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Human Dignity and Assisted Dying: Navigating the Legal and Ethical Complexities of End-of-Life Choices

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Abstract: The desire to promote assisted dying is linked to concerns about living in a fast-paced world, dependence, pain, suffering, and uncertainty. Society must consider whether humans have a fundamental right to choose when and how to die. This debate involves medical doctors balancing their ethical duties with patient autonomy. Patients nearing the end of life and their families often face emotional and ethical dilemmas, which are often complicated by legal restrictions that limit decision-making. A legal framework for assisted dying is essential to balance patients' rights and doctors' duty to do no harm. These discussions prompt society to reflect on life, death, and personal choice, highlighting the need for ongoing dialogue and policy review to uphold the dignity of terminally ill adults at the end of their lives. The article explores the legal and ethical issues surrounding end-of-life decisions, focusing on proposed assisted dying legislation for terminally ill patients in Great Britain. It also emphasises the importance of patient autonomy in these decisions and assesses how the proposed legislations align with the fundamental right to human dignity. The article concludes by underscoring the importance of safeguards to prevent coercion and undue influence.

Keywords: Autonomy, Capacity, Dignified death, Euthanasia, Assisted suicide.

1 Introduction

The concept of death is profoundly complex and raises essential existential questions about humanity and personhood (Sarkar, 2018; Chau and Herring, 2007). These questions are more prominent now, especially against the backdrop of changing attitudes toward death in recent years (Herring, 2020). In the past, death was simply something that happened to humans and had to be accepted (Huxtable, 2007). However, with technological advancements, it has become possible to exercise greater control over our dying (Murphy et al., 2024; Shemie, 2014; Bernat, 2013). In the past, the signs of death were clear and indisputable, but advancements in medical technology have blurred those lines (Herring, 2020; Warraich, 2017). Today, medical doctors can perform life-saving techniques on individuals, raising critical questions about the thin line between life and death. Medical doctors are now able to revive a person who, in earlier times, would have been classified as dead. It is this state of unconscious or barely conscious living that raises the issues around assisted dying and human dignity which has generated critical questions and ethical debates within clinical and legal fields about the definition of death, the precise moment of death and particularly the rights of those in unconscious or unresponsive states, as well as the societal implications of prolonging life (Bullock, 2023; Genuis, 2021).[1] This debate also centres on the value of prolonging life in a state of poor health and a patient's right to die with dignity (Huxtable, 2007). Given the foregoing, definitions and answers to these questions are now shaped by a complex interplay of religious, philosophical, cultural, and legal factors. It is in this context that tensions have arisen between respecting patient autonomy and the ethical responsibilities of doctors. The pressing question is how to reconcile patient autonomy and the ethical responsibilities of doctors, particularly when the implications of these choices could impact medical integrity.

[1] Great Britain recognises brain stem death as the point of death without a statutory definition, whereas some United States legislation like the Kansas statute of 1971 defines death as the complete lack of spontaneous brain function; see also Smith v Smith and R v Potter.

The recent resurgence of discussions on assisted dying in Great Britain signifies a notable shift in societal attitudes, reflecting a crucial global movement that advocates for patients' rights to determine their destinies (Burns and Agerholm, 2025). This article aims to guide policymakers, legal practitioners, and healthcare professionals in refining the proposed assisted dying legislation to include additional appropriate safeguards. The article fosters an understanding of patient autonomy and dignity at the end of life, emphasising that legislation should safeguard vulnerable individuals while upholding the rights of competent adults to make informed decisions. Special emphasis will be placed on the rights of competent and terminally ill adult patients and the critical dynamics of the doctor-patient relationship. The article will begin by defining and contextualising assisted dying in its broader context, laying the groundwork for a thorough analysis. Subsequently, it will navigate the intricate legal landscape, examining various legal positions across Great Britain while highlighting key judicial decisions and medical cases that have influenced the ongoing discourse. By addressing these issues, the article seeks to contribute to the debate on assisted dying and offer potential legal reforms.

2 Methodology

This article employs a doctrinal methodology, involving a comprehensive examination of legal texts, statutes, case law, and other relevant scholarly literature related to assisted dying. A literature review was conducted, focusing on the analysis of Bills, legislative proposals, judicial interpretations, and ethical debates concerning end-of-life decisions in Great Britain. The analysis draws on multiple multidisciplinary databases, including SCOPUS, PubMed, Taylor and Francis, as well as legal databases such as Westlaw and LexisNexis, and academic repositories like JSTOR. The method involved analysing and reviewing documents related to proposed legislation regarding assisted dying, in conjunction with relevant case law, to better understand the existing legal framework and suggested amendments. The process included collecting relevant information from peer-reviewed research, legal opinions, and ethical critiques to situate the legal arguments within broad ethical frameworks. A synthesis of findings was conducted to connect legal texts with ethical analyses, aiming to develop a coherent

argument regarding the future of assisted dying legislation in Great Britain. Additionally, the analysis reviewed the implications of these findings for proposed legislative frameworks, particularly in relation to ethical considerations surrounding assisted dying.

3 Distinction Between Euthanasia and Assisted Suicide

Assisted dying is a broad term that encompasses euthanasia and assisted suicide (Solari et al., 2025; Wyatt, 2015). I will examine both aspects to provide an understanding of what assisted dying entails. The key differences between euthanasia and assisted suicide are summarised in Table 1.

