Rectifying 'Forced Dying' or Normalising Neglect? Interrogating the Risks of Assisted Dying Legislation

Ceri Lois Hughes

Abstract

This article examines the profound legal and ethical paradox at the heart of the assisted dying debate: whether legalisation rectifies the moral injustice of 'forced dying' or introduces a new, systemic injustice for vulnerable populations. The author argues that a purely autonomy-based justification for assisted dying is legally and ethically insufficient, drawing upon Martha Fineman's vulnerability theory. This paper conceptualises vulnerability as a universal human condition and shifts the focus from procedural consent toward institutional responsibility for mitigating structural determinants. By analysing the phenomenon of 'mission creep' and legal developments and reported concerns surrounding Canada's Medical Assistance in Dying (MAiD) regime, the article examines how socio-economic marginalisation and inadequate palliative care can transform assisted dying from a meaningful choice into a response to social neglect. Assisted dying legislation can only achieve moral and legal legitimacy if it is embedded within a justice-oriented framework that proactively addresses structural inequality and ensures robust social support.

Introduction

The diffusion of assisted dying (AD) legislation across liberal democracies has sharpened a dispute about the responsibilities of healthcare at the end of life.[1] Prohibition may compel competent individuals to endure suffering they regard as

[1] David Clark and others, 'A Moment for Compassion: Emerging Rhetorics in End-of-Life Care' (2017) Social Science & Medicine 177, 11–19; Dominique Flarey, 'Ethics of End-of-Life Care' (1997) 6 Nursing Ethics 424.

intolerable, subordinating their evaluative agency to moral commitments they do not share.[2] Yet legalisation risks a different injustice where poverty, disability, inadequate care or social isolation make continued life difficult to sustain. The ethical issue concerns both the authority to choose death and the circumstances in which that choice becomes intelligible.

This tension is intensified by the widening of eligibility beyond the limits initially adopted, commonly described as mission creep.[3] Expansion does not itself establish that safeguards have failed, but it demands scrutiny of whether social provision develops alongside legal entitlement. Unequal access to care may leave some individuals with substantially fewer bearable alternatives than others.[4] Relational critiques similarly question accounts of autonomy that detach decisions from dependency and social context.[5] Where people internalise the belief that their care burdens others, an apparent freedom to die may acquire the character of an obligation.[6]

Martha Fineman's vulnerability theory provides the framework for examining these concerns. It treats vulnerability as a universal human condition and directs attention to the institutions through which resilience is unequally secured.[7] Applied to AD, this perspective requires more than confirmation of capacity and consent: it demands consideration of the material and relational resources that sustain agency.[8] The article's central claim is that legalisation can remedy the injustice of compelled suffering only

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[2] Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (Knopf 1994) 201–217.
[3] An Act to amend the Criminal Code (medical assistance in dying), SC 2021, c 2, s 1(1).
[4] Emily M Ngui and others, 'Mental Disorders, Health Inequalities and Ethics: A Global Perspective' (2010) 22 International Review of Psychiatry 235.
[5] Leslie Bender, 'A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia' (1992) 59 Tennessee Law Review 519.
[6] J David Velleman, 'Against the Right to Die' (1992) 17 Journal of Medicine and Philosophy 665.
[7] Martha Albertson Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20 Yale Journal of Law and Feminism 1.
[8] Martha Albertson Fineman, *The Autonomy Myth: A Theory of Dependency* (The New Press 2004) 115.

within arrangements that make continued life a supported alternative. Colburn's rejection of claims that legalisation worsens palliative care cautions against treating institutional decline as an inevitable consequence of reform.[9] It requires institutions to address remediable deprivation without dismissing the moral testimony of those seeking assistance.

The discussion first examines compassion and the harms of prohibition, then evaluates the limits of formal choice through relational ethics and vulnerability theory. It subsequently considers eligibility expansion, using Canada as its principal example, before identifying the institutional and legislative safeguards required by this account of justice.

