Ragan stated: 'Nearly seven years ago I sponsored a measure called the Voluntary Euthanasia Bill. The word "euthanasia" has, it seems, acquired some unfortunate connotations; in many people's minds it means bumping off in a painless way somebody who is not particularly wanted. Certainly I was accused of wanting to do away with harmless old people and sometimes I would be told, "I agree that we should not allow handicapped children to survive". One sees from these remarks how muddled people are about the purposes of a voluntary euthanasia Bill…'

[6] There is less clear-cut support for the other scenarios, for example; where euthanasia is carried out by a close relative (39%), where the person is not suffering from a terminal disease (51%) or is completely dependent but not in pain or danger of death (50%) (BSA 2017, 24-5).

[7] In 2019, the 'largest ever' poll on the issue, conducted by Populus on behalf of Dignity in Dying, put the figure at 84%. This was up 2% from their previous survey in 2015. Populus interviewed a random sample of 5,695 adults online between 11th March and 24th March 2019 (https://www.dignityindying.org.uk/news/poll-assisted-dying-support-84-britons/). Another 2019 survey, conducted by the National Centre for Social Research (NatCen) for My Death, My Decision, put the level of support above 90% for legislation covering those suffering from a terminal illness.

[8] This aspect may be even more surprising, given that the UK has introduced permissive legislation in other areas of morality policy - abortion, assisted reproductive technologies, embryo and stell-cell research, and same-sex marriage (Engeli et al 2012, 194).

Peter Saunders of the Care Not Killing Alliance identified four principal areas of conflict in relation to 'assisted suicide and euthanasia': parliament, the institutions [medical and religious], the courts, and the media (Saunders 2011). This paper covers these areas of conflict but has a slightly different coverage and structure, considering in turn: background; medical associations; public opinion and media; courts; interest groups; politicians; and developments in other jurisdictions.

At one point, Saunders raises the question at the centre of this paper, specifically considering 'why is public opinion so much out of step with Parliament and the institutions?'; (although this question might equally be phrased as 'why is Parliament so much of step with public opinion?'). He suggests:

> 'One answer might be that whilst both parliament and the institutions tend to hear both sides of the argument most of the public do not. Exposure solely to hard cases and emotive testimonies understandably induces support; and those trying to change the law will always attract more media interest than those working to preserve the status quo.' (Saunders 2011, 245).

This explanation may indeed be part of the answer, and Saunders makes a detailed and informed case for the importance of the media strategy pursued by pro-assisted dying campaigners. He notes how Dignity in Dying, frustrated by Parliamentary decisions, has turned to the courts and the media to build pressure for change, focusing on 'high-profile legal cases, personal interest stories and celebrity endorsement' (Saunders 2011, 245).

However, there are other issues to explore, not least in relation to how the views of politicians are shaped to produce a different collective view. The suggestion that politicians tend to hear 'both sides of the argument while the public do not' suggests that there may be important political processes to consider that may be less visible than high profile media campaigns: an issue on which there has been little focus in the literature to date.

Background

The moral debate

It is not the purpose of this paper to take a moral position on whether assisted dying should be legalised: this is a highly-charged debate on which a great deal has already been written (for example, Watt 2000; McMahan 2002; Battin 2005; Huxtable 2007; Lewis 2007; Young 2007; Gorsuch

2009; Jackson and Keown 2012). However, it is important to provide a flavour of this debate as context for the discussion that follows.

For those in favour of legislation, personal autonomy is a central argument. The right to die is seen to provide an opportunity for a dignified death in the context of extreme suffering and only the individual, and not society, should determine this decision. As such, it is viewed as compassionate and humane. For those opposed, sanctity of life is a central argument: often, but not always, informed by religious belief. Individual choice in this matter is seen as a threat to the wider society: not least that legislation may not protect vulnerable people (disabled, elderly, or sick) from coercion to request assisted suicide. Moreover, this view rejects the argument that the ill or disabled lack dignity in relying on others. In this view, suffering can be treated by effective palliative care and this is where attention and resources should be focused. In contrast, advocates of legislation suggest that palliative care is not only not available to all, it cannot relieve all suffering and, moreover, it does not address the individual's desire for control and independence.

Opponents also tend to view initial legislation, which is often defined narrowly,[9] as the beginning of a 'slippery slope' that will lead to incremental changes to cover more categories of people. They point to such developments in places where legislation has been introduced,[10] although those in favour of assisted dying often point to the same legislation as evidence that successful safeguards have been introduced to protect the vulnerable.[11]

On medical ethics, opponents of legislation argue that doctors' involvement in assisted suicide would contravene the Hippocratic Oath[12] and would erode trust between patients and doctors; while advocates point to the increasing importance of patient autonomy within medical ethics and a broader interpretation of doctors' responsibility to relieve suffering, and cite evidence that casts doubt on damage to public perceptions of the doctor-patient relationship.[13] While the weight of public opinion in the UK is now regularly cited by advocates of legislation in their favour, opponents question both the reliability and validity of public opinion, which has seen to be heavily swayed by a pro-legalisation media (see Saunders 2011).

These are ongoing areas of conflict in the debate, many of which are founded on different moral beliefs and thus cannot be resolved empirically; although empirical evidence plays an increasing role in debate as more is available from legislative initiatives elsewhere. There are many

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[9] For example, recent legislation in the UK is aimed at those individuals who a doctor indicates are 'reasonably expected' to die within six months.

[10] https://www.economist.com/open-future/2018/08/29/the-slippery-slope-of-assisted-dying-is-real

[11] https://www.bmj.com/content/334/7602/1029.4.full

[12] The principle of 'do no harm'.

[13] The BMA (2016b, 8) found that 'Overall, the public presented a balanced range of views and potential positive and negative impacts on the doctor-patient relationship. Doctors were more likely to focus on the potential negative impacts on the relationship than the public.'

nuances to the debate that will not be covered here because they are not central to the question being addressed. However, the broad themes outlined re-emerge and are dealt with further where appropriate in the subsequent discussion.

The legal position

Under the Suicide Act 1961 it is no longer a crime for a person to commit suicide in the UK, but under Section 2 of the Act it remains an offence for a person to assist the suicide (or attempted suicide) of another.[14] This offence is liable to imprisonment for up to 14 years. In 2009, the language of the Act was amended by Section 59 of the Coroners and Justice Act 2009 to refer to 'encouraging or assisting suicide'. This change was made in order to clarify that encouragement of the offence online was covered (Mullock 2011, 107). However, any prosecutions can only be brought by or with the consent of the Director of Public Prosecutions (DPP) and such prosecutions are rare (see below). Despite legal cases that have garnered much media attention and public debate, judges have regularly stated that any change in the law is a matter for Parliament and not the courts.

There has been increasing Parliamentary activity on the issue in recent years, with the number of Private Members Bill's (PMBs) and other Parliamentary debates accelerating. Assisted dying is not a party-political issue in the UK and thus there has been no government legislation and MPs are not subject to party whips when voting on this and other 'matters of conscience'. Reliance on PMBs, which face a number of constraints compared to government Bills, makes the prospect of legislation less likely and few PMBs become law. One important constraint is time pressure. Parliamentary time is controlled by the government and, to a lesser extent, the official opposition, and they devote their time to their party-political priorities. When time runs out for a PMB it cannot be carried over into the next session of Parliament. The limitations of the PMBs procedure have been viewed as 'merely a reflection of executive dominance in the British system' (Marsh and Read 1988, 184). Because of the sensitivity of the issue, PMBs and debates on assisted dying have been more frequent and more elaborate in the Lords than the Commons (de Bruïne 2017, 20), where members face the pressure of electoral consequences[15] (see *Politics* below). Although few PMBs become law, they are often useful for generating publicity around an issue and, through this, may have a longer-term influence over the prospects for legislation.

Attempts at legislative change

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[14] Section 13 of the Criminal Justice Act (Northern Ireland) also covers criminal liability for complicity in another's suicide- https://www.legislation.gov.uk/apni/1966/20/section/13. This extended s.2 of the Suicide Act 1961.

[15] Both members of the Lords and Commons who are not in the Cabinet can introduce PMBs.

Following the first unsuccessful attempt at legislative change in 1936 (above), the next attempt was in 1950 when the Labour peer Lord Chorley of Kendal, a Vice-President of the Voluntary Euthanasia Legislation Society, brought a pro-voluntary euthanasia motion before the House of Lords. However, following a debate, this motion was withdrawn in the face of strong opposition.[16] In 1969, the Voluntary Euthanasia Bill[17] brought by then Labour peer Lord Raglan,[18] a member of the National Secular Society, was rejected by 61 votes to 40 following an effective campaign against led by the Conservative Norman St John-Stevas (Oakley 2011, 319). Kemp (2002, 194) argued that at this point the reform of euthanasia lagged behind suicide and abortion because of the nature of the advocacy, citing Lord Longford's speech in the debate as illustrative: 'Those who most wish for it, the old and the very infirm are, by their very nature, not in a position to mount an energetic and articulate campaign.'[19] At the same time, he noted the important role of the British Medical Association (BMA), which was 'vehemently opposed' to legalising voluntary euthanasia (Kemp 2002, 95).

In the 1990s, high profile court cases[20] led to the first House of Lords Select Committee review on the issues of assisted suicide and euthanasia. The Committee unanimously ruled that there should be no change in the law. In May 1994, Committee Chair Lord Walton summarised the position:

> 'We concluded that it was virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the United Kingdom could not be abused. We were also concerned that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death'.[21]

Saunders (2011, 246) suggests that the findings of the Select Committee 'effectively stalled the campaign to legalise euthanasia for over ten years'. When the issue of legalisation next came to Parliament with the Doctor Assisted Dying Bill (1997), proposed by Labour MP Joe Ashton, it met with a resounding defeat by 234 votes to 89.

In 2004, Labour peer Lord Joffe, a member of Dignity in Dying, introduced the Assisted Dying for the Terminally Ill Bill [HL]. This aimed 'to enable a competent adult who is suffering unbearably as

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[16] https://api.parliament.uk/historic-hansard/lords/1950/nov/28/voluntary-euthanasia

[17] https://hansard.parliament.uk/lords/1969-03-25/debates/22666bfd-54d8-4bf4-957b-626362e2b945/VoluntaryEuthanasiaBillHl

[18] He left the Labour Party and joined the Social Democratic Party in 1983

[19] Lord Longford's speech, Voluntary Euthanasia Bill HL Deb 25 Mar 1969, c1190).

[20] These cases were of 'Tony Bland, a football supporter who ended up in persistent vegetative state secondary to a head injury sustained during the Hillsborough disaster, and Nigel Cox, a Winchester rheumatologist who killed a patient with an intravenous injection of potassium chloride' (Saunders 2011, 245).

[21] Medical Ethics: Select Committee Report. HL Deb 09 May 1994 vol 554 cc1344- 412

a result of a terminal illness to receive medical assistance to die at his own considered and persistent request'.[22] The Bill lapsed at the end of the 2004/05 session but was reintroduced in the following session in November 2005 and had its Second Reading in the Lords in May 2006, when it was defeated by 148 votes to 100.

