Compromising on assisted suicide: is 'turning a blind eye' ethical?

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Abstract

Following the decision of the House of Lords in *Purdy*, the Director of Public Prosecutions was required to promulgate guidance as to how prosecutorial discretion is exercised over the decision of whether to prosecute or not under the Suicide Act 1961. The resulting policy essentially confirms that if a lay person, who is motivated wholly by compassion, provides minor and reluctant assistance to a mentally competent adult, he or she is extremely unlikely to be prosecuted. Consequently, prosecutorial policy over cases of complicity in suicide might be viewed as presenting a procedural compromise between explicitly allowing and robustly prohibiting assisted suicide. This paper explores the legal and ethical implications of compromising over complicity in suicide.

Introduction

The Coroners and Justice Act of 2009 updated the language of the Suicide Act of 1961, so that complicity in suicide might be proved when a person 'does an act capable of encouraging or assisting the suicide or attempted suicide of another person'. A person convicted of complicity in the suicide of another remains punishable by up to 14 years in prison, yet in the context of assisting an individual who chooses death in order to escape suffering, the law seems increasingly willing to turn a blind eye. Since its inception in 1961, section 2(4) of the Suicide Act, which provides that 'no proceedings shall be instituted under this section except by or with the consent of the Director of Public Prosecutions' (DPP), has created uncertainty over the manner in which prosecutorial discretion is exercised. The House of Lord's swansong in the case of *Purdy* determined that Debbie Purdy's desire to seek an assisted suicide, in order to avoid a natural death from multiple sclerosis, engaged the right to respect for private and family life under Article 8(1) of the European Convention on Human Rights (ECHR).¹ Thus, in order for any interference with Article 8 rights to be lawful under the exception provided by Article 8(2), the law must be articulated clearly. The House of Lords ruled that the existing general prosecutorial policy guidance was inadequate and insufficiently clear with respect to its application to a case of suspected complicity in suicide.

Thus, Purdy was victorious in her application to compel the DPP to promulgate specific guidance as to how prosecutorial discretion is exercised.

The resulting policy essentially confirms that if a lay person, who is motivated wholly by compassion, provides only limited and reluctant assistance to a mentally competent adult, he or she will avoid prosecution.² Health-care professionals and carers are identified as being at greater risk of prosecution, and anyone who might be seen as a professional suicide assistor would also risk prosecution according to the policy.³ But for the friend or relative who is 'wholly motivated by compassion', the risk of criminal censure seems negligible, especially where the suicide occurs abroad. Nevertheless, the policy does not change the law, and it might be observed that over the years a series of DPPs have adopted a motive-centred approach to determine which cases should be prosecuted, resulting in no prosecutions for assisting in a suicide that occurred abroad. However, the clear articulation of the factors that will place a complicit individual beyond the reach of the criminal law represents an important development in the law. Consequently, prosecution policy with respect to the exercise of prosecutorial discretion over cases of complicity in suicide might be viewed as presenting a pragmatic, procedural compromise which sits in the middle ground, between explicitly allowing assisted suicide (which would be unlawful given the Suicide Act) and robustly prohibiting it.

This paper considers the legal and ethical implications of such a compromise by contrasting the current approach to two alternative approaches at either end of the spectrum; the legalization of some form of assisted dying, or a prosecutorial policy which reinforces the criminal prohibition irrespective of motive. Because the opposing arguments and issues are primarily principled, value-laden

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and consequently highly subjective, with extremely entrenched ethical conflict over what is and what should be acceptable in relation to assisted dying, determining whether compromise is ethical is difficult. Nevertheless, I propose that by comparing the prosecutorial compromise to the two alternative positions, we can determine some conclusions about the ethics of compromise in this context. Throughout my comparative exercise, the nature of the ethical compromise is considered by reference to the key arguments for and against the legalization of assisted suicide, as well as the possible respective consequences. After balancing the potential risks, burdens and benefits of continued compromise against the alternatives, I conclude that although there may be some benefits to turning a blind eye, obfuscating over important moral questions is ultimately unsatisfactory. Thus, clear parameters are required in order to determine exactly when assisting in suicide is justifiable.