Assisted suicide can be described as a compassionate option for patients enduring intolerable pain and are physically unable to end their lives due to illness or incapacitation. This is often with their doctor's guidance, meaning that the final act is done by the patient themselves (Ahmad et al., 2024). In jurisdictions where it is legal, assisted suicide is conducted through prescribed medication and procedures to ensure that death occurs swiftly and without complications (Solari et al., 2025). In *Pretty v DPP* (2002), Diane Pretty, terminally ill, sought her husband's help to end her life. Although she referenced the European Convention on Human Rights (ECHR), her legal request was rejected by the courts, including the House of Lords, as well as the ECHR. Her claims of an implied right to die under Article 2 and inhumane treatment under Article 3 were dismissed. The court recognised the importance of personal autonomy under Article 8 but ultimately upheld the State's obligation to protect vulnerable individuals, leading to the denial of her appeals. The word 'euthanasia', on the other hand, is a Greek word meaning 'good death.' It is commonly defined as the deliberate act of mercy killing (Maboloc, 2024). The question is whether assisted dying or euthanasia specifically can be considered a good death, given the premeditated intention behind it, and thus it is considered a crime in most countries. Euthanasia can be categorised into active and passive forms (Bhagyamma and Ramesh, 2023). Active euthanasia involves intentionally ending life for compassionate reasons, while passive euthanasia is characterised by withholding or withdrawing life-sustaining care, leading to death by omission (Bhagyamma and Ramesh, 2023; Wyatt, 2015; Goel, 2008). It is further

categorised into voluntary, non-voluntary and involuntary. It is voluntary in instances where patients consent; it is non-voluntary when patients lack the capacity to express their wishes; and it is involuntary when patients do not consent, even though they may have the capacity to do so. Understanding these distinctive aspects promotes a clearer discussion about the moral implications of euthanasia in contemporary society.

Differences between Assisted Suicide and Euthanasia

Criteria	Assisted Suicide	Euthanasia
Definition	A process where a doctor provides a patient with the means to end their own life, typically through prescribed medication.	The deliberate act of ending a person's life by a medical professional, usually through a lethal injection.
Involvement of Doctor	Passive involvement; the doctor prescribes medication, but the patient self-administers it.	Active involvement: the doctor administers the substance that causes death.
Legal Status	Legal in several jurisdictions (e.g., some states in the USA, Canada) under specific conditions.	Generally illegal in most jurisdictions, with few exceptions (e.g. Netherlands)
Patient Autonomy	Strong emphasis on patient's autonomy and choice in ending their life	May involve consent, but is often perceived as a decision made by the doctor
Ethical Considerations	Focuses on the ethics of allowing individuals to choose their own death.	Raises questions about the moral implications of a doctor actively ending life

Table 1

Recent legislative efforts in Great Britain are increasingly leaning towards the acceptance of assisted suicide, distinguishing it from euthanasia. Proponents argue that this approach aligns with fundamental Anglo-Saxon values of individual choice and freedom, rendering it more acceptable to the public (Wyatt, 2015). Since assisted

suicide emphasises patient autonomy and choice, ethical considerations regarding its legalisation tend to favour it over euthanasia. Assisted suicide enables the dying person to control the process, which exemplifies self-determination, giving the patient the option to die when and how they wish. Euthanasia raises ethical questions regarding the morality of doctors actively killing patients, conflicting with their role in caring for their patients. Assisted suicide is also viewed as less coercive. The patient must actively decide to take the prescribed medication, ensuring that the decision is deliberate.

4 Refusal, Withdrawal, and Withholding of Treatment

Withholding or withdrawing treatment and assisted dying are distinct concepts. While both can result in death, they involve different processes, with assisted dying stemming from medical futility or a patient's informed request (Borovecki, 2022). Withholding treatment means it was never initiated, whereas withdrawing means it was previously considered beneficial but is now stopped. Such decisions typically relate to terminally ill patients and are influenced by their specific medical conditions.

The fundamental legal principle asserts that it is illegal to administer medical treatment against a competent patient's wishes, regardless of the potentially fatal outcomes (Mordue, 2024). Competent patients have the right to refuse treatments and make life-limiting choices, as long as they understand the consequences. Tensions may exist between medical doctors and patients in these contexts, especially regarding inevitable death. Doctors are generally not liable if a patient chooses to withdraw treatment as an expression of autonomy. Moreover, if treatment is deemed futile, it can be ceased to support a dignified passing. For instance, in the case of *St George's v S* (1999), the patient rightfully refused treatment, understanding that both she and her unborn child risked death without it. This principle holds only when the patient can make informed decisions. However, suppose a doctor suspects the patient has a severe mental illness that impairs their decision-making. They may proceed with life-saving treatment deemed in the patient's best interest (Wade and Kitzinger, 2019; Wyatt, 2015). In *Washington et al. v Glucksberg* (1997) and *Vacco et al. v Quill* (1997), the importance of distinguishing between allowing a patient to die by refusing treatment and actively causing death through drug administration was emphasised. Therefore, refusing or

discontinuing treatment is justified under certain conditions: if the patient is mentally competent, if a representative is designated, if there are clear written instructions, and if the treatment aligns with ethical standards, especially in situations involving severe or terminal illnesses where the benefits do not outweigh the burdens. Additional factors, such as quality of life, financial considerations, and age (though not exclusively), also play a role in these critical decisions (Kontomanolis et al., 2018).