In 2009, Labour peer Lord Falconer sought to amend the Coroners and Justice Bill to remove the threat of prosecution from those who go abroad to help an 'assisted suicide'. The amendment was defeated by 194 to 141. Four years later, Falconer introduced the Assisted Dying Bill [HL] (2013-14), which sought to enable competent adults who were terminally ill and 'reasonably expected to die within six months' to be allowed assistance with ending their life. The Bill was based on the Oregon Death in Dignity Act, which had been introduced in 1997.[23] The Bill was debated over a two-year period before time ran out because of 2015 General Election. The Bill was subsequently reintroduced in the following Parliamentary session by Falconer, but this did not progress beyond its first reading. In the same session, The Assisted Dying Bill No.2, (2015-16), which mirrored Falconer's Bill, was brought to the Commons by Labour MP Rob Marriss. In the first Commons vote on the issue since 1997, Marriss's Bill was rejected by 330 to 118, following a four-hour debate.

There were a number of related debates in the Lords after Marriss's Bill (see House of Commons Library 2020, 25) and a general debate on the Functioning of the Existing Law Relating to Assisted Dying in the House of Commons Chamber on 4 July 2019.[24] During this debate, Conservative MP Nick Boles asked the Secretary of State for Justice to initiate a formal call for evidence on the impact of the existing laws on assisted dying, which only the government can do. Boles suggested that this would allow Parliament to benefit from a comprehensive assessment of the facts for when it next decides to debate and vote on a possible change in the law. The call was rejected by the government. In April 2020, Justice Secretary Robert Buckland restated the position that the government had no plans to initiate a review of the law in this area, nor publish a call for evidence.[25]

In October 2021, Baroness Meacher's Assisted Dying Bill received its second reading in the Lords, following its first reading in May of the same year. Again mirroring Lord Falcolner's Bill it sought to 'enable adults who are terminally ill to be provided at their request with specified assistance to end their own life'. Following seven hours of debate the Bill proceeded to the Committee stage without a vote being taken. While there were claims on the pro-legislation side

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[22] https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8614.htm

[23] https://www.dignityindying.org.uk/assisted-dying/the-law/lord-falconers-assisted-dying-bill-2014/#:~:text=Introduced%20by%20the%20former%20Lord,being%20approved%20by%20two%20doctors.

[24] Led by Nick Boles (Conservative), Sarah Champion (Labour) and Norman Lamb (Liberal Democrats)

[25] This was at a hearing of the Joint Committee of Human Rights - https://care.org.uk/news/2020/04/minister-no-plans-to-review-the-current-law-on-assisted-suicide

that the Bill went through 'unopposed'[26] and on the anti-legislation side that a vote was not called because 'they realised that they would be unlikely to have sufficient support to win a vote',[27] an unopposed second reading is conventional in the Lords. [28] At the time of writing, the Bill remained at the committee stage. However, commentators claimed that 'plans to wreck the Bill traditionally come to the fore at committee and report'[29] and that as the Prime Minister Boris Johnson did not support the Bill it was 'unlikely to become law without government support'.[30]

To understand more of the reasons for these unsuccessful attempts to change the law, the paper now turns to various sites of conflict, beginning with the role of the major medical associations.

The medical associations

As the BMA (2016a, 75) notes, 'The issue of whether doctors should be involved in assisted dying processes has been seen as axiomatic in countries where it is legal'. However, while the involvement of the medical profession has been mandatory elsewhere, the participation of individual practitioners is optional (Jackson 2018, 72), and UK Bills have followed this trend.[31] Studies have shown that involvement of medical practitioners is strongly preferred by both the public in general and patients who are considering assisted dying. On the former, the British Social Attitudes survey of 2017 found that while 78% are in favour of 'voluntary euthanasia' where it is carried out by a doctor for a person with an incurable disease, only 35% are in favour where it is carried out by a close relative (BSA 2017, 24-5). On patients, Richards' (2017, 353) study of UK citizens who were actively planning to travel to Switzerland for an assisted death found that the involvement of a medical professional was preferred because it had 'both a guaranteed outcome and some social legitimacy'.[32]

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[26] https://www.dignityindying.org.uk/news/assisted-dying-bill-progresses-with-majority-of-speakers-in-favour-lord-field-baroness-davidson-among-peers-declaring-change-of-mind-onissue/

[27] https://righttolife.org.uk/news/meacher-assisted-suicide-bill-debate

[28] https://www.standard.co.uk/news/uk/frank-field-government-justin-welby-house-of-lords-campaigners-b962082.html

[29] https://www.politicshome.com/members/article/assisted-dying-bill-progresses-with-majority-of-speakers-in-favour-lord-field-baroness-davidson-among-peers-declaring-change-of-mind-on-issue

[30] https://www.mirror.co.uk/news/politics/law-allow-assisted-dying-passes-25280574

[31] Typically, in recent UK Bills proposed, the assisting health professional may only be — (a) the attending doctor; or (b) another registered medical practitioner or registered nurse who has specific prior written authorisation signed by the attending doctor (Assisted Dying (No.2) Bill, 2015-16).

[32] Richards (2017, 358) found that for some participants physician involvement meant that responsibility for death would be shared and it thus felt less like suicide, which carries 'both religious sanctions and social stigma', while other participants rejected the idea that their decision required validation in this way and simply wanted the physician's 'power as prescriber'.

However, UK medical associations have generally opposed legislation on assisted dying: not least because many feel strongly that assisting in death is incompatible with the ethical principles of non-maleficence (do no harm) and beneficence (do good). Moreover, it is clear that even where medical practitioners support and agree to participate in assisted dying, this is an onerous duty. This duty weighs more heavily when the process is physician-assisted death (administering fatal drugs) rather than voluntary euthanasia (prescribing drugs for patients to self-administer) (Mullock 2011, 211-12). In either case, practitioners are generally required to stay with the person until they have died. Thus, it is not surprising that while the views of practitioners vary, not least by specialism,[33] it is generally the case that the number of physicians supporting legislation is greater than the number willing to assist dying. For example, a Royal College of Physicians (RCP) survey in 2015 found 40.5% of physicians in support of a change in the law to permit assisted dying but only 24.6% stating that they would be prepared to actively participate.[34]

As Richards (2017, 359) has argued, a central question in the legalisation debate is 'where the limits of medicine lie in terms of the medical profession's responsibility to relieve suffering', noting that in cases of 'hopeless' suffering, 'medical assistance in suicide is increasingly viewed as a legitimate "treatment."' The context within which debate now takes place is one where traditional ethical principles are challenged by an increased emphasis on patient involvement and choice within healthcare settings, such as the UK National Health Service (NHS) 'no decision about me, without me' policy. [35] As the discussion below illustrates, their position on assisted dying has been a very live issue for the key medical associations in recent years.

The British Medical Association (BMA)

For most of its history the BMA has opposed all forms of assisted dying, although in 2005 it took a neutral stance for the first time before reversing its position in 2006. In 2016, the Annual Representative Meeting (ARM) rejected a motion to adopt a neutral position and reaffirmed its policy of opposition, which set out that the BMA:

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[33] The BMA reported that those specialities that were generally more supportive were: anaesthetics, emergency medicine, intensive care and obstetrics & gynaecology. Those specialities generally more opposed were: clinical oncology, general practice, geriatric medicine and palliative care. https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying/physician-assisted-dying-survey

[34] https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral

[35] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf

- 'believes that the ongoing improvement in palliative care allows patients to die with dignity;
- insists that physician-assisted suicide should not be made legal in the UK;
- insists that voluntary euthanasia should not be made legal in the UK;
- insists that non-voluntary euthanasia should not be made legal in the UK;
- insists that if euthanasia were legalised, there should be a clear demarcation between those doctors who would be involved in it and those who would not' (BMA 2020).

There was criticism over the BMA's decision-making process on assisted dying (see Davis 2019) and, in particular, its reluctance to go beyond the 500 members of the ARM and survey its membership of around 160,000. In defence of this position, Anthea Mowat, chair of the BMA Representative Body, and John Chisholm, chair of the BMA Medical Ethics Committee, stated:

> 'Although this might sound counterintuitive, such nuanced, complex, and potentially divisive ethical issues do not lend themselves to decision making through direct polling or surveys. Instead, we have clearly defined and longstanding deliberative and democratic processes through which we typically make policy' (Mowat and Chisholm 2019, 1).

Mowat and Chisholm went on to express concerns about the accuracy of survey results and the potential for results to be easily swayed one or the other, expressing a preference for qualitative rather than quantitative data on issues such as the effects on the doctor-patient relationship and how doctors are viewed in society. They argued that a position of neutrality would risk the BMA being ignored from the assisted dying debate altogether and make it difficult for it to lobby on behalf of doctors in relation to their role in the process and the safeguards they would like to see in any legislation.

In response to these arguments, Emeritus Professor of Medicine Graeme Catto suggested that the BMA had shown no willingness to learn from colleagues in other countries and cited the Canadian Medical Association's explanation of how a neutral stance had enabled it to 'participate fully in the public debate for all its members who held divergent views on a change in the law' (Catto 2019, 364). The BMA position was seen also to send an 'unfortunate message' to nursing colleagues as the Royal College of Nursing had held a neutral stance on the issue since 2009 but had since 'engaged constructively' with legislators whenever Bills had been presented, while the BMA told Parliament in 2014 that 'for reasons of inconsistency with BMA policy, it would be inappropriate to engage with the detailed proposals in the Assisted Dying Bill' (Catto 2019, 364).

In the context of an intensifying debate on the issue, in June 2019 the ARM passed a motion that noted the recent decision of the Royal College of Physicians (below) to adopt a neutral position after surveying its members and agreed to carry out a membership poll on whether the BMA should adopt a neutral position with respect to a change in the law (Politics Home 2020). Subsequently, the BMA announced In February 2020 that it would conduct its first ever membership survey on the issue. The BMA membership survey assumed the criteria for assisted dying legislation would cover patients who: are adults; have the mental capacity to make the decision; have made a voluntary request; and have either a terminal illness or serious physical illness causing intolerable suffering that cannot be relieved.[36]

On the issue of prescribing drugs for self-administration by eligible patients the survey found 40% of doctors believed the BMAs position should be one of support, 33% said it should oppose, 21% wanted neutrality, and 6% were undecided. When asked for their personal view on this, 50% were supportive, 39% opposed and 11% undecided. On their willingness to 'actively participate in any way in the process', 36% said yes, they would be, 45% said no and 19% were undecided (Chisholm 2020). On doctors administering drugs to end the life of an eligible patient, 40% believed the BMA's position should be opposed, 30% said it should be supportive, 23% were neutral, and 7% were undecided. When asked for their personal view, 37% were supportive, 46% opposed and 17% undecided. And finally, on their willingness to actively participate, 26% said yes to being willing to actively participate in some way in the process, 54% said no, and 20% were undecided (Chisholm 2020).[37]

Informed by the survey, on 14 September 2021, the BMA's representative body[38] voted 49% to 48% in favour of a motion changing the BMA's policy from opposition to a change in the law on assisted dying, to a position of neutrality. The BMA stated the decision meant that:

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[36] https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying#:~:text=In%20our%202020%20member%20survey,made%20a%20voluntary%20request%20and

[37] The survey had 28,986 responses: 19.35% of all members who received an invitation to participate. It was described as 'higher than other surveys we have carried out of our full membership and higher than or in line with the typical market research response rate for this type of survey… one of the largest surveys of medical opinion ever carried out on this issue'. This sample was considered to be 'broadly representative' of the BMA membership when assessed by nation, branch of practice and specialty with a few exceptions: 'GPs were slightly over-represented and junior doctors and medical students were slightly under-represented.' - https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying/physician-assisted-dying-survey