Compassion, Harm and the Ethics of Forced Dying

A commitment to preserving life can conflict with compassion when it prolongs suffering that a person regards as incompatible with dignity.[10] Compassion is used here to mean an ethically attentive response to suffering that seeks to relieve it while taking seriously the person's own account of what makes life tolerable. It is not synonymous with preserving biological life at any cost. The medical and legal understanding examined in this section nevertheless treats preserving life and preventing intentional killing as central means of protecting vulnerable patients.[11] While opposition to AD is frequently presented as an expression of societal and professional care, such restraint may conceal a deeper injustice: obliging competent individuals to continue living in

[9] Ben Colburn, 'Palliative Care-Based Arguments against Assisted Dying' (2025) 39 Bioethics 187, 193–194.
[10] David Clark and others, 'A Moment for Compassion: Emerging Rhetorics in End-of-Life Care' (2017) Social Science & Medicine 177, 11–19.
[11] Bernard E Rollin, 'Ethics and Euthanasia' (2006) 19 Journal of Agricultural and Environmental Ethics 525–540; World Medical Association, 'WMA Declaration on Euthanasia and Physician-Assisted Suicide' (adopted October 2019) <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/> accessed 17 September 2026.

circumstances they can no longer reconcile with their own values.[12] From a justice-oriented perspective, refusal is not a morally neutral act of preservation where it actively imposes suffering and distributes its burdens unevenly.

This concern is most clearly articulated within liberal bioethical accounts that characterise "forced dying" as a distinct form of moral injustice. Ronald Dworkin argues that individuals possess legitimate moral authority over the narrative shape and evaluative meaning of their own lives, including their deaths, particularly where continued existence no longer serves values they regard as central to their identity.[13] To deny assistance in dying under such circumstances is not merely to protect biological life, but to subordinate a person's evaluative agency to external moral ideals about the sanctity of life that they may not share.[14] Justice is thereby compromised, not simply because autonomy is overridden, but because individuals are compelled to shoulder existential burdens that others, often healthier or more socially advantaged members of society, are never required to bear.[15]

Importantly, this injustice cannot be reduced to an appeal to personal liberty alone. A justice-based analysis instead asks how prohibitive regimes distribute suffering. Those with access to comprehensive palliative care (an approach that seeks to improve the quality of life of people and families facing life-threatening illness by preventing and relieving physical, psychosocial, and spiritual suffering) may find continued life tolerable,[16] whereas others facing unmanaged pain, functional deterioration, or social

[12] Dominique Flarey (n 1).
[13] Ronald Dworkin (n 2) 201–217.
[14] Tom L Beauchamp, 'The Medical Ethics of Physician-Assisted Suicide' (2019) 44 Journal of Medicine and Philosophy 1–15.
[15] Carl Tollef Solberg, 'The Badness of Death and Priorities in Health' (2012) 38 Journal of Medical Ethics 709–714.
[16] World Health Organization, ‘Palliative Care’ <https://www.who.int/news-room/fact-sheets/detail/palliative-care> accessed 17 September 2026.

isolation may be required to persist in conditions that erode their sense of dignity.[17] When the State insists upon preservation irrespective of lived experience, it mandates endurance most heavily for those already disadvantaged by illness, dependency, or inadequate care.[18] Compassion then hardens into harm because it refuses to recognise suffering as the person experiences it.

Critics often resist this line of reasoning by invoking the moral distinction between killing and letting die, suggesting that prohibiting AD merely allows the natural course of illness to unfold rather than constituting an act of harm.[19] For many opponents, this distinction remains ethically significant because it reflects longstanding commitments to the sanctity of life, the doctrine of double effect, and the belief that intentionally causing death is morally different from permitting death to occur naturally. Nevertheless, the distinction becomes ethically fragile in healthcare systems that actively intervene to prolong life while simultaneously withholding the means to bring it to a close.[20] In such circumstances, non-assistance cannot plausibly be characterised as moral passivity. Rather, it represents a deliberate normative choice to sustain suffering in the service of broader moral commitments, particularly respect for the sanctity of life, the principle of non-maleficence, and traditional conceptions of professional medical ethics.[21] Justice therefore demands scrutiny of whose values are being prioritised and at whose expense. Where continued existence itself becomes the site of harm, insisting upon life at all costs risks transforming care into coercion. This concern must nevertheless be considered alongside Velleman's warning that making