5 The Legal and Ethical Dimensions of Assisted Dying

5.1 Humanist and Religious Perspectives

Article 2 of the ECHR (amended 2021) affirms everyone's right to life, which European courts interpret as excluding the right to choose death. This perspective highlights the duty of medical professionals to preserve life, making assisted dying a contentious issue in legal and moral debates (Bhagyamma and Ramesh, 2023). Humanists often argue that voluntary assisted dying is morally justified, while many religious individuals, particularly within Christianity, believe it is wrong (Wang, 2024). This clash stems from differing views on the intrinsic value of life, leading critics to offer alternative perspectives that support assisted dying. The traditional and Christian views hold that every life is sacred from conception to death, as God creates it. This is supported by the biblical verse 'God created man in His image' (Genesis 1:27). Although the Bible does not explicitly mention the phrase "sanctity of life", it emphasises the holiness of human life as a gift from God, stating that only God can create and end life. According to Christian belief, humans should not interfere with these divine matters, as doing so is considered an act of arrogance and a grave sin (Holcombe, 2025; Wang, 2024; Smith, 2021). Religious adherents often argue that doctors should not intervene in matters of life and death, as that is God's role. Nevertheless, it is suggested that all medical interventions could be seen as 'playing God' (Wang, 2024; Clarke, 2023; Chauhan and Ahmed, 2022; Lockhart et al., 2022).

The commitment of doctors is often regarded as for the protection and preservation of life, creating a profound irony and confusion in the controversial topic of doctors' involvement in assisted dying and its conflict with the Hippocratic Oath (Obi,

2025; Askitopoulou, 2024; Potts, 2021).[2] Critics maintain that these issues render assisted dying unethical and unsafe, thereby presenting significant ethical challenges within the medical profession. The opponents of assisted dying instead advocate for hospices and palliative care, stressing the value of a peaceful death and effective pain management (Mario, 2023; Joolaee et al., 2022; Mathews et al., 2021). Most palliative medicine specialists oppose legalising euthanasia, focusing on alleviating physical and emotional suffering in terminal patients (Campbell, 2025; Solari et al., 2025).

5.2 Slippery Slope Argument

The slippery slope argument posits that legalising assisted suicide might lead to a broader acceptance of euthanasia, especially voluntary euthanasia, and could lead to challenges in preventing involuntary or non-voluntary euthanasia (Pic on-Jaimes et al., 2022). Opponents of assisted dying fear that initial voluntary requests could eventually lead to advance directives for assisted dying based on specific health conditions, with decisions potentially being made by surrogates or healthcare agents without patient consent (Wyatt, 2015). They argue that it is particularly difficult to differentiate between justified and unjustified cases of assisted death, and they express concerns that legalising euthanasia may erode societal barriers to killing (Jones, 2024; Carsten, 2022; Meier, 2020). This also raises important ethical questions about the well-being of vulnerable groups, as a major criticism of assisted dying legislation is its potential for coercion, particularly among the elderly, people with disabilities or mental incapacity, or those facing socio-economic challenges.[3] Disability rights advocates also express concerns, arguing that assisted death is a dangerous option that takes advantage of the disproportionate challenges faced by these communities, including poverty,

[2] The Hippocratic Oath states, “to please no one will I prescribe a deadly drug nor give advice which may cause death”.

[3] See Dembo J, Schuklenk U, Reggler J. (2018) ‘‘For their own good’: A response to popular arguments against permitting Medical Assistance in Dying (MAID) where mental illness is the sole underlying condition’ *Can J Psychiatry* ; 63, 451–456; Rooney W, Schuklenk U, van de Vathorst S. ‘Are concerns about irremediableness, vulnerability, or competence sufficient to justify excluding all psychiatric patients from medical aid in dying?’ *Health Care Anal* 2018; 26: 326–343; Schuklenk U, van de Vathorst S. (2015) ‘Treatment-resistant major depressive disorder and assisted dying’ *J Med Ethics* 41, 577–583.

homelessness, inadequate mental health care, and other obstacles to a good quality of life (Walsh and Horrox, 2025; Asada et al., 2024). These individuals may feel pressured to choose assisted dying because they believe they are a burden on their families or society. This raises ethical concerns about whether their decision is truly voluntary, and it could eventually lead to broader applications.[4] Thus, allowing a morally permissible act may lead to ethically questionable practices, risking dangerous consequences for incompetent individuals and failing to protect vulnerable populations from coercion into euthanasia. Humanists counter these points, arguing that the line between voluntary and involuntary euthanasia is clear and manageable (Steele, 2024). This, however, necessitates that adequate protections must be implemented to safeguard vulnerable groups from coercion or manipulation through independent counselling and adequate oversight of patients. These safeguards must be implemented to prevent the potential misuse of the legislation and to reassure the public about the integrity of the process.

5.3 Assisted Dying as a Criminal Act

In Great Britain, particularly in England and Wales, euthanasia and assisted suicide are legally regarded as murder, regardless of the individual's intentions or status (Fakonti 2021). In England and Wales, the law significantly impacts the regulation of assisted dying, overlooking benevolent motives and the patient's wishes, as it does not allow doctors to manage these decisions (Ward, 2022; McLean, 2008). In Scotland, even though the law does not explicitly criminalise assisted dying, such a person may still be found culpable for murder or culpable homicide (Fakonti and Papadopoulou, 2025; Ward, 2022).

[4] Reports in Canada have revealed that medical professionals are struggling with assisted death requests from vulnerable individuals whose suffering could potentially be alleviated through financial support, social connections, or adequate housing. Providers of assisted dying services have expressed strong unease about ending the lives of vulnerable individuals, even if their deaths might have been preventable or if they meet Canada's criteria for medical assistance in dying (MAID). This has led some to question whether more vulnerable people will pursue MAID as a way to escape their suffering. However, it is important to note that, unlike in the English and Scottish Bills, there is no requirement for the individual to be suffering from a terminal illness. See Associated Press, (2024) 'Canadians with nonterminal conditions sought assisted dying for social reasons' *The Guardian* <https://www.theguardian.com/world/2024/oct/17/canada-nonterminal-maid-assisted-death> accessed 13 July 2025.