[38] The BMA's representative body consists of representatives from all divisions and branches of practice, regional and national councils, and is governed by BMA articles and by-laws. It meets once a year at the ARM and is the BMA's main policy-making function. https://www.bma.org.uk/about-us/about-the-bma/how-we-work/bma-governance#:~:text=The%20RB%20(Representative%20body)%20meets,representatives%20to%20roles%20and%20committees

> '…we will neither support nor oppose attempts to change the law. We will not be silent on this issue, however. We have a responsibility to represent our members' interests and concerns in any future legislative proposals and will continue to engage with our members to determine their views.'[39]

The Royal College of General Practitioners (RCGP)

While the RCGP has long opposed assisted dying, in June 2019 its governing council announced it would survey its 53,000 members on the issue. It had previously done so six years earlier, announcing in February 2014 that the College should not change its stance. In 2013, 77% of those polled agreed that the College should remain opposed to assisted dying legislation, 18% wanted a neutral position and 5% advocated legislative change.[40] The new survey was commissioned in acknowledgement that in the context of much debate on the issue the views of the membership may have shifted. The purpose of the consultation was to inform the council's decision-making. The initial results released in February 2020 showed 47% opposed to legislation, 40% supportive and 11% advocating a neutral position. While this was a very significant shift, the RCGP Council concluded that the findings did not support a change in its stance. Within the governing council, 44 members voted that the College should continue to oppose a change in the law, 13 voted that the College should not continue to oppose a change in the law, and five abstained.[41] The council announced that it would not consult members again for at least five years unless there were 'significant developments' on the issue.[42]

This RCGP Council's decision was fiercely criticised by pro-legislation advocates, who pointed out that there was no longer a majority opposing legislation and there had been an eight-fold increase in the number supporting legislation.[43] When the full weighted results of the survey were released shortly afterwards, following a petition by those criticising the RCGPs lack of transparency on the process and the decision not to move to a neutral position, the figures demonstrated a slightly greater shift in the views of RCGP members, with only 46% opposed and 41% supporting legislation, providing a clearer majority of those supporting either advocating change or neutrality.[44]

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[39] https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying

[40] https://www.rcgp.org.uk/policy/rcgp-policy-areas/assisted-dying.aspx

[41] https://www.rcgp.org.uk/policy/rcgp-policy-areas/assisted-dying.aspx

[42] https://www.rcgp.org.uk/about-us/news/2020/february/royal-college-of-gps-remains-opposed-to-change-in-the-law-on-assisted-dying.aspx

[43] https://www.dignityindying.org.uk/news/gp-opposition-assisted-dying-plummets-remains-opposed/

[44] https://www.politicshome.com/news/article/royal-college-of-gps-assisted-dying-survey-reveals-even-greater-shift-in-opinion-after-council-petitioned-to-release-weighted-results

However, the RCGP Council argued that it was not possible to accurately compare the results of the two exercises because they had employed different methodologies.[45]

The Royal College of Physicians (RCP)

The RCP has long been opposed to assisted dying legislation. It took a neutral position in 2005 but announced its return to opposition just two days before the second reading of the Joffe Assisted Dying Bill in 2006, following a survey of its members. This shift made headline news and, Saunders (2011, 243) suggests, 'substantially wrong-footed DiD [Dignity in Dying], which had built its campaign around the high-profile hard case of Dr Anne Turner and had hoped to capitalise on a vote held the day after the fifth anniversary of the (natural) death of Diane Pretty on 11 May'. Following a further survey of members in 2014 in the context of the Falconer Bill, the RCP retained its position of opposition, although opinion on this was softening.

The level of opposition expressed by RCP members in the 2014 survey varied on different questions and thus the results were open to greater interpretation than usual. When asked *Do you support a change in the law to permit assisted suicide by the terminally ill with the assistance of doctors* the response was: No, 57.5%; Yes, 23%; Yes, but not by doctors, 10.2%. On *what should the College's position be on 'assisted dying' as defined in the RCP's consultation document,* 44.4% were in favour of opposition, 31% favoured neutrality, and 24.6% favoured support. However, the only question in the 2014 survey that was also asked in 2006 – and because of this the one that tended to get most attention - was the least neutral in its phrasing. This was: *We ask you to consider the following statement: '(We) believe that with improvements in palliative care, good clinical care can be provided within existing legislation, and that patients can die with dignity. A change in legislation is not needed.' Do you agree?* On this the response in 2014 was Yes 62.5%, No 37.5%, compared with Yes 73.2% and No 26% in 2006.[46] This question did not appear in the next survey in 2019, which led the RCP to adopt a neutral position.

Ahead of the 2019 survey the RCP Council[47] announced that it would move to a neutral position on assisted dying unless there was a supermajority (of 60%) either supporting or opposed to legislation (Hurley 2019, 1). The survey revealed that those favouring RCP opposition to a change in the law fell from 44.4% to 43.4% and the number favouring RCP support increased from 24.6% to 31.6%. Those seeking a neutral position decreased from 31% to 25%.[48] While this was a further

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[45] https://www.rcgp.org.uk/policy/rcgp-policy-areas/assisted-dying.aspx

[46] https://www.rcplondon.ac.uk/news/rcp-reaffirms-position-against-assisted-dying

[47] This is the RCP's main decision-making body. It comprises 49 people, mostly doctors, including 17 members elected by the College's fellows and 11 representatives elected by specialist societies (Hurley 2019, 1).

[48] https://www.rcplondon.ac.uk/news/rcp-clarifies-its-position-assisted-dying#:~:text=In%20early%202019%20the%20RCP,the%20RCP%20should%20be%20neutral.

softening in opposition to legal change, the requirement for a supermajority and the choice of questions demonstrated that the key change leading to the position of neutrality had been a shift in its governing council's position. In defending its decision to adopt this position, it noted that not only was a supermajority not achieved, but also that 'neutrality also reflects the lack of a simple majority for any particular view.'[49] The point was accurate but, depending on the question considered, this had also been the case in 2014. In response, RCP fellow and former Chair of its Ethics Committee John Saunders described the exercise as a 'sham poll with a rigged outcome' (Hurley 2019, 1). Subsequently, a group of RCP members led an application for a judicial review, which was refused. [50] The move to neutrality was upheld and the College stated its intention to repeat the survey every five years. The RCP's President said the move to neutrality would allow the RCP to 'reflect the differing views of its fellows and members in discussions with government and others' (Hurley 2019, 1).

Analysis

As the above discussion suggests, the position of medical associations on assisted dying is complex and intensely debated. Governing bodies make the decisions rather than membership as a whole and the interpretation of members' views by such bodies has on occasions been seen as controversial. However, as a general trend, opposition to legislation appears to be softening both among members and governing bodies.

In introducing her bill to the House of Lords in October 2021, Baroness Meacher stated that since the Marris Bill in 2015 there had been a 'radical shift in the views of doctors',[51] noting both the change in position of the RCP and the BMA. In the previous month, a proposal for an Assisted Dying Bill in Scotland by Liam McArthur MSP (see below) had also referenced the shift in position of the RCPG and BMA, and noted that the Royal College of Nursing, Royal College of Nursing Scotland, Royal College of Psychiatrists, and Royal Pharmaceutical Society all held a neutral stance on assisted dying, with many other professional bodies not taking a formal position. McArthur argued that 'It is clear that both in this country and overseas, there has been a fundamental shift in opinion amongst healthcare professionals' (McArthur 2021, 13).

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[49] https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral

[50] This review was refused on the grounds that: the RCP's decision was not a decision of a public law nature that is amenable to judicial review; permission to bring charity proceedings from the Charity Commission pursuant to section 115 of the Charities Act 2011 had not yet been granted; and, it was unarguable that the RCP decision was either procedurally unfair or irrational. https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral

[51] https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)

Courts

Heichel et al (2013) have argued that courts can ‘trigger’ mortality policy change in four different ways. First, they can create situations in which the legislature is either challenged or forced to react. Second, court decisions can be central to how a problem is defined. Third, courts can shape policy at the implementation stage. And, finally, they note that ‘there is an enormous relevance for strategic interaction between the judicial and the legislative or executive branch’ (Heichel et al 2013, 329). In the UK, a number of cases have brought challenges to the Suicide Act 1961, which have not brought about a change to the law but have on occasions caused the courts to refer the matter of assisted dying to Parliament and draw significant media coverage.

In 2001, Diane Pretty, who suffered from motor neurone disease, sought clarification from the Director of Public Prosecutions on whether her husband would be prosecuted if he helped her to die. The DPP refused to give such an undertaking and her case was subsequently rejected by the House of Lords, which stated that the DPP could not be required to give such an undertaking and did not have the power to undertake to withhold consent to prosecution. Pretty appealed to the European Court of Human Rights, where it was held that her desire to end her life engaged with Article 8.1 of the European Convention of Human Rights (ECHR) on the right to respect for private and family life. However, she failed in her case because the interference with her right under Article 8.1 was held to be justified by Article 8.2, which states:

> ‘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.’[52]

The Court described the provisions of Article 8.2 as ‘designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life’.[53] The Court added that many ‘terminally ill individuals … will be vulnerable, and it is the vulnerability of the class which provides the rationale for the law in question.’[54] As such, it was ‘primarily for states to assess the risk and the likely

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[52] https://www.echr.coe.int/Documents/Guide_Art_8_ENG.pdf

[53] https://www.supremecourt.uk/cases/docs/uksc-2013-0235-judgment.pdf

[54] https://www.supremecourt.uk/cases/docs/uksc-2013-0235-judgment.pdf

incidence of abuse if the general prohibition on assisted suicides were relaxed or exceptions were to be created'.[55]

In light of the ruling in the Pretty case, in 2008, Debbie Purdy, who suffered from progressive multiple sclerosis, sought clarification on how the 1961 Act would be enforced. Specifically, she challenged the refusal of the DPP to disclose the criteria that would be applied to decide whether or not an individual would be prosecuted for assisting suicide: this would inform her decision on whether her husband would accompany her to Dignitas in Switzerland[56] or whether she would go alone at an earlier date, while she was still able. In July 2009 the House of Lords upheld her contention that the DPPs refusal to provide clarification infringed her Article 8 rights. It stated that she had the right to determine how she spent the closing moments of her life, which was part of the act of living.[57] The Lords ordered the DPP to produce guidance on the matter that would go beyond a generalised conception of the public interest to specify the factors that would be considered in deciding whether or not to consent to a prosecution.