The nature of compromise

Compromise is an amorphous concept that carries both positive and negative implications. Compromising for the greater good may be seen as heroic in some contexts, but compromising one's principles can equally be damaging, involving a loss of integrity that may be difficult to recover. Given that the law must determine solutions that balance society's conflicting interests and concerns in the least harmful manner, it is evident that the law might often be seen to provide compromises. For example, the 14-day-rule with respect to experimentation on human embryos reflects a position of compromise which seeks to facilitate research while according status to human embryos.⁴ While the law on assisted suicide has remained formally unchanged and, thus, steadfast in its prohibition, the exercise of prosecutorial discretion has reflected a more liberal approach, which has perpetuated a permissive climate which might be seen to offer a procedural compromise. With the post-Purdy policy, we see formal recognition of the factors and circumstances which will excuse an individual from committing acts which remain technically criminal.

In consideration of the effects of the policy, if continued prohibition serves to deter most from assisting in suicide while overlooking those who do so compassionately, we might observe that the legal *status quo* is working reasonably well as a *de facto* compromise between legalization and prohibition. It might be argued that the views of those opposed to the legalization of assisted suicide or euthanasia are formally respected by the criminal prohibition, while individuals determined to have an assisted suicide have had certain limited rights of autonomy legally endorsed. Alternatively, does this compromise position fail adequately to address any of the legitimate competing concerns? Is the so-called prohibition as effective as a sleeping watchdog, while those pressing for meaningful rights remain entirely dependent on helpful relatives (and often an expensive Swiss assisted-suicide organization) in the absence of any substantive right to die?

Others have considered whether, and to what degree, compromise between the polarized pro- and anti-legalization groups on the issue of assisted suicide or euthanasia is possible. Søren Holm⁵ has observed that 'agreeing to disagree' about what should be permitted in relation to euthanasia is philosophically complicated. The opposing arguments seem non-negotiable, with extremely entrenched ethical conflict over what is and what *should be* acceptable in relation to assisted dying. Because the differences between, for example, what John Harris and John Keown would like the law to look like,^{6,7} are principles which neither party would willingly cast aside, resolution is clearly difficult if not impossible. For Holm, the possible 'compromise' identified involves the legalization of voluntary euthanasia. Unsurprisingly, Holm concludes that for those opposed to legalization, such a move would be too bitter a pill to swallow. Any movement away from the existing prohibitive *status quo* would be a terrible blow, thus there is nothing to be gained by such a compromise. It should be noted, however, that Holm's compromise is one-sided. Those opposed to legalization would lose everything while those in favour are not required to compromise at all, except perhaps in relation to any restrictions placed upon the legal model.

In contrast, Richard Huxtable has explored a more neutral proposition in order to consider how a move from conflict to compromise might be possible.^{8,9} Such a compromise, according to Huxtable, would stop short of actually legalizing euthanasia or assisted suicide – instead adopting a more nuanced approach to homicide law. This would, for example, reduce murder to voluntary manslaughter on grounds that the defendant was motivated by mercy. Thus, Huxtable's compromise inhabits the middle ground rather than going so far as to legitimize any form of assisted dying. Such a middle ground compromise might be seen to reflect what has occurred in relation to complicity in suicide. Consequently, it is interesting to develop the notion of compromising on assisted dying in order to explore whether such an approach might provide a solution to this most difficult of moral dilemmas.

Excusing the inexcusable?

Assuming that there are good reasons for maintaining an absolute criminal prohibition against assisting in suicide, the sanctity of life principle together with concerns over protecting the vulnerable and avoiding sliding down a slippery slope toward a culture of euthanasia might be identified as the main arguments against legal change.⁷ With this in mind, the practical consequences of turning a blind eye might be seen to provide evidence that the ethical concerns are justified, and in order to avoid morally dubious outcomes, we should seek to reinforce the criminal prohibition more robustly. How, then, does the current policy serve these concerns? In order to address this question, I shall first compare current policy to a more rigorous prosecutorial approach.

The first potential problem with a policy of turning a blind eye relates to the manner in which we have arrived at