[17] Emily M Ngui and others (n 4).
[18] Kate Hurn and Rebecca Badman-King, 'Care as an Alternative to Killing: Re-conceptualising End-of-Life Care' (2019) 184(10) Veterinary Record 1–4.
[19] John Keown, 'Causing Death or Allowing to Die? Developments in the Law' (1997) 23 Journal of Medical Ethics 308.
[20] Lars Øystein Ursin, 'Withholding and Withdrawing Life-Sustaining Treatment: Ethically Equivalent?' (2019) 45 Journal of Medical Ethics 606, 609–612.
[21] Leslie Bender (n 5).

death an available option can itself impose burdens on those expected to justify continuing to live.[22]

Moreover, framing opposition to AD as inherently protective obscures the moral agency of those who seek it. Treating requests for AD as necessarily pathological or misguided reinforces paternalistic assumptions about what constitutes a life worth living.[23] From a justice-oriented perspective, this is ethically troubling because it signals a failure to consider the moral testimony of those whose experiences of suffering challenge dominant narratives that equate dignity with perseverance, celebrate endurance despite intolerable suffering, or assume that continued biological existence is always preferable to death.[24] When compassion is defined solely through the preservation of life, it risks silencing individuals for whom continued existence represents not a benefit, but a sustained violation of their sense of self.[25]

This argument does not amount to an uncritical endorsement of AD, nor does it deny the ethical risks associated with its legalisation. Rather, it establishes a necessary starting point. Any ethical evaluation that neglects the injustice of compelled suffering remains fundamentally incomplete. Justice requires more than the preservation of life in the abstract; that is, the protection of biological life as an intrinsic moral good without sufficient regard to the quality, dignity, or lived reality of that life. Instead, justice demands sustained attentiveness to how moral and institutional arrangements shape lived experience at the end of life.[26] Without such recognition, the refusal to permit AD

[22] J David Velleman (n 6).
[23] Caroline Variath and others, 'Relational Influences on Experiences with Assisted Dying: A Scoping Review' (2020) 27 Nursing Ethics 1501.
[24] Martha Albertson Fineman (n 7).
[25] Martha Albertson Fineman (n 8) 1–15.
[26] Jennifer Hickey, 'The Foundations of Vulnerability Theory: Feminism, Family, and Fineman' (2023) 41 Law & Inequality 89–101.

risks amounting to an ethically indefensible imposition of harm rather than an expression of care.[27]

The Illusion of Choice in Assisted Dying

The moral force of arguments in favour of AD is most commonly grounded in respect for autonomous choice. Within liberal bioethics, the capacity to make an informed and voluntary decision is treated as the primary ethical threshold for permissibility, with justice often presumed to be satisfied once procedural consent is secured.[28] Yet this presumption becomes ethically fragile when choice is exercised under conditions of dependency, social asymmetry, or compromised relational contexts.[29] From a justice-oriented perspective, the central concern is not whether individuals choose AD, but whether the social conditions under which such choices are made render that choice meaningfully free.[30] A choice can only be regarded as meaningfully free where individuals have genuine alternatives, including equitable access to effective palliative care, adequate social and financial support, protection from coercive influences, and sufficient time and opportunity to deliberate free from structural disadvantage. Where these conditions are absent, apparent autonomy may conceal decisions shaped more by circumstance than by genuine self-determination. It is here that the language of autonomy risks obscuring rather than illuminating moral responsibility.[31]

Feminist and relational critiques have long challenged the individualistic conception of agency that underpins autonomy-based ethics, arguing that decisional capacity is never

[27] Dominique Flarey (n 1).
[28] Tom L Beauchamp (n 14).
[29] Sofia Morberg Jämterud, 'Acknowledging Vulnerability in Ethics of Palliative Care: A Feminist Ethics Approach' (2022) 29 Nursing Ethics 952–964.
[30] Martha Albertson Fineman (n 8) 1–15.
[31] Samantha Ashall, *A Feminist Ethic of Care for the Veterinary Profession* (University of York 2018) ch 2, 41–48.