Assisted dying is a contentious issue in medical law, with criminal law prohibiting life-ending actions, even in mercy killings. In *R v Inglis* (2011), Judge CJ noted that the belief one is acting out of mercy does not, and cannot, constitute a defence against the charge of murder.[5] The Suicide Act (1961), applicable to England and Wales, states that helping someone attempt or complete suicide can lead to up to fourteen years in prison. While taking one's own life is not a crime, assisting in such actions is punishable under Section 2 of the Act (Brazier and Cave, 2016). In *R v McShane* (1977), a daughter was convicted for trying to convince her elderly mother to commit suicide to inherit her money. Police found evidence through a secret camera showing her giving drugs disguised as candy and leaving a note saying, "Don't bungle it." In *Attorney General v Able* (1984), the court examined whether it was illegal for the Voluntary Euthanasia Society (VES) to sell a booklet about suicide methods to members aged 25 and over. The VES maintained a neutral stance on suicide, viewing it as a personal choice. Evidence showed that after distributing the booklet, there were fifteen suicides linked to the VES and the booklet. However, the court determined that distributing the booklets typically did not constitute an offence, as members' intentions were often unclear. To prove an offence, it would need to be shown that the society knowingly distributed the booklet to someone contemplating suicide with the intent to assist in the act. Prosecutions can only be initiated with the consent of the Director of Public Prosecutions (Bache, 2025).

A murder conviction requires proving beyond a reasonable doubt that the defendant intentionally caused the patient's death. Key factors include the defendant's actions, such as administering a lethal injection, or inaction, like failing to resuscitate the patient, which are essential for determining criminal liability. Generally, individuals are not held criminally liable for failing to act; however, prosecution can occur in cases where a duty of care has not been met (Biggs, 2004). Therefore, the victim would not have died at the time they did. In *R(Jenkins) v HM Coroner for Portsmouth* (2009), it was also highlighted that no crime occurs when assistance is withheld from someone who explicitly refuses medical help. However, if a person cannot make informed decisions, the situation changes. In murder cases, it is essential to prove that the defendant's

[5] See *Nicklinson v Ministry of Justice*, 2014 UKSC 38, [17].

actions were a significant factor in the death, rather than the sole cause (Herring, 2020; Reagan et al., 2003). Thus, an autopsy revealing that a patient's death resulted from a combination of disease and a doctor's injection raises questions about the doctor's responsibility in the death. Two key points must be considered: First, if the administered drug only slightly reduces the patient's life expectancy, it might not be seen as a significant factor in the death. However, if the treatment were intended to cause death and effectively does so, then the loss of life, whether it is weeks, months, or even years later, would be deemed murder. The second point is that courts are often reluctant to conclude that standard medical treatment is the cause of death, complicating legal interpretations of such cases (Herring, 2020).

5.3.1.1 The Double Effect

Identifying a doctor's intention is crucial for establishing legal responsibility. However, while providing pain relief is defensible, it can have unintended consequences that affect its legal status due to the principle of double effect, which considers both the intention and the foreseeability of consequences (Potter, 2015; Biggs, 2004). In patient care, especially terminal care, this doctrine acknowledges that administering high doses of analgesics might lead to complications (Kendal, 2024; Potter, 2015). The principle describes how certain actions can have both intended and unintended consequences. While it is unethical to commit an evil act for a good outcome, one may pursue a good act despite potential negative consequences. For instance, administering narcotic drugs to alleviate terminal pain can improve quality of life, but may also necessitate higher doses as the patient's condition progresses. While these medications are essential for palliative care, they carry risks like drowsiness and reduced appetite, which could lead to serious complications (Doerflinger and Gomez, 2016; Biggs, 2004). Thus, managing pain in terminal care often presents a dilemma of dual effects. If a patient dies due to necessary medication, homicide charges are likely not viable; however, if the medication was in fact considered to be unnecessary or ineffective, criminal liability could arise in the event of death.

5.3.2 Dying as an Expression of Autonomy

Autonomy, derived from Greek words 'autos', meaning self and 'nomos', meaning law or rule, refers to self-governance (Lewis, 2023; Wyatt, 2015; Huxtable, 2007).

Personal autonomy encompasses thought, will, and action, enabling individuals to think independently, make informed decisions, and act upon them (Lewis, 2023). Autonomous individuals can make meaningful choices aligned with their values, utilising their cognitive and emotional strength. In contrast, non-autonomous individuals struggle to make decisions and often lack the ability to consent. While autonomy emphasises patients' preferences in medical care, competent patients retain the right to refuse treatment.

The principle of autonomy allows patients to set their boundaries regarding life and death, although these boundaries can sometimes become unclear. As long as they are not severely impaired, these boundaries should be respected by medical doctors (Kontomanolis et al., 2018). The General Medical Council (GMC) recognises that patients have the right to consent to or refuse medical treatment (GMC, 2022), and the doctor is legally and professionally bound to accept it, provided it is competently expressed. Lord Donaldson stated in *Re T* (1992) that:

> The appeal is not for the right to die since there is no suggestion that Miss T wants to die… this appeal is about the right to choose how to live. This is quite different, even if the choice when made may make an early death more likely.

Some scholars, however, believe that there is irony in applying the principle of autonomy to death, as it signifies the loss of choice (Herring, 2020). While autonomy aims to allow individuals to live fulfilling lives, assisted dying, in contrast, marks the end of a person. Thus, opponents believe the principle of autonomy cannot justify it.