this juncture. It might be argued that the current policy has, in the absence of any democratic process, determined that the existing prohibition provided by the Suicide Act should be ignored in the majority of cases. Indeed, the House of Lords decision in *Purdy* has been subject to some criticism for promoting the autonomous rights of individuals at the expense of the criminal code.¹⁰ Equally, the nature of the office of the DPP has led to questions over whether, in placing the responsibility for formulating policy on such an important moral matter in the hands of an unelected official, constitutional traditions have been disregarded. For example, Williams has argued that ‘...ordering the DPP to publish a policy guidance document which effectively decriminalises assisted suicide, is not the way in which the law can or should be changed in the UK’.^{11,12} In response, it can of course be argued that the House of Lords were fulfilling their judicial obligation (under the Human Rights Act 1998) in recognizing the importance of Article 8 of the ECHR, which had, in the earlier case of *Pretty*,¹³ been established as being engaged on the question of an individual seeking an assisted suicide. Thus, having correctly understood that Article 8 provides an obligation upon the state to articulate the nature of the interference with a competent adult’s right to choose death, the House of Lords were compelled to charge the task of clarifying policy to the DPP. In turn, the DPP was fulfilling his duty and merely acting within his role as chief prosecutor by specifying which factors will influence the decision to prosecute. Moreover, the DPP did not simply pluck the policy from thin air. An interim policy sought to reflect existing prosecutorial practices and a public consultation exercise gathered views from interested parties, which were then influential to the final policy. As I have discussed elsewhere,¹⁴ however, the nature of the final policy invites concern over the parameters of excusable complicity. As Lewis notes, ‘The consultation document simply listed public interest factors for and against prosecution. No attempt was made to explain the reasons why these factors were chosen and why other factors were not’.¹⁵

Turning to the effects of current policy, it might be contended that in perpetuating a policy of non-prosecution, the current approach fails to uphold a sufficiently stringent or clear message that it is criminal to assist in suicide, thus negating any deterrent value of the prohibition. Accordingly, assuming the law has a deterrent effect, it fails (or at least falls short) in the valuable objective of deterring people from assisting in suicide. If the chances of being prosecuted are so low as to be negligible, what is to prevent increasing numbers of people from disregarding the criminal prohibition? Moreover, would a robust policy which sought to defend the prohibition provide a more effective deterrent? While consideration of the deterrent value of the criminal law on an issue like complicity in suicide might be difficult to measure, and there is not the space for more detailed consideration here, it seems reasonable to speculate that the nature of the offence is such that it may well be subject to possible deterrence. Unlike other broadly comparable offences against the person, assisting in suicide is not a

‘heat of the moment’ offence. Generally, careful planning is involved and so possible offenders will have time to consider any negative consequences, as will the so-called victim, who might be deterred from asking for assistance if he or she knows that it will spell trouble for any assistor. Indeed, this was one of Debbie Purdy’s key arguments. But bear in mind that if complicity is excusable on the basis that the individual acted compassionately and unselfishly, an altruistic assistor might put aside fears of criminal consequences in the quest to enable the victim to escape terrible suffering. The very nature of excusable complicity under the policy implies putting aside selfish concerns. Consequently, we may speculate that the majority of potential offenders might not be deterred even if the criminal consequences seemed more serious. Moreover, it is arguable that only prosecuting in obvious cases of bad motive maintains the deterrence to those who seek to benefit from the death of the victim, while excusing those who have acted compassionately.

On the question of the impact on our justice system, the current policy clearly avoids overcrowding the criminal justice system with (seemingly well-intentioned) people who reluctantly complied with desperate requests from relatives (or partners or friends), and who are extremely unlikely to offend again. Thus, the policy saves expending state resources in prosecuting well-meaning suspects and then possibly even imprisoning them. In view of the main objectives of imprisoning offenders (deterrence, retribution, rehabilitation and protecting society), it seems that if a more robust prosecution policy resulted in many assisted suicide convicts spending time in prison, it would be a disproportionate response. Custodial sentences would not, in the majority of cases, serve any purpose other than perhaps retributive justice, and in the context of a criminal justice system in which more obviously ‘bad’ offenders, such as those committing acts of violence, are often not imprisoned, it would hardly seem appropriate to imprison the majority of suicide convicts.

Following on from questions over the possible deterrent effect of the law and the impact on our criminal justice system, it might be argued that the current policy fails to protect public safety because vulnerable people (for example, the disabled or the terminally ill) are at risk by virtue of a policy which tolerates assisted suicide. Particularly where the services of Dignitas are concerned, it seems that the option of an assisted suicide is increasingly being viewed as an end-of-life possibility. Moreover, if the state condones this option by failing to intervene in order to prevent or even discourage it,¹⁶ a Swiss suicide will become normalized among end-of-life choices. Furthermore, it can be contended that we are failing to promote important societal values such as the sanctity of life. By accepting that some people should reasonably be permitted to choose death (if one views the policy of so doing), are we failing in our duty to care for the most vulnerable people in society by supplanting quality-of-life concerns over the sanctity of life?