exercised in isolation from the social conditions that shape people's lives.[32] This resonates particularly strongly within end-of-life contexts, where relational influences, including family dynamics, societal expectations, and dependency upon others for care, significantly shape how available options are perceived and evaluated.[33] Where social support is inadequate, the ethical problem is not one of overt coercion but of the subtle internalisation of social norms that frame dependency as undignified and care as burdensome, thereby undermining the idea of autonomous choice as an isolated act.[34] This devaluation narrative intensifies when individuals internalise broader societal messages concerning dependency, scarcity of healthcare resources, and personal "burdensomeness", particularly where material support is itself insufficient.[35]

One manifestation of this relational pressure is the burden-of-care narrative: the perception, whether explicitly expressed or internally experienced, that an individual has become a financial, emotional, or practical burden upon relatives, caregivers, or the healthcare system. Even without direct pressure, the internalisation of that belief may encourage a person to regard death as the responsible or altruistic response to dependency.[36] In AD decision-making, the concern is therefore not confined to overt coercion; it includes the quieter social conditions that can make continued care feel morally unavailable.

The Canadian debate illustrates the institutional concerns at stake. In a February 2021 communication about Bill C-7, UN experts warned that poverty and inadequate support networks could expose people to pressure to seek Medical Assistance in Dying (MAiD).

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[32] Leslie Bender (n 5) 519–548.
[33] Caroline Variath and others (n 23).
[34] Meta Rus and Chris Gastmans, 'Euthanasia and Assisted Suicide: Who Are the Vulnerable?' (2024) 19 Clinical Ethics 18–27.
[35] Sammy Chown, 'Disability Community Feels Ignored in Canada's Assisted Dying Expansion' (2024) BMJ 385 q806.
[36] Sammy Chown (n 35); Caroline Variath and others (n 23).

They also recalled earlier reports of disabled people being offered a choice between institutional care and assisted death.[37] These were reported concerns, not findings establishing that all requests were involuntary or that deprivation was the sole cause. Their significance for this article is narrower: assessing consent should include scrutiny of whether community support and viable alternatives are available, rather than assuming that legal eligibility establishes the adequacy of the circumstances in which a request is made.

These concerns are particularly acute for individuals already positioned as vulnerable through illness, disability, poverty, or social marginalisation. The conceptual literature consistently emphasises that vulnerability is not synonymous with diminished autonomy but instead reflects a universal and relationally mediated feature of the human condition, the ethical significance of which cannot be captured adequately through narrow liberty-based models.[38] The House of Commons Health and Social Care Committee documented geographical inequalities in palliative care and concerns about the sustainability of hospice funding.[39] Where such inequalities constrain a person's options, the availability of AD may respond to unmet need without resolving it. Clinical ethics scholarship further demonstrates that vulnerability manifests simultaneously across physical, psychological, social, and moral dimensions, none of which can be adequately evaluated through procedural consent alone.[40]

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[37] UN Special Rapporteur on the rights of persons with disabilities, Independent Expert on the enjoyment of all human rights by older persons and Special Rapporteur on extreme poverty and human rights, 'Communication to Canada' (3 February 2021) OL CAN 2/2021, 3–4 <https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=26002> accessed 5 October 2026.

[38] Emily M Ngui and others (n 4) 235–242.

[39] House of Commons Health and Social Care Committee, Assisted Dying/Assisted Suicide (Second Report of Session 2023–24, HC 321) paras 266–273 <https://publications.parliament.uk/pa/cm5804/cmselect/cmhealth/321/report.html> accessed 12 October 2026.

[40] Meta Rus and Chris Gastmans (n 34) 21–24.

