Augustine Bioethics Network Digest
Vol. 1, Issue 1, May 2026.

Welcome to the first Digest of the Augustine Bioethics Network covering the months of March and April 2026. We aim to bring newsletters out monthly.

The current issue is heavy on assisted suicide and euthanasia, but that is because this issue is very much in the news, especially in the United Kingdom.

On 17 March 2026, after almost five years of debate, the Scottish Parliament rejected an attempt to legalise assisted suicide by 69 votes to 57 (reversing a previous vote of 70 to 56 in favour). MSPs were not convinced that Assisted Dying for Terminally Ill Adults (Scotland) Bill would protect vulnerable patients from being coerced into seeking their own death. They were also unhappy that the conscience clause had been removed from the face of the Bill.

On 17 April 2026, the UK Ministry of Justice informed the Isle of Man Government that it was unable to recommend the Bill for Royal Assent to a Bill that would have legalised assisted suicide on the island. The Bill, in its current form, lacks key legal safeguards needed to meet requirements under the European Convention on Human Rights. It has now returned to the Parliament of the Isle of Man (the Tynwald) to be amended.

On 24 April 2026 the Terminally Ill Adults (End of Life) Bill, which would have legalised assisted suicide in England and Wales, had its last debate in the House of Lords. It did not complete all its stages and has now run out of time. The drafting of the Bill was heavily criticised in the Lords for its use of delegated powers (which gave future ministers the ability to determine or expand the law with little Parliamentary oversight). Advocates falsely accused a 'small minority of peers' of blocking the Bill but in fact an unprecedently large number of peers engaged with the Bill and most were highly critical. One amendment that was much ridiculed by proponents would have required all patients to take a pregnancy test. However, while the wording of the amendment needed improvement, the possibility of terminal illness during pregnancy is a serious topic for a law directed towards people with terminal illness.

These setbacks for the assisted suicide/euthanasia lobby in the British Isles echo similar moves in other

countries, for example in Slovenia, where a referendum on 23 November 2025 overturned the Assisted Voluntary End of Life Act. The referendum result was then challenged but on 24 March 2026 it was upheld by the Supreme Court.

Even in Canada, which arguably has expanded euthanasia more quickly than any other country, there has been resistance to the further expansion of Medical Assistance in Dying to people on the basis of mental illness alone. The Liberal Government has stated it will wait until the Special Joint Committee on Medical Assistance in Dying publishes its report before coming to a decision. In the meantime, the province of Alberta has introduced legislation (Bill 18) to increase state level safeguards on access to MAID.

These instances of prevention or restriction of assisted suicide or euthanasia would not have happened without the work of many concerned citizens. The debate has also required serious research in bioethics by professionals and academics, for example in relation to the likely consequences of a change in the law. This is the kind of research that the Augustine Bioethics Network exists to help foster.

In this digest:

On 14 April 2026 the Augustine Bioethics Network held its inaugural online event, a discussion on Assisted Suicide in England, Scotland, and Wales, with speakers Prof. David Albert Jones, Dr Danielle de Zeeuw and Prof. Mark Taubert. A video of this event is now available and details of how to access it are in the email accompanying this digest.

The current digest includes a letter written by Professor David Albert Jones. This was the basis for individual emails sent to 243 members of the House of Lords in advance of the last day of debate on 24 April 2026.

The digest also includes the speech of Baroness Sheila Hollins in that debate. The speech draws on professional expertise and personal experience to show what is at stake with this kind of legislation. There were many memorable speeches in this debate, but we reproduce this as Baroness Hollins is on the advisory board of the ABN.

Finally, it is our aim to include in the digest a short piece from a member to highlight one or more bioethical issues that are prominent in their own country, region or jurisdiction. This month we will hear from Our Correspondent in Spain, Professor

Marta Albert-Márquez, who discusses a case that gained international prominence. Noelia Castillo Ramos was a young woman whose life was ended by euthanasia despite having mental health problems and a history of suicidal thoughts and feelings.

The aim of a network is to network, so do keep in touch!