Following a public consultation, which led to 'the largest number of responses the Crown Prosecution Service (CPS) has ever received about a single topic',[58] the DPPs policy was published in February 2010. It identified 16 factors that would favour prosecution and 13 that would point against, albeit with different weight attached to factors on different sides and the indication that a specific factor could be decisive in a particular case. Factors tending towards prosecution included that the victim did not have the capacity to reach an informed decision to commit suicide or had not reached a voluntary, clear, settled, and informed decision. Key factors tending against prosecution were that 'the victim had reached a voluntary, clear, settled and informed decision to commit suicide' and that the 'the suspect was wholly motivated by compassion'.[59]

The issue of whether UK law infringed Article 8 of the ECHR was revisited in 2014 in the case of Tony Nicklinson, Paul Lamb and AM ('Martin'), each of whom wished to end their life but could do not so themselves because of physical incapacity. In the first appeal, Lamb and the widow of Nicklinson, who had died since the proceedings had been issued, argued that Section 2 of the Suicide Act imposed a 'blanket ban' on assisted suicide, which infringes Article 8 of the ECHR, even allowing for the wide margin the Strasbourg Court allowed member states. While five of the Supreme Court judges considered that the Court had the power to declare against the general prohibition of

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[55] https://www.supremecourt.uk/cases/docs/uksc-2013-0235-judgment.pdf

[56] A non-profit organisation that provides assisted/accompanied suicide supported by qualified doctors and is available to foreign nationals - http://www.dignitas.ch/?lang=en

[57] https://www.lawgazette.co.uk/law/human-rights-clarifying-the-law-on-assisted-suicide/52048.article

[58] https://www.supremecourt.uk/cases/docs/uksc-2013-0235-judgment.pdf

[59] https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide

assisted suicide, only two were prepared to make such a declaration. Four judges considered that Parliament was better placed than the courts to decide on the matter and ultimately the Supreme Court's decision was to defer the matter to Parliament for consideration (House of Lords Library 2017, 3).

In the second appeal, 'Martin' requested clearer guidance in the DPP policy with regard to prosecuting those from whom he would like advice and assistance in connection with killing himself; in particular, doctors and other members of the caring profession. The Court of Appeal ruled that the DPPs policy on this was insufficiently clear. This ultimately led to the DPP to revise the guidance to clarify that a doctor not currently caring for the patient but brought into assist would be no more likely than a friend or family member to be prosecuted (Dyer 2014, 1).

In 2017, Noel Conway, a motor neurone disease sufferer who was terminally ill, applied to the Divisional Court for a declaration that the ban on assisting suicide under the 1961 Act was incompatible with his rights under Article 8 of the ECHR. Conway argued that the blanket ban constituted an interference with his Article 8 rights in a way which was disproportionate and incompatible with Article 8.2. He proposed an 'alternative statutory scheme', which he argued would sufficiently protect the weak and vulnerable and which would make the blanket ban unnecessary. The application was refused by the Court and he was subsequently refused permission to appeal the decision by the Supreme Court. In rejecting the appeal, Lord Justice Burnett stated that the 'core reason' for doing so was that:

> 'Parliament has reconsidered the issue of assisted dying following the decision of the Supreme Court in Nicklinson, as that court encouraged it to do. Both the House of Commons and the House of Lords have debated the matter in the context of Bills proposing a relaxation of the strict application of section 2(1). The result is that Parliament has decided, at least for the moment, not to provide for legislative exceptions to section 2(1) of the 1961 Act. The policy of the DPP has also been subject to parliamentary scrutiny and debate…. Whilst the Nicklinson case recognised a jurisdiction in the courts to issue a declaration of incompatibility in these circumstances, even where Parliament had struck the balance for itself, the Supreme Court also recognised that Parliament was better placed to resolve these sensitive issues. [60]

In 2019, Phil Newby, also a motor neurone disease sufferer, brought a further case against the 'blanket ban' as being incompatible with Article 8 of the ECHR. Newby's case differed from Conway's

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[60] https://www.judiciary.uk/wp-content/uploads/2017/03/conway-v-justice-secretary-judgment.pdf

in that he was not terminally ill and thus did not have the option of withdrawing from treatment that was keeping him alive. Newby requested consideration of 'legislative facts' relating to ethical, moral and social policy issues that would allow assessment of whether Section 2 of the 1961 was compatible with Article 8. The High Court rejected the appeal to evidence, stating that 'Considerations of morality, upon which the issue turns, are simply not reducible to statistical analysis or any hard-edged, measurable or quantitative conclusions' and restated the view that Parliament is 'the appropriate forum to consider and determine the very difficult balance between sanctity of life and personal autonomy raised in cases of assisted suicide'. [61] The High Court refused Newby's application in November 2019, concluding that: 'Despite minor distinctions to be made in the conditions of the claimants, *Conway* is an authoritative case for present purposes, and in our judgment is binding on this court in relation to this issue'.[62] Newby's appeal for a judicial review was rejected in January 2020.

Application of the law

Despite unsuccessful challenges to the law through the courts, there has been criticism that the police and judiciary do not uphold the will of Parliament on this matter 'with an apparent trend towards police not investigating, the DPP not prosecuting, juries returning perverse verdicts and judges giving light sentences' (Saunders 2011, 244). One illustration that this trend still holds is that from 1 April 2009 up to 31 January 2020, of the 156 cases referred to the CPS by the police that were recorded as assisted suicide, 105 were not proceeded with by the CPS, 31 were withdrawn by the police and four were ongoing. Three cases of encouraging or assisting suicide had been successfully prosecuted, one case was charged and acquitted after trial in May 2015, and nine others were referred onwards for prosecution for homicide or other serious crime.[63] Saunders (2011, 244) observed a 'similar pattern' in the Netherlands, noting that 'a steady increase in cases of assisted suicide and euthanasia (both voluntary and non-voluntary) between 1980 and 2000 led eventually to this apparent "legal sanction" being given statutory force in 2002'.

Analysis

The courts have played a significant role in assisted dying debates in the UK. High profile cases, even when unsuccessful, have received considerable media attention and have helped to define the issue in the public sphere. In addition, decisions such as the request to the DPP to provide guidance on the conditions for likely prosecution for assisting someone to travel to Dignitas have been seen as a

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[61] https://www.bailii.org/ew/cases/EWHC/Admin/2019/3118.html

[62] https://www.bailii.org/ew/cases/EWHC/Admin/2019/3118.html

[63] https://www.cps.gov.uk/publication/assisted-suicide

softening of the law. The way in which the law has been applied has been seen as a further softening. On the substantive issue, however, the courts have repeatedly sought to defer to Parliament.

Public opinion and the media

As noted earlier, opinion polls report high levels of support for legislation on assisted dying and little overall change to attitudes over recent decades. Moreover, the British Social Attitudes survey has found 'relatively few major differences in views towards euthanasia[64] among the major demographic subgroups of the population' (BSA 2017, 27). The main differences evident relate to religious affiliation, with those with no religion being most likely to support euthanasia (see *Religious Groups* below). The same survey also identified some differences by age, with those in the oldest age groups (75+) tending to be less supportive than younger age groups, with the middle age groups tending to be most supportive (see below – *Elderly People*). However, the survey found no evidence that the level of support is associated with educational qualifications and also found 'no marked differences' by party identification (BSA 2017, 27).

There is evidence that public opinion has been increasingly referenced in Parliamentary debates on assisted dying since the early 1990s. De Bruïne (2017) presents interesting findings on this issue. For example, in the House of Commons debate in 1997, public opinion[65] was only referenced three times: once by proponents of legislation and twice by opponents. In 2008, there were 16 references (13 by proponents, 3 by opponents); in 2012, 32 references (25/7); and, in 2015, 37 references (20/17). Debates in the House of Lords show a similar trend: in 1993-4, public opinion was not referenced at all by proponents but was mentioned 12 times by opponents: by 2014 this had moved to 62-23. De Bruïne (2017, 8) argues that, over this period, public opinion went from playing no significant role in Parliamentary debates to become 'one of the central points of strife between opponents and supporters of PAS [physician assisted suicide]'. Increasingly, public opinion has been used by pro-legislation advocates as a strategic resource: it is seen to bring a sense of rationality, moral validity, and democratic legitimacy to their arguments (De Bruïne 2017, 32).

As Saunders (2011) notes 'the wording of the question does to some extent determine the response and most surveys of this type are launched by members of the pro-assisted dying camp'. However, a wide range of surveys, including those by organisations that do not affiliate to pro-legalisation groups, such as British Social Attitudes, consistently produce similarly high levels of

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[64] Used in this context as a synonym for assisted dying

[65] The search for terms included not only 'public opinion' but also others including 'poll' and 'society'. References to the views of individual members of the public, for example by referring to 'letters to MP', their 'postbags', were also counted (de Bruïne 2017, 18).

public support.[66] Thus, while there may be justified scepticism towards some polling, the broad thrust of public opinion on assisted dying is not seriously doubted: the key issues are to understand how public opinion is formed and what role it plays in decision-making.

Understanding public opinion

A key issue identified in seeking to understand the high levels of public support for assisted dying, in comparison to the position of MPs, is that politicians are more exposed to 'both sides of the argument' than the general public (above). In a similar vein, Badcott (2010, 395) suggested that 'few individual members of the public have the ability to do deal with such complex assessment, which is why we rely on politicians assisted by civil servants and expert opinion to act for us.' In its conclusions, the House of Lords Report on the Assisted Dying for the Terminally Ill Bill [HL] of 2005 highlighted the argument of the Market Research Society on the 'gulf' between the attitudes of the public and politicians, that 'MPs, by definition, are more accustomed than most to taking into account the implications for society as a whole of proposed legal reforms as a separate issue to their personal feelings on the subject" (House of Lords 2005a, 77). This point relates in particular to the contrast between what an individual would want for themselves (choice) rather than consideration of the risks for vulnerable people.

There are no detailed studies on how the UK public's views might be shifted by exposure to more information and this is a potentially interesting issue for future research. However, the BMA (2016c, 66) found that 'It was apparent that despite considerable coverage of the assisted dying debate in the media, there was a lack of knowledge of certain aspects and much of the detail'. This finding applied both to the general public and to doctors. The knowledge that was seen to be lacking related to: the jurisdictions where assisted dying was permitted; the actual methods used, where most assumed it was through a lethal injection rather than drugs orally; the complications (or occasional failure) that can arise with assisted dying; and the time until death, which is not immediate. The BMA reported that 'We heard from a number of participants that they had assumed "it was like taking a pet to the vet"' (BMA 2016c, 67). However, the report did not indicate whether this information led to a change in position on the issue by those exposed to it. On how public opinion is shaped on the issue, the main focus has been the role of the media.

The media and public opinion

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[66] Attitudes to voluntary euthanasia, British Social Attitudes surveys (2017, 38): Proportion saying voluntary euthanasia should be allowed for a person who has a painful incurable disease, 1983-2016 - (Yes%/No %) 1983 (77/22) 1984 (75/24) 1989 (79/20) 1994 (82/15) 2005 (80/18) 2012 (81)/16) 2016 (77/21)

The extent to which the media shapes or reflects public opinion is often contested. However, it is widely accepted that the media can be a powerful agenda-setter:

> ‘The media can move issues to centre stage or keep them out of public view. They serve as filters through which people receive news and interpretations of events. The information they convey, their visual and verbal images, and the tone of their presentation can define the significance of events, shape public attitudes, and legitimate – or call into question – public policies’ (Nelkin 1991, 302).

Birenbaum-Carmeli et al (2006, 2154) suggest that media framing particularly affects issues where most people have no direct experience: euthanasia being a case in point. They argue that: ‘How journalists cover euthanasia debates - the aspects they highlight, the types of information they choose to convey, the moral judgments they imply, the forms of authority they rely on – will have a substantial impact on public perceptions’ (Birenbaum-Carmeli 2006, 2154).