Principlism offers a widely applicable framework organised around autonomy, beneficence, non-maleficence, and justice. Its universal ambition is a strength: the four principles supply a shared ethical vocabulary across diverse clinical settings without requiring agreement on a single comprehensive moral theory. Beauchamp and Childress present them as prima facie obligations that must be specified and balanced rather than applied mechanically. Yet this abstraction can become a weakness in AD when autonomy is operationalised chiefly through decisional capacity and valid consent, while the social conditions producing the decision are treated as external to the ethical assessment. Fineman's vulnerability theory does not discard the four principles; it exposes what a universal framework may miss when unequal access to care, support, and material security determines whether a nominal choice is genuinely available.[41]

Fineman rejects the liberal fiction of the autonomous and self-sufficient subject, conceptualising vulnerability as both universal and differentially distributed through social institutions.[42] Human beings are inevitably dependent upon social structures throughout their lives, yet access to the resources necessary to respond to that vulnerability is distributed unequally. Consequently, vulnerability is not an exceptional characteristic belonging only to particular groups, but a shared condition whose practical consequences depend upon the quality of institutional support available to individuals.

On this account, justice cannot be satisfied merely by respecting formal choice. Instead, it requires proactive institutional responsibility for cultivating the conditions in which agency is genuinely supported.[43] Applied to AD, vulnerability theory fundamentally

[41] Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, OUP 2019) 13–14, 101–149; Martha Albertson Fineman (n 7).
[42] Jennifer Hickey (n 26) 89–101.
[43] Martha Albertson Fineman (n 7).

reframes the ethical inquiry. Rather than asking only whether an individual has chosen freely according to procedural standards, it asks whether society has fulfilled its prior obligation to minimise avoidable suffering, provide equitable healthcare, and ensure meaningful alternatives to assisted death.

Assessing capacity at a single point in time cannot establish whether a request emerged from adequate care or from its absence. The relevant inquiry must also examine the applicant's practical alternatives and the institutional decisions that constrain them. This extends the assessment beyond a balance of individual interests to the distribution of resources on which those interests depend.[44] Relational autonomy reinforces this approach by locating agency within the relationships and social conditions through which decisions are formed.[45] Vulnerability theory gives that insight an institutional focus: responsibility falls also upon those able to remedy the deprivation shaping the request.

This analysis does not require opposition to assisted dying per se. Rather, it insists that the ethical legitimacy of AD depends upon its availability within a healthcare system characterised by robust social support, equitable palliative care, effective disability services, and meaningful alternatives to death.[46] Only where such conditions exist can autonomy operate as a genuine expression of self-determination rather than a response to structural disadvantage. Without these conditions, the rhetoric of choice risks becoming illusory, concealing structural injustice beneath the appearance of procedural autonomy.[47]

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[44] Carl Tollef Solberg (n 15) 709–714.
[45] Carlos Gómez Vírseda, Yves de Maeseneer and Chris Gastmans, 'Relational Autonomy in End-of-Life Care Ethics: A Contextualised Approach' (2020) 21 BMC Medical Ethics 50
[46]Alex Mullock and Jonathan Lewis, 'Assisted Dying, Vulnerability and the Potential Value of Prospective Authorisation' (2023) 31 Medical Law Review 567–589.
[47] Meta Rus and Chris Gastmans (n 34) 24–26.

The resulting standard evaluates the conditions supporting a decision alongside the decision itself. It provides the basis for examining whether expanding access to AD is accompanied by a corresponding commitment to care.[48]

Mission Creep and the Risk of Self-Defeating Reform

The concern, described here as mission creep, is that widening legal eligibility may expose deficiencies in the support available to people contemplating AD. UN experts raised this concern when scrutinising Canada's proposed expansion beyond reasonably foreseeable death.[49] Expansion should not, however, be equated with deterioration in safeguards. Downie and Schuklenk reject social disadvantage as sufficient grounds for denying assisted dying to otherwise eligible people who retain decision-making capacity.[50] Canadian law also introduced additional safeguards for applicants whose natural death is not reasonably foreseeable, including discussion of available means of relieving suffering.[51] The question is therefore whether those safeguards operate alongside accessible services, rather than whether widening eligibility is intrinsically unjust.