Professor David Albert Jones

Secretary, Augustine Bioethics Network

Augustine Bioethics Network

A Letter to Peers

Professor David Albert Jones

Professor of Bioethics, St Mary's University, Twickenham, UK.

Dear Lord/Baroness

I am writing to thank you for the time and serious attention you have given to the scrutiny of the Terminally Ill Adults (End of Life) Bill.

While the House of Lords has been criticised in the media and it has been alleged that a handful of peers (as few as six) have alone been responsible for derailing the Bill, I have been impressed on the contrary just how many Peers have engaged seriously with the Bill. By my count 244 have been involved directly (either by putting forward or sponsoring amendments, or by sitting on one of the committees to examine the Bill, or by speaking in Second Reading or in the Committee Stage, or in all of these ways). In Committee the average speech was less than 7 minutes. The total time taken is a reflection not of lengthy contributions but of the number of Peers wishing to speak.

I also note that not since 1965 and the Murder (Abolition of Death Penalty) Bill,have the Lords taken two days to debate a Private Members Bill at Second Reading. Now, as then, the upper chamber has shown the level of seriousness that such issues require. Now, as then, the focus has been on potential harm or benefit in practice, and not on the alleged level of public support in principle. Now, as then, the focus has been on preventing

people from having their lives ended on the basis of mistaken evidence.

I also think it unfair to compare the time taken on this Bill with the time taken on a government bill of a similar length, as government bills have the benefits of pre-legislative scrutiny and of drafting by civil servants. Weighed as a Private Members Bill, the Terminally Ill Adults Bill is of unprecedented length and would create an unprecedented number of delegated powers (42 in total). I was struck forcefully by the reports of the Constitution Committee and the Delegated Powers and Regulatory Reform Committee, and by the comments of Baroness Butler-Sloss at Second Reading, that she '[did] not remember ever before reading in such a report words like "the power… is inappropriate and should be removed", and, among others, "the highly inappropriate nature of Clause 37(7)"'(Col. 2527).

I recognise that there is one further session set aside for the Bill, but it seems widely acknowledged that the Bill will fail from lack of time. I wish therefore to express my gratitude that the Lords did not succumb to pressure to push the Bill through in haste without sufficient scrutiny. I have commented on polling that shows that the majority of the public do not think that the Lords have deliberately delayed a Bill that was not in real need of amendment. A subsequent survey confirms that people want the Lords to amend or, if necessary, reject legislation that would threaten the vulnerable. I think this is what the Lords have done in this case and I hope that this will be appreciated also by members in another place. Please note that, while I am an academic with a longstanding interest in this topic, and in medical ethics more generally, the views expressed here are my own and do not represent the University or any other organisation to which I am affiliated.

With Gratitude

David Albert Jones MA (Cantab) MA MSt DPhil (Oxon) FHEA

House of Lord Terminally Ill Adults (End of Life) Bill debate 24 April 2026 (Hansard Volume 855 (Cols. 863-864)

Baroness Hollins

My Lords, I thank the noble and learned Lord for an opportunity to reflect on this debate. Nearly 250 Members have spoken in the debate, not the minority that have been spoken about. I remind the House that I am a past president of the Royal College of Psychiatrists and a fellow of three other royal colleges.

When my husband was diagnosed with motor neurone disease, he read that motor neurone disease was the most feared illness. He took a different view. He joked that he was just fading away. He had good care. I wish everybody did. He died naturally and peacefully at home with a smile on his face. Fear is infectious. Please let us not feed on fear.

The Bill's aim was to provide patients with a choice at the end of their lives. For that to be meaningful, it needs to be a real choice. I have introduced amendments to try to address the other side of choice: the lack of palliative care and the gaps in services that underlie so many of the distressing stories that we have heard; the lack of clarity about

the actual means by which someone would be assisted to end their own life; and the risk of implicit institutional coercion, when new processes and procedures change the culture in the NHS.