Advocates for legalising assisted dying emphasise the importance of individual autonomy in making life and death choices, especially in cases of current or anticipated suffering (Shenouda, 2024). While autonomy can be limited for public safety, such as in speed limits and pandemic lockdowns, it extends to medical practices, including the right of healthcare providers to conscientious objection (Triviño-Caballero et al., 2023). Legal debates about assisted dying highlight the insufficient protections for those who oppose it on moral grounds, with some scholars suggesting a conflict between medical responsibilities and personal beliefs (Martins-Vale et al., 2023; Mengual, 2023). There is an ongoing debate about whether patient access to care should take precedence over doctors' rights to refuse participation based on conscience (Cavanagh et al., 2024; Sethi

et al., 2022). The Terminally Ill Adults (End of Life) Bill (2024) in England and Wales, allows for conscientious objection without penalty (Section 23), while the Assisted Dying for Terminally Ill Adults (Scotland) Bill also includes similar provisions but gives doctors a choice to either opt in or out of participation, addressing concerns about potential pressures on healthcare professionals to act outside their conscience or personal objections (Section 18, Scottish Bill). These provisions explicitly permit doctors to refuse participation in assisted dying if it conflicts with their moral, ethical, or religious beliefs. This ensures that, while patients can access assisted dying, healthcare providers are not compelled to act against their principles. However, although doctors can refuse to participate in assisted dying, they should also have a legal obligation to refer patients to another provider willing to assist. This maintains patient access to care while respecting the rights of individual practitioners.

5.3.2.1 The Intersection of Capacity and Autonomy in Assisted Dying

Patient consent is essential for ethical medical practices, as it aligns with personal choices. Capacity refers to a patient's mental ability to understand their medical situation and make informed decisions (Wyatt, 2015). Section 3 of the Terminally Ill Adults (end of life) Bill aligns the definition of a person's capacity with Section 2(1) of the Mental Capacity Act 2005, which states that a person lacks capacity if they cannot make decisions due to mental impairment. Section 3(2) of the Scottish Assisted Dying Terminally Ill Adults Bill defines capacity as the absence of a mental disorder affecting decision-making. It includes understanding information related to the request, making a decision, communicating that decision, comprehending the decision, and remembering it. The Scottish definition of capacity, however, notes that a person should not be excluded on the basis of capacity owing to a deficiency in a faculty of communication if that lack of capacity can be made good by human and technological aid (Section 3(3)). Typically, individuals can consent or refuse treatment if they are conscious and mentally sound. However, unconscious patients are unable to provide informed consent (Farrel and Dove, 2023). Every adult is legally presumed to have the capacity to consent, unless proven otherwise. This presumption is, however, not absolute. In a *Local Authority v E* (2012), a court approved forced feeding for a 32-year-old anorexic patient for up to a year. Informed consent for medical procedures can only

be given by the patient in adulthood (Marton et al., 2020). For individuals aged sixteen and older, there is a legal presumption of capacity; for those under sixteen, the presumption is that they are incapable of consenting (John, 2014).[6] Competence is context-dependent, varying based on the nature of the decision, which means an individual might be competent to consent to marriage while simultaneously unable to draft a detailed will (Kuosmanen, 2021; Akdeniz, 2021; Biggs, 2004). Competence to consent is assessed for each decision individually and does not grant a blanket status of competence.[7] Individuals with mental illness or limited capacity can still be deemed competent for specific decisions. Treatment choices for incompetent adults focus on their best interests, similar to those for minors and input from significant others and proxies is taken into account during this assessment (Birchley, 2021).[8]

When an issue arises regarding lifesaving treatment and a person lacks capacity, the first question is whether the individual has provided an effective advance directive indicating that they do not wish to receive treatment (Kuosmanen, 2021; Akdeniz, 2021; Herring, 2020; Brazier and Cave, 2016).[9] An advance directive can strongly suggest treatment preferences; however, it does not legally bind healthcare providers. Advance decisions to refuse treatment under the Mental Capacity Act are not valid unless the treatment is clearly specified, conditions for refusal are detailed, and unforeseen circumstances that could have influenced the decision are addressed (Buchbinder and Berens, 2024).[10]

6 Assisted Dying as an Expression of the Right to Human Dignity

Kantian deontological ethics evaluates actions based on their nature, making dignity and autonomy essential considerations in patient care (Knoepffler and O'Malley,

[6] See also *Miss B v an NHS Hospital Trust* 2002; Note that under the English Bill, the proposed eligibility age is eighteen as opposed to sixteen.
[7] See *Re C Adult refusal of treatment* 1994 1 W LR290
[8] See Section 1 *Mental Capacity Act* 2005
[9] See Section 24 and 25 *Mental Capacity Act* 2005
[10] See Aintree University Hospitals NHS foundation trust 2013 UKSC 67

2021; Deepa, 2020). Immanuel Kant believed that human dignity stems from the capacity for free, rational choices (Kerstein, 2023; Sinha, 2022). He argued that those who choose to end their lives do so by relinquishing their rationality, often due to factors like pain. However, respecting individuals' dignity ultimately means recognising their rationality. Therefore, a person facing suffering or illness may justifiably seek assisted dying; in such circumstances, it preserves their dignity (Scopetti et al., 2023; Cholbi, 2015).[11] Human dignity is an essential attribute linked to self-determination and autonomy, representing a quality of life where individuals can make self-directed choices (Twycross, 2024; Deepa, 2020). The term derives from the Latin *dignitas*, meaning worthiness (Braun, 2023). For many, a dignified death represents freedom, allowing them to escape lives that do not reflect their true values (Lambert, 2023; Poss, 2021). Individuals suffering from unrecoverable pain or with terminal illnesses may prefer death over life due to concerns that a prolonged dying process could compromise their dignity and sense of control (Schulman, 2008; Biggs, 2001).