Canada supplies the article's principal example. Bill C-7 removed reasonably foreseeable natural death as an eligibility requirement in 2021.[52] UN experts had warned that expanding access in circumstances of poverty and inadequate support could increase pressure on disabled people.[53] This concern remains contested: Downie and Schuklenk defend the expansion against objections based on social determinants of

[48] Sofia Morberg Jämterud (n 29) 959–962.
[49] UN Special Rapporteurs and Independent Expert (n 37) 3–4.
[50] Jocelyn Downie and Udo Schüklenk, 'Social Determinants of Health and Slippery Slopes in Assisted Dying Debates: Lessons from Canada' (2021) 47 Journal of Medical Ethics 662, 664–667.
[51] An Act to amend the Criminal Code (medical assistance in dying) (n 3) s 1(7), inserting Criminal Code, s 241.2(3.1).
[52] An Act to amend the Criminal Code (medical assistance in dying) (n 3) s 1(1).
[53] UN Special Rapporteurs and Independent Expert (n 37) 3–4.

health and slippery slopes.[54] The position advanced here does not infer coercion from disability or disadvantage alone. It requires examination of whether an individual's options have been narrowed by remediable institutional failures, while respecting that person's capacity and account of their own suffering.

Two propositions must accordingly remain distinct. Widening eligibility establishes that the law has expanded; demonstrating that this expansion produces injustice requires evidence of how the amended regime operates in practice. The Canadian amendment and the concerns expressed by UN experts demonstrate the importance of that inquiry, but neither alone proves an inevitable progression towards abuse.[55] The analysis that follows addresses the institutional conditions under which the risk could arise.

Access to care is central to this inquiry. The House of Commons Health and Social Care Committee documented geographical inequalities in palliative provision, while Colburn rejects claims that legalising assisted dying causes palliative care to deteriorate.[56] These positions concern different questions. Existing shortcomings in care do not establish that AD caused them, but they remain relevant to the alternatives available to an individual considering it. In an under-resourced system, facilitating death without addressing remediable suffering risks transferring responsibility for institutional failure to the person affected.[57] The concern is not that palliative care removes every reason for requesting AD, but that an assessment of voluntary choice should examine whether practicable alternatives were accessible.

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[54] Jocelyn Downie and Udo Schüklenk (n 50) 666–667.
[55] An Act to amend the Criminal Code (medical assistance in dying) (n 3) s 1(1); UN Special Rapporteurs and Independent Expert (n 37) 3–4.
[56] House of Commons Health and Social Care Committee (n 39) paras 266–273; Ben Colburn (n 9) 193–194.
[57] Caroline Variath and others (n 23); Dominique Flarey (n 1) 429–433.

Material deprivation is compounded by relational pressure. Narratives of burden, dependency, and diminished social worth may shape the preferences of older and disabled people without any explicit encouragement to choose death.[58] UN experts and reporting on disability perspectives in Canada have highlighted concerns about inadequate support and the availability of alternatives.[59] These concerns illustrate why vulnerability cannot be inferred from diagnosis alone: it is produced through the interaction between impairment, social messaging, and the institutional resources that make continued life practicable.

Applied to these conditions, Fineman's theory changes the object of inquiry. The question is not whether MAiD applicants belong to a fixed class labelled 'vulnerable', but whether institutions have equipped them with the resilience needed to exercise agency: adequate care, income, housing, disability support, and social connection.[60] A formally competent request may therefore remain ethically compromised where the state has left the conditions making life tolerable beyond the applicant's reach.

Viewed through this lens, mission creep represents more than a gradual expansion of legal eligibility. Rather, it reflects the possibility that institutional responses to vulnerability have become misdirected. Where AD becomes increasingly accessible within healthcare systems characterised by inadequate palliative care, insufficient disability support, social isolation, or economic disadvantage, vulnerability theory exposes what may be described as a moral inversion. Instead of prioritising the social conditions that enable people to continue living with dignity, institutions risk responding to suffering by facilitating death before adequately addressing the structural

[58] Meta Rus and Chris Gastmans (n 34) 22–26.
[59] UN Special Rapporteurs and Independent Expert (n 37) 3–4; Sammy Chown (n 35).
[60] Martha Albertson Fineman (n 7).

conditions that produced that suffering in the first place.[61] In practical terms, this moral inversion occurs where investment in care, support, housing, disability services, or palliative provision fails to develop alongside expanding access to assisted dying, creating the perception that society has become more willing to assist individuals to die than to remove the conditions making life intolerable.