Baum (2002) draws attention to how ‘soft news’ may be particularly influential on people who are not generally interested in politics. Soft news is distinguished from hard news through a greater focus on what is personal and familiar, rather than distant and institutional, and through presenting stories that emphasise human-interest themes and dramatic subject matter (Baum 2002, 92). Somerville (2014) suggests that one of the reasons medical stories and medical ethics are so popular in the media is because people identify with the drama of illness and the hope for resolution. Stories can capture the public imagination and help deal with concepts and abstractions that might otherwise be overwhelming. However, for Somerville (2014, 292), ‘this causes serious problems in the euthanasia debate – which really does need in-depth, broad-based, consideration in both practical and theoretical terms, if we are to find a wise collective response’.

Birenbaum-Carmeli et al (2006) looked at press coverage on family assisted suicide in the UK in the mid to late 1990s, focusing on cases in which family members had been charged with assisting a relative to die. They found that the press took a ‘a consistently supportive stance’ on the issue that involved ‘depictions of dying persons and perpetrators as autonomous and conscientious individuals… idyllic portrayals of family relations… and by praising judges for their lenient verdicts’ (Birenbaum-Carmeli et al 2006, 2153). They suggested that opposing voices were marginalised and the current law was presented as a product of a dated state system. The media bias was also identified by the omission of doubts on the part of perpetrators or victims and of considerations of alternatives to assisted dying, such as palliative care.

Saunders (2011, 239) has argued that the legalisation of assisted suicide has been given 'an extraordinary level of exposure by the British media', raising important questions for its role in shaping public opinion and policy. He suggested that:

> 'Given the media's fascination both for what is "new, true and interesting" and also for "personal stories" it is perhaps no surprise that cases involving people ending their lives at the Dignitas suicide facility in Zurich, Switzerland or high-profile cases going through the courts provoke high media interest and evoke huge public sympathy' (Saunders 2011, 244-45).

The broadcast media in particular was criticised by Saunders for giving 'high-profile coverage' to cases seeking legalisation.

Saunders (2011, 246) argues that after the report of the first Lords Committee in 1994 effectively stalled the campaign on legalisation (above), pro-legislation campaign groups began to switch their focus from cancer patients to neurology patients because advances in palliative care had undermined the case for ending a life because of unbearable pain, while there was no effective treatment for paralysis. Thus, the media profile given to cases, such as that of Diane Pretty, 'enabled the VES [Voluntary Euthanasia Society] to further build its financial support base through personal donations and legacies and guaranteed a rich source of media stories to maintain momentum' (Saunders 2011, 246).

Beyond court cases, the use of Dignitas was a further source of media stories. The attention given to the issue by the media provided momentum for Lord Joffe's PMBs in 2003 and 2004. Following the first reading of Joffe's third Bill in January 2006, the VES was relaunched as Dignity in Dying and the following day television crews accompanied Anne Turner, a doctor suffering from progressive supranuclear palsy, to Dignitas: a story that received wide attention and 'provided the springboard' for Dignity in Dying's campaign. In response, the anti-legalisation coalition launched Care Not Killing Alliance the following week (Saunders 2011).

Saunders details other aspects of the pro-legalisation strategies and media bias. He was particularly critical of the BBC, which he described elsewhere as a 'cheerleader' for legalising assisted suicide.[67] He reported that between 2008 and 2011 the BBC produced five documentaries or docudramas portraying assisted suicide in a positive light, but not one presenting the opposite point of view (Saunders 2011, 249-50).

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[67] https://www.dailymail.co.uk/news/article-1377062/BBC-accused-cheerleader-assisted-suicide-Terry-Pratchett-documentary.html

Analysis

A number of persuasive arguments have been advanced on media bias on assisted dying and the strategic use of the media by the pro-legalisation lobby. Personalised stories of those seeking assistance to die are a familiar theme of media presentations, which the anti-euthanasia lobby finds difficult to counter:

> 'Some arguments against euthanasia, those based on potential harm to society in both the present and the future, are very much more difficult to present in the mass media than those for euthanasia… Visual images are difficult to find. We do not personally identify with these arguments in the same way that we do with the pleas of dying people who seek euthanasia. Society cannot be interviewed on television and become a familiar, empathy-evoking figure to the viewing public.' (Somerville 2014, 293).

So, on the one hand, assisted dying is an issue that may present itself more easily for the pro-legislation campaign, but critics also sense an underlying bias in coverage. This has been attributed largely to the growth of individualism. Birenbaum-Carmeli et al (2006) refer to a '"neo-liberal spirit" that had become prominent in the UK since the 1980s'; de Bruïne (2017, 10) refers to the 'importance of autonomy in making decisions about life and death without interference of church or government'; while Somerville (2014, 290) suggests that 'most mass-media researchers are small-*l* liberals – civil libertarians who defend personal autonomy'. The extent to which this bias is reflecting or shaping public opinion is inevitably contested, although the argument that personal stories are easier to present than societal arguments is persuasive. However, it is important that the role of the media on this issue is placed in context.

Kingdon (2011, 58) notes that while 'mass media clearly do affect the public opinion agenda', and that there are examples of media campaigns exerting significant pressure for policy change, 'much more common is the instance of quite an intensive period of sensational coverage, with the policy community riding serenely above the media storm. Active policy makers often express their disdain for media sensationalism' (Kingdon 2011, 58). Thus, the media might play an important role in drawing attention to an issue and in shaping public opinion but it does not follow that this necessarily leads to policy change: to date, this has been the case with assisted dying in the UK. Moreover, the use of the media is a strategy often employed by lobbies that lack other, more effective, levers of change, as Saunders (above) highlights.

Interest Groups

There is a wide range of groups involved in debate and lobbying on assisted dying. An indication of the extent of those engaged with the issue is given by the submissions of evidence to the Select Committee on the Assisted Dying for the Terminally Ill Bill in 2004-05; the most recent public consultation on the issue by the UK Parliament.

The Committee received evidence from 60 organisations in addition to 14,000 letters or emails from individuals (House of Lords 2005a, 10). The majority of evidence submissions came from medical organisations or institutes, including a number from overseas. This included the BMA, General Medical Council, eight royal colleges, and representation from particular fields such as cancer, motor neurone disease and palliative care. There were also submissions from five religious-medical bodies, such as the Association of Catholic Nurses for England and Wales and the Christian Medical Fellowship. Religious organisations accounted for eight submissions, which included those from the Catholic Union of Great Britain, the Church of England House of Bishops, the Methodist Church and the Office of the Chief Rabbi, while the British Humanist Association provided secular input. There were submissions from three pro-legislation campaign groups (EXIT, Friends at the End, and the Voluntary Euthanasia Society) and three from campaign groups opposed (ALERT, CARE and Right to Life). Two disability groups submitted evidence (Disability Awareness in Action and the Disability Rights Commission) and two groups representing the elderly (the British Geriatrics Society and Help the Aged). Sixteen overseas organisations with a connection to assisted dying in the Netherlands, Oregon and Switzerland, also submitted evidence.

As this paper has already dealt with the medical associations, this section firstly covers the issue-specific campaigning groups and groups representing the disabled and the elderly, noting that there is some overlap in these categories. The discussion then turns to religious organisations.

Issue-specific campaigning groups

At the time of writing[68], prominent issue-specific groups favouring legislation are Dignity in Dying (DiD), Disabled Activists for Dignity in Dying (DADID) and My Death, My Decision. Prominent groups opposed to legislation are Care Not Killing, Living and Dying Well, and Not Dead Yet.

Pro-legislation groups

DiD argues for a law that allows dying people with six months or less to live to access assisted dying and states that it does not support a wider law, referring specifically to one that would allow anyone to end another's life: a protection that DiD argues would ensure that an assisted death is completely

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[68] February 2022

voluntary. It highlights the situation of those who spend large sums of money to travel abroad to guarantee a safe and peaceful death arguing that those cannot travel risk a ‘painful and gruesome death’ by ending their lives at home. It also argues that the law should respect the wish of healthcare professionals who do not wish to support dying people to control their death. It argues for UK legislation to be based on the law introduced in Oregon in 1997, and subsequently adopted in other US states (see below), so that doctors, patients and the public ‘have confidence that the law on assisted dying will work in practice, will be safe and will remain unchanged’.[69]

DADID is led by disabled people and works in partnership with DiD. It makes the same call as DID for a law for that allows terminally ill ‘mentally competent adults the choice of an assisted death within upfront safeguards’, whether disabled or non-disabled. It highlights that organisations representing disabled people only oppose change, but should instead reflect the views of all disabled people, including those who support change. DADID points to a 2015 survey that found that 86% of people with a disability supported the Assisted Dying Bill[70] and a 2019 survey which found that: 46% believed disability rights groups should remain neutral on the issue of assisted dying; 36% believed disability rights groups should support assisted dying; and 8% believed disability rights groups should oppose assisted dying.[71]

My Death, My Decision describes itself as a ‘grassroots movement’ that calls for ‘a compassionate law on assisted dying that permits a medically assisted death to adults of sound mind who are terminally ill or intolerably suffering’.[72] As such, it supports legislation for those not only closes to death, but also for those with ‘incurable conditions who face years of constant pain or suffering that they find unbearable’.[73]

Anti-legislation groups

Care Not Killing is an alliance of individuals and organisations that brings together disability and human rights groups, healthcare providers, and faith-based bodies. Its aims are to: promote more and better palliative care; ensure that existing laws against euthanasia and assisted suicide are not weakened or repealed; and to influence the balance of public opinion against any further weakening of the law. It suggests that ‘Any change in the law to allow assisted suicide or euthanasia would place pressure on vulnerable people to end their lives for fear of being a financial, emotional or care burden upon others. This would especially affect people who are disabled, elderly, sick or

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[69] https://www.dignityindying.org.uk/.

[70] https://www.dadid.org.uk/

[71] Poll by Populus in 2019, commissioned by Dignity in Dying - https://www.dadid.org.uk/

[72] https://www.mydeath-mydecision.org.uk/

[73] https://www.mydeath-mydecision.org.uk/

depressed'.[74] It argues that any law establishing the 'right to die' will see activists seeking to expand the categories of people who qualify for it and points to the 'vast majority' of UK doctors being opposed to legislation, along with major medical associations and all major disability rights groups. It argues that 'Public opinion polls can be easily manipulated when high media profile (and often celebrity-driven) 'hard cases' are used to elicit emotional reflex responses without consideration of the strong arguments against legalisation'.[75]

Not Dead Yet is a UK-based network that is part of a global alliance of disabled people, who oppose euthanasia and assisted suicide. It points to the argument that no organisation for the disabled or terminally ill has campaigned for any change to current legislation and to the opposition of the medical profession and religious groups. It aims to respond to 'an increasing number of well-coordinated campaigns aimed at legitimising the killing of terminally ill and disabled people, which would inevitably result from the removal of legal barriers and the promotion of social acceptance of voluntary euthanasia and assisted suicide'[76]

Living and Dying Well does not set out explicit opposition to assisted dying legislation on the home page of its website, but instead states that it 'researches and analyses the evidence surrounding the "assisted dying" debate. Our aim is to present readers with reliable information on which to form their own views'.[77] However, its opposition is made clear, for example, in response to proposed legislation in Scotland, where it argues that 'that such legislation particularly jeopardises people at a vulnerable time and undermines the professional duty of care to patients and their families.[78]

Disabled people and the elderly

Disability groups

As noted above, it has been stated that most major disability groups oppose a change in legislation. Prominent among disability groups who have stated their position on assisted dying in recent years are Disability Rights UK and Scope.