These are difficult questions to address. In response it may be said that the current legal picture tolerates only

the compassionately motivated to reluctantly and non-selfishly assist in suicide, thereby treading a sensitive path. This can be viewed as a humane response, which enables those determined to die to do so in the company of loved ones, with some dignity. In accordance with the House of Lords' instructions, the policy recognizes the importance of autonomy by highlighting the relevance of the so-called victim's 'voluntary, clear, settled and informed decision to commit suicide'.¹⁷ Thus, although the policy may be criticized for turning away from our traditional adherence to sanctity of life principles, it reflects a balance between respect for life and respect for self-determination. Those who assist in the suicide of a person who no longer values life (instead insisting on the right to choose death), will not be prosecuted, but for those who encourage the suicide of a person who has not made that choice, or whose mental competence is in doubt, the policy is clear that prosecution is likely.

Before considering how legalization might impact on society, one final advantage of a more robust stance might be seen in promoting a more transparent approach, such as is advanced by most criminal offences. Notwithstanding that prosecutorial discretion is a common element of our justice system, the level of discretion and consequent obfuscation that surrounds the offence of complicity in suicide presents a morally incoherent approach that fails to engage with the important objective of determining an ethically acceptable path. In spite of the post-*Purdy* policy, the prosecutorial question remains highly discretionary, and by focusing on the suspect rather than the circumstances which compelled the victim to seek death, the moral basis of the possible excuse is elliptical. While the policy identifies bad motive and evil intent as rendering one liable for prosecution, as well as identifying factors which are almost certain to excuse one complicit in suicide, it fails to really engage with the ethical question of exactly when complicity in suicide *should be* excused. For example, according to the policy, the health of the victim is irrelevant to the prosecutorial decision. Clearly, there were sound reasons for removing the original reference to the victim's health which featured in the interim policy,¹⁸ but the majority view seems to be that assisting in suicide (or euthanasia) is only acceptable for those suffering from terminal or very serious illness.¹⁹ With this in mind, note that misguided compassion is compassion nonetheless. If assessing the motivation of the accused is an entirely subjective exercise, what happens to the person who compassionately assists in the suicide of a temporarily depressed but otherwise healthy friend? While the academic exercise of comparing existing policy to a policy of robust prohibition may not provide answers to fundamentally subjective questions, we can, at least, see some advantages in a position that is morally coherent and instructive as to which behaviour is regarded as acceptable.

Live and let die?

Having considered how a more robust prosecutorial policy might at least provide clearer answers to the question of

what is permissible, arguably such an approach would also override any consideration of the autonomy and suffering of the so-called victim. Thus, I consider whether legalization might avoid some of the problems identified. Before focusing on what impact legalization might have, it is worth noting how some jurisdictions have addressed the moral dilemma over assisted dying by some form of legalization. For example, in the Netherlands, both voluntary euthanasia and physician-assisted suicide (PAS) are legal for those suffering unbearably without prospect of improvement, within a strictly medical model of assisted dying on request.²⁰ Meanwhile, across the Atlantic in the USA, the states of Oregon and Washington have legalized PAS. For instance, in Oregon, competent adults suffering from a terminal illness from which they are expected to die within six months, may, subject to fulfilling the legal criteria, receive a fatal prescription in order to commit suicide.²¹ Having regard for how legalization within this jurisdiction might be achieved by reference to previous attempts by Lord Joffe,²² it is proposed that the comparative model would bear resemblance to the Oregon law, legalizing only PAS for competent adults suffering intractably from a terminal illness from which they are expected to die within six months. This model is proposed in order to limit the scope of legal change to complicity in suicide rather than also, and more controversially, requiring reform of homicide law. Moreover, the key arguments in favour of legal change (autonomy, the alleviation of suffering) would arguably be satisfied by legalizing PAS but not euthanasia. Even those, such as Dianne Pretty, with extremely restricted physical capability would be able, with assistance, to ingest the necessary drugs. While the Dutch approach effectively advocates euthanasia as the easier route for the patient,²³ there are arguably advantages in making such an irrevocable decision, one which is not too easy, requiring the final act to be carried out by the patient. With this in mind, how would such a legal model compare with the existing policy of turning a blind eye?