Justice, understood through Fineman's framework, therefore cannot be satisfied solely through procedural safeguards or assessments of individual decisional capacity. Rather, it demands sustained institutional responsibility for addressing the structural determinants that shape end-of-life decision making, including equitable access to comprehensive palliative care, disability support, mental healthcare, social security, and protection against isolation and neglect.[62] Only when these conditions are meaningfully secured can AD plausibly operate as one autonomous option among several genuinely available alternatives rather than becoming a response to institutional failure.

The absence of such commitments fundamentally alters the ethical character of AD. Rather than functioning solely as an expression of individual liberty, legalisation risks accommodating the very inequalities that generate vulnerability. In this respect, the ethical legitimacy of AD cannot be divorced from the broader social environment in which requests arise. If individuals seek assisted dying because adequate care, treatment, financial security, or social support remain inaccessible, then the law risks legitimising choices produced, at least in part, by avoidable structural injustice.

Expansion detached from adequate support may therefore become ethically self-defeating. A legal framework introduced to alleviate suffering may inadvertently

[61] Martha Albertson Fineman (n 8) 33–38.
[62] Emily M Ngui and others (n 4) 235–242.

obscure the institutional failures that continue to generate it.[63] Instead of challenging social inequality, it risks adapting to it. Vulnerability theory therefore redirects attention away from the narrow question of whether legal safeguards have been procedurally satisfied and towards the broader justice obligations owed by the state before AD can be regarded as a genuinely ethical option.

Mission creep should therefore be treated neither as an inevitable consequence of legalisation nor as a rhetorical reason to avoid reform. It is a warning that expansion detached from investment in healthcare, disability services, and social protection may undermine the values used to justify AD. A justice-oriented framework must ensure that assisted death does not become a routine response to structural neglect, institutional abandonment, or preventable social suffering.

Looking Forward: The Future of Assisted Dying Law and Policy

Translating this analysis into law requires safeguards that test the quality of available alternatives, not merely decisional capacity at the moment of request. A justice-centred regime should require documented offers of specialist palliative care, disability and mental-health support, independent examination of coercion and unmet social need, and transparent reporting of the circumstances in which AD is requested. These measures should not operate as paternalistic vetoes. Their purpose is to distinguish a settled preference for death from a choice narrowed by remediable deprivation.

The institutional duty is wider than case-by-case assessment. In 2024, the House of Commons Health and Social Care Committee concluded that palliative provision in England was uneven and called for universal coverage, better population data, and adequate hospice support. That evidence supports a prior-obligation model: legislatures

[63] Carl Tollef Solberg (n 15) 712–714.

considering AD should connect reform to measurable duties concerning access, funding, and monitoring, followed by periodic independent review.[64] Only then can autonomy operate as a choice among supported alternatives rather than as formal permission exercised against institutional scarcity.

This model does not promise to eliminate all suffering or all risk. Nor should access to palliative care be used to deny AD categorically, since even excellent care cannot make all suffering tolerable. The point is sequential and justificatory: before the State treats an assisted death as autonomous, it must be able to show that avoidable failures in care, income, housing, or disability support did not create the conditions in which death became the least burdensome option.

Conclusion

A central ethical question posed by AD is whether the state may facilitate death before it has discharged its duties to make continued life with dignity a realistic option. Prohibition may itself be unjust where it compels a competent person to endure intolerable suffering. Yet autonomy alone cannot legitimate a decision formed through unmet need. Fineman's account exposes AD as an institutional practice whose moral character depends upon the distribution of care, support, and resilience.

The decisive question is therefore not simply whether the law permits death, but what the State has done to make life with dignity possible. A justice-centred regime must couple any route to AD with enforceable access to care and support, safeguards attentive to structural pressure, and continuing scrutiny of eligibility expansion. Without those conditions, legalisation risks converting abandonment into consent. With

[64] House of Commons Health and Social Care Committee (n 39) paras 249–279.

them, AD may remain an exceptional response to intolerable suffering rather than an ordinary answer to inequality.