On the Assisted Dying (No. 2) Bill 2015-16, Disability Rights UK identified this as a 'complex issue' on which people hold different views. It stated that its main campaigning challenge was to 'get rights to independent living in practice: that is, being able to live the life you want to lead, including when you live with life threatening conditions or are nearing the end of life'.[79] The organisation did

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[74] (https://www.carenotkilling.org.uk/

[75] (https://www.carenotkilling.org.uk/).

[76] (http://notdeadyetuk.org/)

[77] (https://livinganddyingwell.org.uk/).

[78] https://livinganddyingwell.org.uk/wp-content/uploads/2022/01/LDW-Scottish-Consultation-Response.pdf

[79] https://www.disabilityrightsuk.org/news/2015/september/our-position-proposed-assisted-dying-bill

not feel these guarantees were in place in the Bill and felt that a choice to die 'could be an illusory choice' and thus were 'some real risks in changing the law at this time',[80]

In 2018, Scope expressed its concern at the reported relaxation of assisted suicide guidance by the Director of Public Prosecutions, which would make the likelihood of healthcare professionals being prosecuted dependent on their 'specific and professional duty of care to the person in question' (above). Richard Hawkes, chief executive Scope stated that:

> 'If you are disabled, you all too often face the view that it's not worth being alive, and that you're a burden. The ban on assisted suicide sends a really powerful messaging countering this view. It has provided crucial protection to any person who feels under pressure to end their life'.[81]

Hawkes pointed to Scope's recent research showing that the majority of disabled people believed that the ban on assisted suicide protects them from pressure to end their lives, with almost twice as many disabled people saying they would be concerned by a change in the law (64%) as those who would not (36%).[82]

The survey data on disabled people varies significantly according to the questions asked, how and by whom. For example, a YouGov survey commissioned in 2013 by DiD found that 79% supported the Falconer Bill and 74% would want the option themselves. In circumstances where an individual was not terminally ill but suffering from an incurable disease, legislation had 56% support. However, only 36% thought that disability groups should support legislation, while 46% thought they should be neutral (BMA 2016a, 92). In 2014, a Scope-commissioned survey of disabled people conducted by Opinium Research found that 64% of respondents were concerned about moves to legalise assisted suicide and 55% believed that the current prohibition on assisted suicide protected vulnerable people from pressure to end their lives (BMA 2016a, 92)

The House of Lords consultation in 2004 found differences in the positions of different disability campaigners. On one hand, The Disability Rights Commission (DRC) and Disability Awareness in Action (DAA), while expressing support for greater autonomy for disabled people and 'not opposing in principle assisted suicide or voluntary euthanasia for disabled people who could freely choose' had reservations about how the Bill would work in practice for disabled people. The

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[80] https://www.disabilityrightsuk.org/news/2015/september/our-position-proposed-assisted-dying-bill

[81] https://www.scope.org.uk/media/press-releases/scope-concerned-by-reported-relaxation-of-assisted-suicide-guidance/

[82] https://www.scope.org.uk/media/press-releases/scope-concerned-by-reported-relaxation-of-assisted-suicide-guidance/

DRC identified terminal illness and disability as being 'inextricably linked' in the eyes of the public and the Bill would provide 'coercion dressed up as choice' (House of Lords 2005a, 50). On the other hand, Dr Tom Shakespeare of the Policy Ethics and Life Sciences (PEALS) Research Institute of the University of Newcastle, argued that it was 'inconsistent that the disability community would support autonomy in every other area of life but not the area of choosing when life becomes intolerable to end it'; and, he did not believe that 'disabled people would be vulnerable to pressure to opt for assisted dying' (House of Lords 2005a, 51).

In summary, the position of disability groups and disabled people is not straightforward. While support for assisted dying legislation among disabled people appears to be broadly the same as the general population in some respects, most major disability groups are seen to be opposed. However, recent research related to the Assisted Dying Bill in Scotland (2021) challenged accepted wisdom on the position of disability groups. It drew on a survey of 140 disability rights organisations in the UK which indicated that only 4% explicitly oppose assisted dying laws and that a substantial majority either remain silent (84%) or explicitly endorse neutrality (4%) (Box and Chambaere 2021).

The elderly

The House of Lords consultation of 2004 found that the views received on the elderly showed similarities with those regarding disabled people. For example, the British Geriatrics Society (BGS) reported that:

> 'We feel that older people can be very vulnerable to adverse influence from outside, families and carers, and many of our members have felt that requests to end somebody's life artificially have usually come from families and carers rather than from the patients themselves' (House of Lords 2005a, 52).

Help the Aged expressed opposition to the Joffe 2004 Bill. Its principal objection related to 'the absence of robust and effective protective mechanisms against potential abuse' (House of Lords 2005b, 379). It also expressed concern that some vulnerable older people might 'pick up little bits of the story… in the same way as they are picking up around "do not resuscitate" stories', leading to fears that if they went into hospital a doctor would have the right to take their life (House of Lords 2005b, 81).

In terms of public opinion, British Social Attitudes found that those in the oldest age groups (75+) tend to be less supportive of euthanasia than other age groups. For example, while 77% of the youngest age group (18-34) say 'euthanasia by a doctor for someone who will die from a painful disease should be allowed', this figure is 69% of the oldest age group (75+). The middle age groups are most supportive of voluntary euthanasia in this situation, with 85% of 45–54-year-olds and 84% of 55–64-year-olds in favour. The same is also true of 'euthanasia for a person who is completely dependent on their relatives', with 57% of 45–54-year-olds being accepting of this compared with 49% of 18–34-year-olds and 42% of people aged 75 or older (BSA 2017, 27). A 2012 ComRes poll for ALERT, an anti-assisted dying group, found that 33% of disabled and elderly people would feel 'more valued' if assisted suicide were available on the NHS, compared to 37% who said they felt they would be less valued (BMA 2016a, 92).

Religious organisations

Most religious organisations are opposed to assisted dying legislation. Central to religious opposition to assisted dying is the notion of sanctity of life, irrespective of human suffering, the imminence of death, or the individual's wishes. Kettell (2019, 387) notes that, while religious adherence in Britain is in a state of progressive decline, 'religious actors have been at the forefront of resistance to changing the law in this area'.

While religious organisations can be viewed as interest groups, they are best understood as 'parapublic institutions' (Katzenstein 1987) that 'take on a heightened status because of the special public recognition, which links the private and public sectors firmly together' (Minkenberg 2003, 206). They are viewed as having a 'structural advantage' in comparison to most other interest groups, partly based on their close relation to the state in some contexts but also due to the level of public esteem in which they are held (Heichel et al 2013, 235). While they tend to keep their distance from some issues they have a particular voice in relation to morality policies.

A starting point for understanding the relationship between religion and assisted dying in England and Wales is the church-state relationship. This relationship provides an 'opportunity structure' for religious interests in the political process (Minkenberg 2003, 196). Historically, the Church of England has been the established church for the English part of the UK, which provides it 'in reality, primus inter pares for the whole of the country' (Anderson 2015, 419). This status has given the Church of England a privileged place in public decision-making, not least through its representation in the House of Lords, where 26 Anglican bishops still take seats. The monarch remains the head of the Church of England and senior church appointments are made by the monarch as Head of State.

The Church of England has long been seen to have a close relationship with the Conservative party, often being described as the 'Tory party at prayer'. As Seagrave (1974, 400) suggests 'the affinity between the Church and the Conservative Party lies in a shared conception of national unity transcending diversity'. However, while this relationship has weakened over time and the Conservative party is not a religious party, it remains the one most closely associated with the established church.

While the Church of England is still formally established and continues to retain a visible role in public life, its influence has declined somewhat, with a shift away from traditional Christian morality reflected in a decline in the number identifying with the Church. For example, in 2018 only 12% of the British public identified as Anglican (belonging to the Church of England or sister churches in Scotland and Wales) compared with 40% in 1983 (BSA 2019, 20). British Social Attitudes found a 'dramatic decline in identification with Christian denominations' more generally, along with 'a substantial increase in atheism and in self-description as "very" or "extremely" non-religious; and a very low confidence in religious organisations' (BSA 2019, 17). However, while Britain might be seen as a post-Christian society, there is greater religious pluralism, and the influence of religious bodies is related more to a positive public perception of their role than to specific institutional arrangements. As this perception extends beyond the Church of England to a wider group of religious communities, which are increasingly included in public ceremonies, the term 'ecumenical establishment' more accurately describes the present situation (Minkenberg 2002, 203).

Religious organisations make representations on assisted dying both directly to politicians and through the media. For example, Saunders (2011, 243) reports that just before the House of Lords debate on the Committee report on Lord Joffe's second Bill in 2005, 'nine high British faith leaders, representing the six major world faiths of Christianity, Judaism, Islam, Hinduism, Buddhism and Sikhism wrote to every member of the House of Lords expressing their opposition to any change in the law'. Prior to the vote on the Joffe Bill, the Radio 4 Today programme hosted a 'unique' debate on the issue, involving the Archbishop of Canterbury, the (Catholic) Archbishop of Westminster, the Chief rabbi, and the head of Muslim Council of Great Britain (Saunders 2011, 243). In relation to Lord Falconer's 2014 Bill, leaders of 'all major faiths' signed a joint letter to peers describing the Bill as a 'grave error' that would change British society forever (Bingham 2014).[83] In 2019, in the context of rising debate across countries on the issue, representatives from the Catholic and Orthodox churches and the Jewish and Muslim faiths signed a joint declaration at

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[83] Bingham (2014) notes those involved included: The Archbishop of Canterbury, the Most Rev Justin Welby; Cardinal Vincent Nichols, the leader of the Roman Catholic Church in England and Wales; the Chief Rabbi, Ephraim Mirvis; Dr Shuja Shafi, the secretary general of the Muslim Council of Britain; Ramesh Pattni, leader of the Hindu Forum of Britain; and Lord Singh, director of the Network of Sikh Organisations, as well as Buddhist, Jain and Zoroastrian leaders. He suggested that 'All the major Christian denominations including Methodists, Baptists, Pentecostals and free churches, have also added their voices to the warning'.

the Vatican reaffirming each religion's clear opposition to euthanasia and physician-assisted suicide.[84]

However, it is important to signal a more nuanced picture, as not all religious leaders are opposed to legislation. In the context of the Assisted Dying Bill 2021 the former Archbishop of Canterbury George Carey and rabbi Jonathan Romain announced a new religious alliance in support of doctor-assisted dying to counter the impression that all faith groups are ‘implacably opposed’ to changes in the law. They suggested that a ‘massive change’ is taking place in religious attitudes to assisted dying, noting that most church goers are in favour of assisted dying (Romain and Carey 2021, 1). In addition to pointing to public support they noted the Oregon experience as one that should give reassurances that legislation in the UK would not lead to a threat to vulnerable people through the law being extended or abused. This, they suggested, is the main reason for strong opposition to assisted dying by some religious groups rather than theological issues, stating that ‘there is nothing in our bibles or prayer groups that directly mentions this matter’ (Romain and Carey 2021, 1). They also pointed to the court cases, including those of Debbie Purdy and Noel Conway, as having created a ‘new mood’ in Parliament.