Having assessed how the key arguments about legalization are served by the current policy in comparison with a more prohibitive stance, I consider how far the key arguments in favour of legal change are met by the respective positions. On both sides of the debate there are numerous arguments, but for the purposes of this exercise, it is proposed that self-determination coupled with concerns over alleviating terrible suffering are the most powerful arguments in favour of legalization. Although dignity is often cited as an important argument supporting legalization,²⁴ because there is no consensus on its meaning in this context, it is of limited assistance to any appraisal of possible approaches. As Biggs observes, 'it is the fluidity of the concept of human dignity that enables the hospice movement and the pro-euthanasia lobby to share the common goal of avoiding pointless pain and suffering at the end of life'.²⁵

One crucial advantage of legal PAS compared with current policy is that we might gain greater control over the phenomenon of assisted suicide by bringing it 'above

ground'.²⁶ This links into concerns that people with insufficiently serious health problems or with mental health problems might not be protected by current policy. Where suicide tourism is concerned, Swiss law does not require a terminal illness or even unbearable suffering in order to access PAS, although the Swiss doctor must assess the health of the patient in order to ensure he or she has capacity and has voluntarily determined to have an assisted suicide. For example, cases of UK citizens travelling to Dignitas have included a number of elderly people suffering existentially, as well as people with relatively minor health concerns.²⁷

Currently, we have only the retrospective opportunity to assess the appropriateness of the suspect's actions following the so-called victim's death. Clearly, this fails to provide any pre-emptive system of control and scrutiny which might appraise the reasons for suicide and seek to limit access to assisted suicide. An inevitable consequence of turning a blind eye is a lack of opportunity to offer possible alternatives or ensure, for example, proper psychiatric assessment and possible counselling. Evidently, legal PAS would provide opportunities to assess and protect potential victims and we may speculate that a significant number of those seeking an assisted suicide might be provided with alternative treatments which would deter them from seeking help in dying. What legalization could not necessarily do is prevent people from taking matters into their own hands or travelling to Switzerland in order to obtain what is unavailable at home due to any legal model being restrictive. Moreover, if those unable to have legal PAS within the jurisdiction simply turn to other means to get what they want, a key argument of legalization (gaining control and offering protection) is defeated. However, whereas the current approach offers little moral coherence by failing to determine exactly when assisting in suicide is acceptable, a legal model would at least differentiate between legally *justified* PAS and complicity which is not justified. For example, assisting in the suicide of a disabled person who is not terminally ill would not be justified. Thus, whereas Dianne Pretty would receive the help she wanted, a person seeking an assisted suicide because of disability, such as Daniel James,^{28,29} would not. This would reinforce a moral line even if after the event such complicity might be excused (but not justified), because there is no public interest in prosecuting.

Another way in which current policy fails to provide a morally coherent approach relates to the factor identifying health-care professionals and workers as being at heightened risk of prosecution despite the fact that they are arguably far less likely to be motivated by the prospect of gain rather than, for example, the victim's family. It is beyond the scope of this paper to consider the merits of medical assisted dying against the alternative.³⁰ However, if our current prohibition reflects a desire to limit assisted suicide, any legalization would arguably continue a policy of restriction and, as legalization subject to health-based limitations seem to meet with societal approval, we might assume that such limitations would

be required. Thus, doctors would have an important role to play in diagnosing and assessing patients. Trained medical professionals of some description would also have responsibility for prescribing, although in the event that this function conflicted with religious or ethical beliefs, any law could contain a conscientious objection clause which would enable a doctor, nurse or pharmacist, for example, to decline to provide assistance.

As noted above, a potential problem with creating health-based limitations upon access to assisted suicide lies in the message it sends out to certain potentially vulnerable groups. By not identifying certain groups as potentially eligible, or at least less worthy of protection, current policy does not discriminate. However, despite providing legal equality, is the policy actually more likely to fail the truly vulnerable, such as those who choose death for objectively trivial health troubles? If so, how might any legal model compare? Research from the Netherlands and Oregon on the effects of legalization on vulnerable groups is open to interpretation.^{31,32} Patients suffering from HIV in Oregon were clearly identified as being more likely to turn to PAS, which might indicate that the alternatives for such patients were inadequate. Evidence from Oregon also suggests that improvements in assessing depression are necessary, but it seems possible that any legal model within the UK could address such concerns. One of the main problems in assessing the evidence from abroad lies in the conflicting interpretations of vulnerability. Determining what 'vulnerable' means is a vexed question, resulting in circular arguments which often cloud our understanding.³³ Moreover, without dismissing concerns that vulnerable people might feel disadvantaged by legalization, we might question whether promoting theoretical equality is more important than devising a morally coherent approach to the question of when assisted suicide is justifiable.