The discussion on assisted dying legislation primarily focuses on the right to die with dignity based on an individual's right to human dignity. The concept of human rights posits that all individuals have inherent rights by virtue of being human (Dige, 2022; Peel, 2004). As individuals approach death, they increasingly lose control over their bodily and mental functions, which can lead to helplessness and reliance on others. Advocates believe people should have the right to die with dignity before reaching such a dependent state (Herring, 2020).

Advocates also contend that the denial of Laws on assisted suicide is seen as discriminatory, compromising an individual's dignity and right to die, although jurisprudence does not recognise a right to die as implied by the right to life (Beriozovas and Avižienė, 2023; Peel, 2004; Wall and Butler, 2004). They emphasise the importance of safeguarding the dignity of those who are dying and argue that the right to life does not entail a duty to continue living, especially in cases of severe suffering or irreversible

[11] Although Kant opposed euthanasia, Kantian ethics is one of the most influential moral theories in the history of philosophy. Two fundamental concepts – autonomy and dignity – emerge in an intertwined relationship in Kant's moral theory. These two concepts are also frequently highlighted in debates about the morality of euthanasia.

conditions. They also assert that allowing someone to endure a prolonged and painful death undermines human dignity, making it morally justifiable to assist in ending their suffering (Kayacan, 2022; Biggs, 2001). In *Re O* (2016), Hayden argues that in cases of minimal brain activity, courts should not prioritise the principle of respect for life to the extent that it undermines the dignity and rights of the patient.

Kant's perspective posits that dignity and humanity are vital virtues, stating that losing dignity reduces life to mere biological existence, which lacks inherent value. Therefore, he emphasises that biological life does not have absolute worth, highlighting the greater importance of honour (Deepa, 2020). Hardwig (1997), in a controversial article, suggested that individuals may have a moral duty to die, particularly in cases of severe illness where they may burden their families and caregivers. This view, while framed as a moral obligation, has faced criticism for implying that terminally ill individuals waste their families' time and health resources, which some find offensive and discriminatory (Herring, 2020; Levvis, 2012; Cholbi, 2010). Critics of assisted dying argue it may undermine the dignity of those administering it and society at large, advocating instead for palliative care as a more dignified option. Advocates counter this by stating that individuals should choose between assisted dying and palliative care based on their needs (Herring, 2020). Despite the various views and perceptions of dignity in dying, it is essential to recognise that a person's perceived value can differ based on their personality and social standing (Deepa, 2020). Generally, human dignity is linked to identity and status, with a distinction made that humans hold more intrinsic value than animals or plants. Discussions surrounding personal dignity highlight cultural and societal values, yet do not diminish basic dignity; they merely offer varied viewpoints on a core concept (Deepa, 2020). Dignity encompasses physical, mental, and self-image aspects, along with universal belonging to humanity. Macklin (2003) takes a different view. Instead, she argues that dignity, which she defined as 'respect for persons and autonomy', can be secondary in medical ethics, as it does not provide clear guidelines for ethical decisions. Because of this ambiguity, she is convinced that autonomy is a more effective guide for resolving moral dilemmas in healthcare.

In contemporary discourse, patient autonomy is often regarded as a more influential guiding principle than the right to human dignity when discussing the

legalisation of assisted dying (Steinmann, 2016; Macklin, 2003). Modern legal frameworks increasingly emphasise individual rights and personal freedom, placing autonomy at the centre of ethical decision-making in healthcare. Landmark cases and legislation in various jurisdictions also reflect a societal shift towards recognising individuals' right to make autonomous, informed choices about their bodies and lives. Therefore, while dignity remains an essential aspect of end-of-life care, it is often seen through the lens of individual choice, self-determination, and ultimately, autonomy. However, describing human dignity solely as autonomy presents an incomplete definition, as it does not capture the multifaceted nature of the concept, and reducing this complex concept only diminishes its depth (Barilan, 2011). Human dignity goes beyond the idea of autonomy. While autonomy is a significant aspect of human dignity, tThe broader meanings of human dignity in the context of assisted dying also include respect for inherent worth and quality of life.

Human dignity has been characterised in two key elements. One element requires that each person be treated with inherent worth simply because they are human, independent of any social status, classification or personal attributes. Another element for respecting human dignity is the autonomy and respect for persons (Steinmann, 2016; Barilan, 2011). A third element exists in the context of assisted dying; this is the consideration for the quality of life. Legal perspectives on human dignity primarily focus on safeguarding individuals from dehumanising treatment.[12] Human dignity encompasses ethical and legal duties to safeguard individuals from suffering and degradation through terminal conditions.[13] Evidently, human dignity and autonomy are linked but not the same or interchangeable. Autonomy highlights personal decision-making rights, whereas human dignity emphasises the moral duty of society and the state to ensure these choices occur in a manner that respects a person's inherent value. Another way to view this difference is to consider that while human dignity provides a

[12] In the context of assisted dying, this involves upholding the right of terminally ill patients to die with dignity and avoiding unnecessary suffering. See Steinmann (2016)

[13] See also Beyleveld D and Brownsword R (1998) 'Human Dignity, Human Rights, and Human Genetics' *MLR* 661-680; McCrudden C (2008) 'Human Dignity and Judicial Interpretation of Human Rights' *EJIL* 656-724; Rao N (2011)'Three Concepts of Human Dignity in Constitutional Law' *Notre Dame L Rev* 183-274

moral basis for respecting autonomy, autonomy can reinforce human dignity by allowing individuals to make choices aligned with their values and beliefs, thereby enhancing their self-worth (Barilan, 2011). In the context of assisted dying, the ethical obligation to protect human dignity must not be overlooked. Autonomy should be balanced with a strong commitment to ensuring that these patients are not put in situations where their dignity might be compromised. Instead, discussions should focus on developing a legal and ethical framework that honours both autonomy and dignity, recognising that they are not mutually exclusive but rather interdependent.