Romain and Carey (2021) identified certain faiths as ‘undoubtedly opposed’, such as Roman Catholicism, Anglicanism (as far as the leadership is concerned, with all 26 Lords Spiritual ‘following Canterbury’s line’), Jewish Orthodoxy, and Muslim sects. In addition, they noted that while many Christian and Jewish clergy—especially those in leadership—held to the traditional opposition, a number of faiths were now in favour, with Liberal Judaism and Unitarians backing the Bill, and the chief executives of the think tank Ekklesia and the liberal Christian society, the Modern Church. Religious support for the new alliance came primarily from Anglicans but they also noted a wider range of denominations - Methodist, Baptist, Congregationalist, Unitarian—along with Reform and Liberal rabbis.

In response to the new Alliance a number of church leaders expressed their continuing opposition. Another former Archbishop of Canterbury Lord Williams, while noting the levels of public support and shifts in professional opinion, stated that ‘it is hard to see that any new facts have emerged in recent years that would justify the changes envisaged. The arguments remain essentially the same’ (Wilkinson 2021, 1). The Church of England’s medical-ethics adviser, the Revd Dr Brendan McCarthy, played down the importance of opinion polls, suggesting that ‘The Church of England debates serious issues with serious intent… Correctly, policy is decided by informed debate, not by opinion polls’ (Wilkinson 2021, 1). Consistent with the argument made by Carey and Romain

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[84] https://www.americamagazine.org/politics-society/2019/10/28/jewish-christian-and-muslim-leaders-sign-declaration-against-euthanasia

(above), the argument advanced by McCarthy was not theological but concerned with the 'grave risk' to vulnerable people.

Kettell (2019) found that, while theologically motivated, religious actors have strategically adapted to the increasingly secularized nature of British society in using secular rather than theological modes of argumentation. This view is shared by the National Secular Society, which has argued that 'Britain's increasingly secular outlook on life means religious arguments these days tend go down like a lead balloon when served up in public and political debates… The religiously motivated are therefore forced to couch their arguments in secular language'.[85] Such a trend has been observed elsewhere. Purvis's (2012) study of Oregon argued that the Catholic Church's rhetoric during the 1994 campaign on the Death with Dignity Act was characterised by moral and religious arguments but in the 1997 campaign this shifted to a more secular strategy, emphasizing terminally ill misdiagnoses and clinical failures. For Kettell (2019, 400) such a shift in strategy is a risk for religious actors as it 'exposes them to changes in the underlying evidence base that can prove fatal to the credibility of their case'.

The influence of religion and religious actors

There are no detailed case studies on the influence of religious actors on assisted dying legislation proposals in the UK. While positions are clearly expressed and reported, and there are assumptions made about the structural advantages of religious groups, there has been no attempt to investigate whether and how effectively other strategies are employed.

In terms of public opinion, the BSA (2017, 27) found that while there were relatively few differences in views towards euthanasia among the demographic subgroups of the population, the major differences occur by religious affiliation, with 'those with no religion being most likely to support euthanasia (for example, 89% of people without a religion say euthanasia by a doctor for someone with a terminal disease should be allowed, compared with 67% of people with a religion)'. In a similar vein, Cohen et al's (2014, 145) analysis of the public acceptance of euthanasia in 47 European countries found a generally higher degree of acceptance corresponding to a lower level of religiosity. On the views of doctors, the BMA (2016a, 93) stated that those who report being religious or having faith 'was a statistically significant factor in a number of studies which negatively influences the opinion of doctors towards assisted dying'.

However, while there is a clear relationship between religious faith and public opinion - although not one that significantly impacts the consistently high levels of support for legislation - the impact of religion and religious lobbying on politicians is less clear. Information on the religious

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[85] https://www.secularism.org.uk/opinion/2019/02/religious-dogma-still-plagues-the-assisted-dying-debate

beliefs of all MPs is not required to be held by the House of Commons and is thus not officially available.[86] From the limited survey material available, there is no suggestion that the general level of religiosity among MPs is significantly out of line with the rest of the population,[87] although there is some variation in the extent to which particular religions are represented in Parliament.[88] Whether there are less visible channels through which politicians are persuaded on assisted dying by religious actors is a question that remains to be answered.

Analysis

As the discussion above has illustrated, there are a number of issue-specific campaign groups on both sides of the debate, which often involve senior figures in politics and other fields. There are also important groups representing disabled people and the elderly, again often with high-profile involvement. Added to this are the various religious organisations who make regular representations on the issue. However, the influence of these groups is difficult to assess as there have been no detailed studies of their strategies and tactics – particularly those that strategies may be less visible – and no empirical evidence of the extent to which politician's views are shaped by their representations. For example, there are claims about the structural advantage of religious groups and the historic relationship between the Church of England and the Conservative Party. There is also research that suggests that the Catholic Church has influence on morality policies through Catholic MPs, especially in the Labour party (Plumb and Marsh 2011). This aspect of the issue is a fruitful area for future research

Politicians

Giandomenico Majone (2006, 623) has argued that 'Most political scientists assume that the main goal of elected politicians is to maximize the probability of being re-elected'. This is a useful starting point for this case in the sense that it raises the question of 'what's in it?' for MPs to vote one way or the other on legislation for assisted dying.

In the UK, this is not a politicized (i.e., party-political) issue, which has been important in some places where legislation has been successful. Green-Pedersen (2007) found that euthanasia was legalised in Belgium and the Netherlands because of a religious/secular divide in party politics, which provided a strategic opportunity for secular parties. Larsen et al's (2012, 117) survey of

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[86] https://commonslibrary.parliament.uk/insights/diversity-in-the-2017-parliament/

[87] A survey of prospective parliamentary candidates in 2015 found that 42% had no religious denomination (https://www.atheismuk.com/tag/mp/), while the number of non-religious people overall was 39% in 2011 and 46% in 2019 (https://humanism.org.uk/2019/04/09/number-of-non-religious-people-in-britain-jumps-by-46-new-figures-show/)

[88] http://muslimnews.co.uk/newspaper/home-news/religious-break-down-of-parliament-revealed/

morality issues in British party manifestos 1964–2010 found that ‘although British parties issue extensive manifestos, there was not a single word on euthanasia.’

However, as Cowley and Stuart (2010, 174) note, while MPs are not instructed on how to vote, ‘party still tends to remain the key determinant of vote outcomes on conscience issues.’ The most recent vote on assisted dying in the House of Commons in 2015 would appear to illustrate this argument. On a similar turnout of around 72%, 88.5% of Conservative MPs voted against legislation compared to 55.8% of Labour MPs.[89] However, morality policy issues such as assisted dying exist on the margins of British politics. They do not fit neatly into the right-left conflict, which is traditionally centred on issues of class and economic redistribution. If there is a second line of conflict it is based on the difference between authority and liberty, which has also failed to provide the foundation for the politicization of morality issues (Larsen et al 2012, 135).[90] In short, morality policies are generally not a priority for the major parties in the UK. Thus, while assisted dying is sometimes a high-profile issue, it is not a key election issue for parties, and MPs vote as individuals.

To the extent that an individual MP might gain any electoral advantage from this issue, this would appear most likely from supporting legislation, given the levels of public support in favour. Thus, on the face of it, Parliamentary voting patterns appear counterintuitive to electoral interests. This gives rise to the explanation frequently proffered that MPs are persuaded by the arguments presented on this issue rather than electoral interest, having been more exposed to ‘both sides of the argument’ than the general public, and have more ability to deal with complex issues and consider the broader implications for society (above). However, the House of Lords Report on the Assisted Dying tor the Terminally Ill Bill [HL] of 2005 suggested that ‘another reason might be a perception that, while a majority of the electorate as a whole might indeed favour or have no objection to a change in the law, the electoral consequences of favouring rather than opposing euthanasia could be more serious’ (House of Lords 2005a, 77). That the unelected House of Lords has tended to provide lower levels of opposition to legislation than the Commons suggests some evidence for this argument, if one assumes the Lords are as adept as MPs at analysing complex material and considering the implications for society as a whole.

Others have identified the risks involved for individual MPs, not least for those with small Parliamentary majorities. For example, Jackson (2018, 65) cited the case of Liberal Democrat MP Dr Evan Davies, who was ‘traduced as “doctor death” in the tabloid press and by his evangelical Conservative opponent’ for his support for embryo experiments, euthanasia and freer abortions. In addition, Clark (1997, 83) has suggested that not only are politicians reluctant to court unfavourable

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[89] https://www.publicwhip.org.uk/division.php?date=2015-09-11&number=69)

[90] However, Larsen et al (2012, 134) noted that while pro-life minorities are found among MPs in both major parties, they are ‘mostly within the Conservative Party’.

opinion and risk polarizing their constituencies by taking a stance on the issue, they are also not forced into taking a position by the perception of 'any real crisis'.

Analysis

In the absence of party pressure or a perceived crisis, and given the low electoral salience of the issue, politicians have no need to take the risk of adopting what for some constituents would be a controversial position. To paraphrase McCann (2015, 182), they have something of a 'get out of jail free card' on this issue with the electorate:

> 'They can justify their legislative inaction by not only relying on the polarized nature of the debate, but by also relying on the lack of mobilized and influential interest groups and, in particular, the formal unwillingness of the medical profession to support legal reform' (McCann 2015, 82).

McCann's point about the absence of mobilized and influential interest groups is one that might be contested, given the discussion of groups above; although their influence does remain unclear.

However, the argument about the position of the medical profession is one that has been regularly identified as important by others. For example, Jacky Davis, Chair of Healthcare Professionals for Assisted Dying and a board member of Dignity in Dying, argued that 'The longstanding opposition of doctors, or rather our representative organisations, is particularly important and is undoubtedly a significant roadblock to the introduction of legislation for AD in the UK. It is quoted in every debate on the subject…' (Davis 2019, 24). On the UK, Larsen et al (2012, 135) argued that 'Medicalization is an effective way for the political parties to avoid deep, moral conflicts and instead to rely on the strong position of doctors, the BMA and scientific communities… '. In short, it is highly likely that the position of key medical associations has been an important factor in the calculation of 'risk' involved for individual MPs.

Developments in other jurisdictions

International developments are of increasing importance in UK debates on assisted dying and the trend internationally has been towards a more permissive position. National cases where assisted dying is permitted are (year of landmark legislation in brackets): Switzerland (1942)[91]; Colombia

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[91] In 1942 the Swiss penal code stated that assisting suicide would no longer be considered a crime as long as there were no 'covetous motivations'. Since the 1990s, right-to-die organisations have interpreted the law as permission to operate organizations to support those wanting assisted suicide, including non-residents (Mroz et al 2020, 2542)

(1997);[92] Netherlands (2002); Belgium (2002); Luxembourg (2009); Canada (2016; Quebec 2014); Germany (2020)[93]; Austria (2021)[94]; New Zealand (2021), Spain (2021). Where authority lies at subnational level, assisted dying is permitted in 11 US states: Oregon (1997); Washington (2009); Montana (2009); Vermont (2013); California (2015); Colorado (2016); District of Colombia (2016); Hawaii (2018); Maine (2019).[95] Five of the six Australian states also permit assisted dying: Victoria (2017); Western Australia (2019); Tasmania (2021), Queensland (2021) and South Australia (2021); and, in New South Wales, the Voluntary Assisted Dying Bill (2021) was scheduled for a decision in 2022.[96]

While in most cases assisted dying has been permitted through legislatures, in some cases this has been through court judgements (e.g., Canada) and the detailed provisions have differed in different jurisdictions. As Mroz et al (2020, 3551) note, there has been 'Considerable variation in terminology and frequency of use exists across jurisdictions as well as in the substantive and procedural requirements.' There is not space here to detail these variations, nor the significant debates in other places. This is a fast-moving picture and will be the focus of a separate paper. However, it is important to note these developments in other jurisdictions as they play an increasing role in Parliamentary and public debates in the UK.