Let me give an example. Exactly 21 years ago this week, I had an encounter with a neurosurgeon. It was a day that changed my family's lives and mine for ever. The outcome could have been so very different, and I do not like to think about that. It was about choice at the end of life, but whose choice? The actual choice about whether to live or die was in the hands of the doctor—let me explain. The doctor's clinical team had been distressed when a judge

approved the request of a previous patient with a high-level spinal injury to turn off her life support. He did not want to put his team through it again. Just one case of having to turn off a young woman's life support had been enough to change his attitude and the culture of care in his team.

My unconscious daughter was being ventilated after a major injury, and the surgeon refused to admit her to intensive care. My daughter's husband was the chief persuader to give her a chance to live—to admit her to intensive care, to give her a chance and to respect the choice of those who knew her best. During the conversation that followed, the surgeon was in tears about the situation, and I, the mother of his new patient, was his comforter. He thought that my daughter's life would not be worth living and that she would be so disabled that she would soon ask for her life support to be turned off too. He admitted her.

My daughter recovered consciousness. She had a high-level spinal injury and would be permanently paralysed, and she could not talk. We taught her to spell words by opening her eyes letter by letter, as we recited the alphabet to her. Ten days after her injury, she blinked the letters of a poem, which gave us hope. It went like this:

"Still Silent Body

But within my Spirit Sings

Dancing in Love-Light".

Some 21 years later, this is her reflection, dictated on her phone:

"I love my life and I'm so grateful to my family for fighting for it. I'm grateful to all those clinicians who helped to keep me alive after my injury, believing in the value of my life, especially in those early days when I doubted it myself. I'm grateful to have a health system that supports and cares for disabled people, supports that enable me to live a full, happy, useful life as a wife, mother, teacher and mentor, in my family and in the wider community. Even though I don't know how my health will look in the future, what I have learned over the past 2 decades of living with a spinal injury, is that, in the midst of the challenges, there are far more surprising gifts than I could ever have imagined".

My point is this: there is a real risk of implicit coercion at both interpersonal and institutional levels. This must be considered alongside explicit coercion in any future legislation. Keeping assisted

dying outside the NHS may mitigate these systemic and institutional pressures. I have tried to find some ways to make the Bill safer, to minimise any unintended consequences on patient care and the NHS. Sadly, the noble and learned Lord responded to all my amendments with the words, “I don’t agree”. I conclude that my concerns, and the concerns expressed by the medical royal colleges and organisations representing disabled people, have not and could not be addressed.

From Our Correspondent in Spain

Professor Marta Albert-Márquez

Professor of Philosophy of Law, Rey Juan Carlos University, Madrid

A month has passed since Noelia Castillo Ramos died. She was 25 years old. A traumatic childhood in a family broken by addiction. Then came the diagnosis of borderline personality disorder and failed psychiatric treatments. Later, abuse, suicide attempts, and a polytraumatic injury whose sequelae compounded an underlying psychiatric condition that included chronified depressive symptoms, long-standing suicidal ideation, and a psychological and emotional suffering that the patient herself described as unbearable. From a strictly somatic point of view, Noelia suffered a spinal cord injury that caused paraplegia in her lower limbs, with limited mobility assisted by a walker and two splints — a serious condition, but not a terminal one. Yet she felt, cruelly, the "absence of any vital horizon in her future".

Spain's euthanasia law and its interpretation by the Constitutional Court configure the right to die as a "fundamental right to self-determination with respect to one's own life in the euthanasia context" (sic) — that is, in

the face of "serious, chronic and disabling suffering, or a serious or incurable illness that generates constant suffering with no possibility of relief". The exercise of this right is subject to a dual condition that borders on an oxymoron: freely consenting while immersed in constant suffering with no possibility of relief.

Once Noelia's euthanasia was authorised, her father initiated a judicial procedure to prevent her death, in which the fulfilment of these requirements was called into question. However, the medical reports presented by Noelia's defence established,

without gaps, that valid consent existed and that her condition was serious and incurable. The judges considered that they were bound by the medical criterion, as they lacked the knowledge required to assess her capacity for understanding or the severity of her suffering.