7 Progress Towards Legalisation in Great Britain

The progress towards the legalisation of assisted dying in Great Britain is navigating a complex landscape of legal and ethical concerns that demand careful consideration. Lately, debates on assisted dying have intensified due to high-profile cases and growing public support, leading to discussions in Parliament about various Bills (Law et al., 2024). The most recent is the Terminally Ill Adults (End of Life) Bill,[14] which applies to England and Wales. Scotland has also introduced the Assisted Dying for Terminally Ill Adults (Scotland) Bill, which allows assisted dying for terminally ill adults. Both Bills grapple with the legal and ethical implications of allowing assisted dying. Both the English and Scottish assisted dying Bills navigate ethical complexities by striving to balance individual autonomy with societal concerns about the potential for abuse and the sanctity of life. The discussion surrounding these Bills often reflects deep-seated beliefs about the sanctity of life, prompting lawmakers to navigate these sentiments, usually incorporating language that respects the value of life while also acknowledging the suffering of terminally ill individuals. The Bills seek to establish an ethical framework that differentiates between actively ending life and allowing death to occur through assisted means, thus trying to reconcile the moral and compassionate need to alleviate suffering with the value placed on life. To this end, Sections 19 and 20 of the Scottish Bill attempts to remove criminal and civil liability in assisting a terminally ill adult. Similarly,

[14] As amended in the Public Bill Committee.

Sections 24 and 25 of the English and Welsh Bill aim to exempt individuals from criminal and civil liability for assisting a terminally ill adult.

The concept of dying with dignity, along with ideas of autonomy and human dignity, is central to debates about the Terminally Ill Adults (End of Life) Bill, and the Assisted Dying for Terminally Ill Adults (Scotland) Bill. Both Bills acknowledge the importance of personal choice in end-of-life decisions, asserting that terminally ill patients should have the right to manage their death in a dignified manner. The core rationale for both Bills appears to be rooted in compassion, highlighting the importance of allowing terminally ill adults to make autonomous decisions about their care at the end of their lives, especially when faced with unbearable suffering. Both Bills aim to provide this option, though they differ in specifics such as age limits and definitions of terminal illness. Therefore, by permitting assisted dying (although without explicitly linking it to the right to die with dignity), the Bills seek to preserve the dignity of terminally ill individuals, respecting their right to avoid prolonged suffering and to control their final days. The Bills also include some safeguards, such as assessments by medical professionals, to ensure that individuals are capable of making this significant decision at various stages (Sections 4–10 and 12 English Bill; Sections 4–11, 13 and 14 Scottish Bill). These measures aim to preserve individual autonomy while also protecting people from hasty or coerced decisions. The requirement for a voluntary and informed request is a crucial element of both Bills, ensuring that individuals retain control over their circumstances. The Bills seek to ensure that only terminally ill adults who voluntarily express their wish to end their life, among other criteria, are eligible for assistance, free from coercion.

Key comparisons of the English and Scottish Bills:

Features	English Bill (England and Wales)	Scottish Bill
Minimum Age	Eighteen years old (Section 1(1)(b))	Sixteen years old (Section 29)
Definition of Terminal Illness	A person is terminally ill if they have a progressive illness, disease or medical condition which cannot be reversed by	A person is terminally ill if they have an advanced progressive disease, illness or condition from

	treatment with death as a consequence reasonably expected within six months (Sections 1 and 2). It clarifies that temporary treatments for symptoms do not qualify as curative (Section 2(2)).	which they are unable to recover and that can reasonably be expected to cause their premature death (Section 2).
Eligibility Requirements	Capacity[15]; diagnosed with a terminal illness; registration with GP; residency in England or Wales for twelve months (Section 1)	Capacity; diagnosed with a terminal illness; registration with GP; residency for twelve months in Scotland (Section 3).
Provision of Assistance	The coordinating medical doctor may provide approved substance directly and in-person to the patient after being satisfied that conditions are met.[16] The decision to self-administer lies with patient.[17] The coordinating medical doctor must remain with the patient until the substance is self-administered and the person has died or it is determined that the procedure has failed or the patient decides not to self-administer, in which case the doctor must take the substance away (Section 18).[18]	The coordinating medical practitioner or authorised health professional, subject to conditions,[19] may provide approved substance and must remain with the patient until they decide whether to use the substance and if so until the patient dies (Section 15).[20]
Conscientious Objection	No duty to participate on the basis of a conscientious objection. No detriment must	No duty to participate on the basis of a conscientious objection.

[15] See 1(1)(a) Section 3 Terminally Ill Adults (End of life) Bill.
[16] See Section 18 (4) Terminally Ill Adults (End of life) Bill. It should however be noted that any other doctor providing assistance must be authorised in writing by the coordinating doctor and the patient. See Section 19 Terminally Ill Adults (End of life) Bill.
[17] See Section 18 (6-8) Terminally Ill Adults (End of life) Bill.
[18] See Section 18 (9) and (11) Terminally Ill Adults (End of life) Bill.
[19] See Section 15 (2)(3) Assisted Dying for Terminally Ill Adults (Scotland) Bill.
[20] It should be noted that the coordinating medical practitioner or authorised health professional need not be in the same room as the patient. See section 15(6) Assisted Dying for Terminally Ill Adults (Scotland) Bill.