Turning to one of Debbie Purdy's main arguments, in relation to the opportunity available in Switzerland but not at home: under the current policy people might feel compelled to travel to Switzerland *sooner* than they would wish, because proper assistance is unavailable within the jurisdiction. Legalization would address this concern. Similarly, because 'professional' assistance is unavailable within the jurisdiction, the policy discriminates against those who are unable to make their own arrangements (to travel abroad independently or obtain the means to commit suicide unaided). Moreover, those who do not have a friend or relative willing to assist, or who cannot afford the cost are, depending on one's view, either disadvantaged or protected by current policy. Accordingly, legal PAS within the jurisdiction would have a dual effect of allowing people to live longer, avoiding a difficult journey to Switzerland, and secondly, equality of access might also be achieved. This would inevitably lead to more people gaining access to PAS than under the current policy, which brings us back to the spectre of the slippery slope. Would legal PAS invite ever-increasing numbers to choose death, and eventually lead to abuse or undesirable developments in our approach to caring

for the sick and elderly? Evidence from jurisdictions where assisted dying is legal suggests that numbers have remained stable and low. In the Netherlands, where euthanasia is preferred (by patients) over PAS, numbers have remained consistent at around or just over 2% of all deaths.³⁴ Numbers even fell from 2000 to 2005 (from 2.8% to 1.8%), although there has been speculation that a corresponding rise in terminal sedation might have accounted for some of the reduction. In Oregon in 2007, there were 49 deaths via PAS, which represented 0.15% of all deaths. In 2010, 65 people died via PAS, which represents a rise although the numbers remain low.³⁵ We should also remember that abuse or dangerous medical behaviour might occur regardless of the legal status of PAS.³⁶ Moreover, turning a blind eye might be seen as facilitating slippage down a slope by failing to engage with the reality of what is occurring.

Before concluding, it is worth considering how political and practical concerns may actually be far more influential to the debate than moral matters. Our elected representatives in Parliament are neither motivated nor sufficiently courageous to tackle this important moral dilemma. Being seen to promote death is politically dangerous, as Dr Evan Harris found to his cost following a campaign in the run up to the 2010 general election.³⁷ The wider implications must also be assessed, particularly at a time of great economic uncertainty. Continuing a policy of turning a blind eye saves placing any burden upon the state in relation to establishing, regulating and (possibly) funding the mechanisms to oversee or facilitate any legal model of PAS.

Conclusion

The compromise that current policy provides seems to meet some of the demands and address some of the legitimate concerns on either side of the debate. Nevertheless, it is argued that maintaining an (apparent) absolute prohibition but then ignoring all but the most heinous examples of complicity in suicide does not avoid the harmful consequences that legalization might bring. In the words of Dworkin, 'There are dangers both in legalizing and refusing to legalize; the rival dangers must be balanced, and neither should be ignored'.³⁸ Determining a satisfactory solution is a delicate balancing exercise that might easily lead to harmful consequences. But sitting on the fence, attempting to avoid commenting either way about the morality of assisted suicide via a policy of prohibition coupled with non-prosecution does not provide a satisfactory solution. As Coggon has observed, '...the best result is not paralysis in the face of epistemic uncertainty'.³⁹ Although, the competing concerns are not rationally comparable, we can nevertheless see how such concerns are served by the respective positions.

The legalization of PAS for the terminally ill would almost certainly invite more people to seek death, but at least those asking to die will be assessed and cared for rather than disregarded. Moreover, just as the current

compromise addresses some of the conflicting demands, legalization could offer a compromise that would address some of the concerns of those opposed. Restrictions that limited access to those in the final stages of terminal illness would respect sanctity of life concerns by reinforcing that it is only acceptable to assist suicide when life is almost over. Further limitations by reference to intractable suffering would also address concerns that only those whose remaining life would involve terrible suffering should be permitted PAS. Finally, concerns over the impact upon vulnerable people might be addressed by stringent safeguards which could provide far greater protection for the vulnerable than is currently provided by the policy of turning a blind eye. Such a restrictive model would also require compromise from those seeking a more permissive legal model. Access to PAS would be strictly limited and so those pressing for more expansive autonomous rights might be disappointed. Nevertheless, a line needs to be drawn, and at least legalization might provide a clearer concept of when complicity in suicide is ethical and when it is not.

Acknowledgements

This article has been developed from a paper presented at the AHRC project (The Impact of the Criminal Process on Health Care Ethics and Practice) conference: 'Privilege or Punishment: Doctors in the 21st Century', April 2011. I am very grateful to Professor Margaret Brazier and to the two anonymous reviewers for their helpful comments on an earlier draft.

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