In introducing her Assisted Dying Bill [HL] in October 2021, Baroness Meacher noted that in the six years since the Marris Bill was defeated in the Commons, seven more US states had legalised assisted dying, along with five states in Australia and that New Zealand was about to. She stated that 'All those jurisdictions have an Act of Parliament very similar to the Bill that we are discussing today'.[97] She also referenced Canada and Spain as among the countries to legalise euthanasia in the past few years to require a doctor to administer a lethal medication; that Italy would have a referendum on the issue in 2022; and that debates were under way in other places including Portugal and Ireland.[98] The international example of most obvious importance for debates in the UK has been the case of Oregon, which has provided the template for recent attempts at legislative

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[92] While the Colombian Constitutional Court decriminalized 'mercy homicide' in 1997, process rules were not put in place until 2015 (Mroz et al 2020, 3542)

[93] The German supreme court overturned a law banning the provision of assisted suicide services in February 2020 (Mroz et al 2020, 3542)

[94] The law took effect in January 2022 - https://www.bbc.co.uk/news/world-europe-59847371

[95] Sixteen other US states were considering death with dignity laws in 2020, or in the current legislative session, including: Utah, Arizona, Minnesota, Iowa, Wisconsin, Indiana, Kentucky, Georgia, Florida, Virginia, Maryland, New York, Connecticut, Rhode Island, Massachusetts, New Hampshire (Mroz et al 2020, 3542)

[96] The Northern Territory first legalized assisted dying in 1995 but this was overturned just nine months later by the Australian federal government (Mroz et al 2020, 3542).

[97] https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)

[98] https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)

change and which was mentioned 48 times in the Lords debate in October 2021, more than any other jurisdiction. [99]

The Oregon Death with Dignity Act (1994) was eventually implemented in 1997 after the failure of attempts to repeal the legislation led by the Catholic Church. This Act emerged from a 'growing dissatisfaction with the medical profession and the development of a national "right to die" movement' (Purvis 2012, 272). Oregon has been identified as a 'prime location' for the first US state to introduce assisted dying legislation, 'with a progressive political history, a recent statewide health care reform bill, and a population wary of religious political influence' (Purvis 2012, 280). It also had a long history of using the citizen initiative: a petition process to force a public vote or persuade decision-makers.[100] With public support for assisted dying reaching 60% it was a ballot initiative proposed by a group called Oregon Right to Die, along with other activists, that catalysed developments leading to the Act.[101] The Act influenced other US states to follow suit, and has been an important point of reference across the world.

In the UK context, developments in Scotland are arguably of particular significance. In introduce her Bill, Baroness Meacher stated:

> 'Perhaps most important is the likelihood that within a few years the Scottish Parliament will legalise assisted dying—there is a majority for it in the Parliament. My challenge to our Prime Minister is: "Boris, do you really want to be upstaged by Scotland on this issue, an issue of such historic proportions?"'[102]

There have been a number of legislative attempts to permit assisted dying in Scotland since devolution in 1997. In 2004 a bill publicised by Liberal Democrat MSP Jeremy Purvis, also modelled on the Oregon legislation, failed to get the required support from MSPs to be introduced into the Scottish Parliament. In 2010 a Bill introduced by Scottish National Party MSP Margo MacDonald MSP was defeated by 85 votes to 16 (with two abstentions) at the stage one debate. She introduced a second bill in November 2013, which was taken forward by Green MSP Patrick Harvie in 2014. The

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[99] By way of comparison, examples of other jurisdictions mentioned were Canada 34, Australia 21, Netherlands 20, and Belgium 13. It should be noted that the Oregon case was cited in the arguments both for and against UK legislation - https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)

[100] https://www.ncsl.org/research/elections-and-campaigns/chart-of-the-initiative-states.aspx - *Citizen Initiative* – a law or constitutional amendment introduced by citizens through a petition process either to the legislature or directly to the voters.

[101] https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)

[102] https://hansard.parliament.uk/lords/2021-10-22/debates/11143CAF-BC66-4C60-B782-38B5D9F42810/AssistedDyingBill(HL)

Health and Sport Committee which reported on this Bill in April 2015 chose not to make a formal recommendation to Parliament. When the Bill was debated in May 2015 it was rejected by 82 votes to 36 (BMA 2016a, 75-6).

In September 2021 the Liberal Democrat MSP Liam McArthur proposed a Bill 'to enable competent adults who are terminally ill to be provided at their request with assistance to end their life'. In January 2022 it was reported that the McArthur Bill had 'attracted more public responses than any other in the history of the Scottish Parliament.'[103] At the time of writing the Parliament was processing and verifying the responses to the consultation with a summary to be published in 2022. McArthur would then seek to gain the support required from other MSPs to introduce a Bill in the Parliament.

Also of significance, in November 2021 Jersey became poised to become the first jurisdiction in the British Isles[104] to permit assisted dying. [105] The island's States Assembly voted in favour of the principle of assisted dying by a margin of 36 votes to 10. This followed the examination of the arguments for and against by a citizens' jury earlier in the year. The jury recommended legislation for citizens who are mentally competent and either terminally ill or unbearably suffering (Iacobucci 2021). Legislation was to be drafted in 2022 with a final decision expected in 2023.

Analysis

In an age of ever-easier information flows, the acceleration in the pace of legislation in other jurisdictions has clear implications for UK debates. The case of Oregon is the most obvious example, providing the template for UK Bills, following on from providing a model for developments in a number of other cases. For some, the case of assisted dying has taken on the characteristics of an 'international social movement'. Richards (2016, 65) illustrates this with reference to the case of Brittany Maynard, a 29-year-old diagnosed with a termina brain tumour, whose campaign to have a physician assisted suicide in California in 2012 'went viral'. She argues that:

> 'The global interest in Maynard's story shows the international nature of this social movement and the way in which personal suffering becomes imbued, via the media, with

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[103] Over 10,000 - https://www.dailyrecord.co.uk/news/scotlands-proposed-assisted-dying-bill-25992978

[104] Jersey, Guernsey, and the Isle of Man are part of the British Isles. England, Scotland, and Wales make up Great Britain, while the United Kingdom includes Great Britain and Northern Ireland. Jersey is a British Crown Dependency.

[105] Jersey is a British Crown Dependency. https://www.gov.je/Leisure/Jersey/pages/profile.aspx As a British Crown dependency, Jersey is able to legislate on the issue independently of Westminster (Iacobucci 2021).

> political meaning… All forms of media, both old and new, now provide the main battleground for the right-to-die debate…' (Richards 2016, 65).

Conclusion

This paper has considered why assisted dying legislation has not been introduced in the UK, despite an increasing trend for legislation in other jurisdictions. Of particular interest in this case is the significant gap between public opinion on the issue and Parliamentary voting. In examining the issue, the paper has reflected on major sites of conflict – the medical associations, public opinion and the media, the courts, organised groups, and politicians – and has reflected on developments in other jurisdictions. This section analyses key developments, seeking to offer initial explanations for the public-parliamentary gap. It begins by discussing public opinion and then turns to politicians.

UK public support for some form of assisted dying legislation has been consistently high for several decades. To some extent, this high level of support may be seen as part of a wider trend emerging from the rise of individualism in European and American societies in which the right to die is viewed as an extension of 'the choice and control people now expect to have in all aspects of their life' (Richards 2016, 66). In many countries this individualism is accompanied by a rise in post-material values and a growing secularisation of society (de Bruïne 2017, 10).

However, the high level of public support in the UK has also been attributed to the role played by the media, which has been characterised as having a (neo-) liberal bias. Media focus on personal stories is seen to over-simplify a complex issue and provide representations that are difficult to counter for those concerned with arguments about the potential harm to society. Court cases on the plight of individuals in suffering who seek to end their lives has provided rich material for such representations.

Yet the extent to which media liberalism is shaping or reflecting wider social trends is not clear. Moreover, it is widely acknowledged that recourse to media campaigns is often a tactic employed by groups who are failing to get their message across in more powerful arenas. To date, such strategies have not led to the desired change. Further, while there is evidence that public opinion is playing a greater role in political debate, it is not obvious that the utilisation of public support is likely to be decisive in legislative change, given its long-standing availability to campaigners. Thus, while there are interesting questions to be considered about how public opinion is shaped by particular representations of the issue, understanding how the views of politicians is shaped is central to understanding the absence of permissive legislation.

Given the lack of party competition on the issue, it has been suggested that politicians have something of a free pass when legislative proposals come forward. Party competition on the issue has been central to understanding permissive legislation in some countries, not least where there is a religious-secular divide between key parties. Thus, while there are numerous groups campaigning on the issue and their arguments are heard in parliamentary debates, their influence is likely to be limited by the absence of this dynamic. However, the strategies, tactics and influence of organised groups is not well understood and more research on this is needed. Comparative analysis on this may be helpful in drawing out the importance of other factors in shaping the context for successful group activity, such as: institutional settings (e.g., the nature of party competition and the potential for citizens' initiatives or referenda); social factors (e.g., the nature and degree or religiosity); and key organisational positions (e.g., medical associations and courts).

Arguably the most significant UK development in recent times has been the shift of key medical associations to a position of neutrality. The position of the medical associations has been recognised as an important factor on this issue and there is historical precedent in other areas of morality policy, with the support of medical associations such as the BMA seen as vital in the ultimate success of the Abortion Act 1967 (Marsh and Chambers 1981, 191-2). There is also significant evidence that the position of the medical profession elsewhere has been important in moves towards more permissive legislation. For example, Mullock (2011, 204) highlights this in the case of the Netherlands, and McCann (2015, 82) the case of Belgium. It also appears to have been a key factor in moves towards permissiveness in Germany.[106] In these cases the key issue is not necessarily the expressed support of medical associations but their lack of opposition.

Finally, the acceleration of permissive legislation in other jurisdictions appears to be of growing importance in the UK. Other cases not only provide the template for legislation in the UK but are increasingly referenced in parliamentary debates. It is important to note that these cases are cited on both sides of the debate, so the nature of their importance for UK developments are still to fully play out. However, that the international trend is towards permissiveness would appear to favour advocates of legislation.

However, while various developments both domestically and internationally appear to to provide a more receptive context for permissive dying legislation in the UK, the large gap between public and parliamentary opinion remains a formidable hurdle for advocates of legislation to overcome and provides reassurance for opponents of legislation. Yet while the literature has extensively discussed the formation of public opinion, there has been little academic scrutiny of the processes through which politicians' views are shaped. As broader trends appear to provide a more permissive UK context, and public opinion appears to be stable, the key to understanding the

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[106] https://www.irishtimes.com/news/world/europe/vote-by-germany-s-doctors-paves-way-for-assisted-suicide-1.4557558

prospects for assisted dying legislation in the UK may well depend on understanding these processes more fully.

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