	arise as a result of a choice not to participate (Section 23).	Burden of proof is on the person claiming to rely on it (Section 18).
Offences	Criminalises inducing a first or second declaration or a patient's self-administration through dishonesty, coercion, or pressure with criminal liability of up to fourteen years imprisonment (Section 26). Criminalises falsification or destruction of documentation for declarations with criminal liability of up to five years, a fine, or life imprisonment as may be applicable to the situation (Section 27).	It is an offence to coerce or pressure a terminally ill adult into making a first or second declaration. Summary conviction up to two years or a fine and conviction on indictment up to fourteen years imprisonment or a fine (Section 21).
Oversight	Codes of practice and guidance by the Secretary of State and Chief Medical Officers (Sections 30, 31, 33–34 and 39). Court approval for a declaration to establish that the requirements of first declaration have been met (Section 12).	Guidance by Scottish ministers (Section 23, 26–27 and 31).
Recording Cause of Death	Assisted death noted on death certificate along with a record of patient's terminal illness by reason of which they were entitled to be provided assistance to end their life (Section 29(2)).	Only terminal illness is recorded as cause of death (Section 17).
Review	Mandated five-year review including palliative care assessment (Section 35).	Scottish ministers review the operation of the Act (Section 27). No specific review provisions addressing palliative care.

Table 2

The main differences between the Scottish and English assisted dying Bills are their age requirements and definitions of terminal illness. The Scottish Bill allows individuals aged sixteen and over to access assisted dying, aligning with Scottish law (Stavert and

McKay, 2020; Stavert, 2015), whereas the English Bill sets the minimum age at eighteen, consistent with international standards. Both Bills face criticism regarding the difficulties of predicting life expectancy and the ambiguity around which conditions qualify as terminal (McCann, 2024; House, 2024). However, the difference is relatively straightforward, with the English Bill requiring that death be expected within six months, while the Scottish Bill covers cases where premature death is likely (Section 2). The English Bill also differentiates between untreatable conditions and mental illness or disability, explicitly excluding them as qualifying criteria for assisted dying (Section 2(3)). In contrast, the Scottish Bill refers to unrecoverable conditions and faces criticism for potentially including individuals who refuse treatment for treatable conditions (Fakonti and Papadopoulou, 2025; Robson, 2024). The Scottish Bill emphasises that people with a mental disorder affecting decision-making are not eligible for assisted death (Section 3(2)). Both Bills generally include strict eligibility criteria to ensure that assisted dying is limited to terminally ill adults suffering from unbearable pain. This aims to prevent a slippery slope towards broader use of assisted dying. Such restrictions are intended to reassure the public that the legislation remains focused and controlled while preventing broad interpretations that could lead to a slippery slope, where people who are not terminally ill, only affected by a mental disability or who have physical disabilities alone may also seek assistance to die. The requirement for multiple healthcare professionals to evaluate and confirm a patient's eligibility is another measure to address the concern about the slippery slope.[21] This process ensures that multiple perspectives are taken into account before a decision is made, helping to avoid hasty or inappropriate applications of the law. This approach demonstrates respect for the seriousness of the decision and the need for careful consideration, aligning with a dignified approach to end-of-life care.

8 Recommendations

While both Bills mark significant progress towards recognising the rights of terminally ill patients, several areas could still be improved.

[21] See section 4-10 and 12 Terminally Ill Adults (End of life) Bill.

1. Legislation should include specific provisions that offer additional safeguards, such as mandatory investigations to verify autonomous decision-making that is free from coercion by individuals or socioeconomic factors. Formalising these safeguards establishes a legal duty for healthcare providers to assess capacity and autonomy, thereby reducing the risk of abuse or undue influence. Legislation should mandate independent evaluations to verify that a patient's decision to pursue assisted dying is voluntary and not coerced. Committees made up of medical experts, legal professionals, and ethicists should assess the patient's mental capacity and decision-making process by conducting in-person interviews and reviewing medical records.
2. Legislation must address the socioeconomic factors that influence these decisions, ensuring equitable access to care and support. Patients should demonstrate they have been fully informed about palliative care options, verified by referral documentation. Implementing programmes to reduce socioeconomic disparities, such as funding psychological counselling for low-income or financially strained patients, can help prevent economic pressures from unduly influencing decisions.
3. Both Bills must also detail procedures for managing potential complications and incorporate mechanisms for legal recourse for patients or their families. Creating an ombudsman or tribunal for grievance redress would help build trust and safeguard rights.
4. A publicly accessible database of assisted dying cases, including demographics, reasons, and outcomes, can promote transparency, accountability, and ongoing ethical review.
5. Finally, a legally mandated annual review process should be instituted during the initial years, involving stakeholders such as medical professionals, ethicists, and patient groups at regular intervals. This review must consider legal precedents and societal attitudes to ensure the legislation remains relevant, effective, and aligned with human rights.

9 Conclusion

This article provided an analysis of the intricate legal and ethical concerns related to assisted dying for terminally ill patients in Great Britain. It highlighted the substantial influence of human rights, particularly the right to human dignity. The discussion highlighted the need to respect a competent patient's autonomy, while also acknowledging society's ethical duty to safeguard its most vulnerable members. Despite notable progress in English and Scottish legislative frameworks, substantial ethical impediments remain, primarily centred on fears of a slippery slope and the risk of exploiting vulnerable populations. Consequently, if the legalisation of assisted dying is to be ethically and socially justified within Great Britain, it must be rigorously regulated with stringent ethical standards to mitigate potential abuses and ensure comprehensive oversight of end-of-life decisions. Ultimately, the effectiveness of these measures depends on proper implementation and continuous monitoring of results. Therefore, regular assessment, robust oversight, and an adaptable legal framework are essential to addressing ethical challenges as circumstances evolve.

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