It should also be noted that, throughout this lengthy process, the only court that examined the substance of the matter was the Superior Court of Justice of Catalonia. Under Spanish procedural law, the Supreme Court is strictly limited to determining whether a case raises questions significant enough to warrant a uniform ruling on the interpretation of the law — and found that this one did not. The court of first instance, the Constitutional Court, and the European Court of Human Rights all declared the case inadmissible — meaning they declined to rule, not that they rejected the father's claim on its merits. The Strasbourg Court's position on euthanasia has not changed following Noelia's case: the Convention does not support the existence of a right to die (Mortier v. Belgium, 2022).

Yet Noelia's case has generated an unprecedented impact on public opinion and deserves a calm and considered debate. In my view, that debate must distinguish between arguments that concern euthanasia in general and those that bear specifically on Noelia's case.

The Spanish law elevates the wish to die to the status of a fundamental right. This categorisation is open to criticism from many angles. Legally speaking, it is untenable insofar as it implies sanctioning a state duty to kill a vulnerable person. However broad the law's recognition of conscientious objection, this is an obligation incompatible with a rule-of-law State, as the Strasbourg Court itself has noted (Haas v. Switzerland, 2011). Having a right to die does not make us freer, because expanding the range of options available through State provision means enlarging the perimeter of State power — conferring upon it authority over a domain we have worked so hard to remove from its reach: the life and death of human beings.

Moreover, from the moment that disappearing becomes a legally protected option, staying alive means converting the fact of continuing to live — and of continuing to be "a burden" — into a conscious, daily decision. This is often an unbearable pressure, and one to which women, in particular, are especially vulnerable. All the more so in a country that, according to the latest global ranking,

sits in 28th place for palliative care — behind Uganda.

Beyond these considerations, Noelia's case raises some unavoidable questions. The first concerns the mechanisms for verifying that dual condition of valid consent and serious, incurable illness generating intolerable suffering — and the response to the wish to die in the context of chronic mental illness. The media have barely mentioned it, but anyone who reviews the case documentation can verify it: Noelia suffered from chronic depression with long-standing suicidal ideation, which the physicians did not consider sufficiently severe to interfere with the valid formation of her wish to die.

Spain is currently combating a sustained rise in adolescent and youth suicide. The Clinical Practice Guide on Suicidal Behaviour published by our own Ministry of Health establishes that persistent suicidal ideation accompanied by a history of prior attempts is a risk predictor, and recommends active intervention oriented towards the protection of the patient. That the verbalisation of a wish to die — even within the parameters of the euthanasia law — should mean exiting this system of protection in order to enter the procedure for access to the assisted dying benefit is not merely a glaring internal contradiction. It is a serious challenge to the credibility of our public policies on the prevention of child and youth suicide. This is all the more striking given that Noelia's physical condition, as described above, was serious but far from terminal.

The second question takes us from the legal terrain to the social. Laws do not merely regulate conduct in the abstract. They send messages; they express our collective stance towards a problem. It is impossible not to be moved by Noelia's tragic story — and it is essential to reflect on the right to die as a response to the meaning of suffering. Our commitment to the pain of others cannot be activated too late. We responded to Noelia when she was already persuaded that her life was unliveable. We did not know how to open that horizon of hope she lacked. We did not commit to her. All we managed to do was set in motion a procedure that would end up killing her without any of us committing homicide, and that authorised us to tell ourselves a version of the story that transformed an abandonment into a civic celebration of the struggle for rights.

But if Noelia died of despair, we all killed her. A person's hope is a reflection of the love she receives — the love others give

her, the love Noelia deserved. To pretend that we settled our debt with her by granting her access to the assisted dying benefit — a benefit provided free of charge by the National Health System, like any other medical procedure — is a supreme exercise in collective hypocrisy.

In this sense, the words of Pope Leo XIV's apostolic exhortation *Dilexit te* acquire full relevance here, hovering over Noelia's case and addressing Catholics and all people of good will alike, inviting each of us to change our entire approach to the problem. Perhaps the question is not whether Noelia truly wanted to die. The question is whether *we have loved her*.