Comment: DPP’s final guidance on assisted suicide prosecutions

The Director of Public Prosecutions has published his final guidance (http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html) on prosecutions for assisted suicide. I reproduce the public interest factors for and against prosecution here, with some initial reactions to the final factors and the changes from the interim guidance (http://kclmedicalethicsandlaw.wordpress.com/2009/09/23/comment-dpps-new-interim-guidance-on-assisted-suicide-prosecutions/).

Public interest factors tending in favour of prosecution
A prosecution is more likely to be required if:

(1) the victim was under 18 years of age;
(2) the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;
(3) the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;
(4) the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
(5) the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;

These factors relating to the victim’s request have been revised so that capacity is assessed according to the Mental Capacity Act 2005, and the request must now be ‘voluntary’ as well as clear, settled and informed. The request is now described as a ‘decision’ rather than a ‘wish’, which is an improvement as a ‘wish to commit suicide’ is insufficiently indicative of decisive action. (Unfortunately ‘wish’ recurs in Factor 5 against prosecution.)

Some jurisdictions have a waiting period between the request and the assisted suicide, to ensure that the request is sustained over time and to further ensure...
voluntariness (Oregon, and Belgium when the patient ‘is clearly not expected to die in the near future’). One way of incorporating such a cooling-off period into a factor-based approach would be to mention within Factor 3 in favour of prosecution the need for a certain amount of time to have elapsed since the request in order for the person assisted’s decision to be considered ‘settled’. The DPP, though, is concerned to avoid the charge that he is creating a regulatory regime for assisted suicide, which such a requirement might suggest. In the summary of consultation responses (http://www.cps.gov.uk/consultations/as_responses.pdf), the decision not to require written evidence of the victim’s request is explained as follows:

[such a requirement] is within the scope of processes and procedures that, in effect, create a regime for encouraging or assisting suicide. Only Parliament can determine the legality of such a regime – not the DPP – and accordingly, the CPS has firmly rejected any factor against prosecution that could be said to be a stepping stone towards the creation of such a regime. ([7.6])

(6) the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;

(7) the suspect pressured the victim to commit suicide;

(8) the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;

(9) the suspect had a history of violence or abuse against the victim;

Factors (6) to (9) are concerned with the suspect’s motives and the possible exercise of undue influence (which might cast doubts on the validity of the victim’s decision).

(10) the victim was physically able to undertake the act that constituted the assistance him or herself;

This factor is unchanged from the interim policy. However, it will bear far greater weight given the DPP’s decision to remove the factors relating to the victim’s condition and engagement with medical care.

In the Interim Policy, Factor 6 in favour of prosecution stated:

The victim did not have:

∞ a terminal illness; or

∞ a severe and incurable physical disability; or

∞ a severe degenerative physical condition;

from which there was no possibility of recovery.
Factor 4 against prosecution was the converse of this factor. Factor 10 against prosecution stated:

The victim has considered and pursued to a reasonable extent recognised treatment and care options.

In the summary of consultation responses (http://www.cps.gov.uk/consultations/as_responses.pdf), the decision to remove these factors is explained as follows:

A large number of respondents questioned the inclusion of these factors, arguing that it may be discriminatory to include factors relating to the health and disability status of the victim (over 1,500 respondents argued this in their general comments) … As a result of these views expressed during the consultation exercise, and upon further consideration, the CPS has removed [these factors] from the Final Policy. ([2.10], see also [6.14]-[6.17])

The removal of Factor 10 against prosecution is explained by the DPP’s decision (http://www.cps.gov.uk/news/press_releases/109_10/) to focus the factors against prosecution primarily on the suspect’s motives rather than on the victim’s characteristics. While the converse factor could nonetheless have been included as a factor in favour of prosecution (eg ‘The victim has not considered and pursued to a reasonable extent recognised treatment and care options.’), this was presumably seen as inconsistent with the decision to drop the references to the victim’s condition, based on concerns expressed by respondents over discrimination.

The need to avoid discrimination is undoubtedly important, but by removing any reference to the victim’s condition, it appears possible that a decision not to prosecute could be reached in cases of non-somatic suffering (suffering caused by a mental disorder, including severe depression) or existential suffering (‘life fatigue’ or ‘tired of life’ cases). The former is permissible under the Dutch regime if the patient is experiencing hopeless and unbearable suffering, the latter is not. In Belgium all reported euthanasia or assisted suicide cases have involved somatic suffering (ie suffering stemming from a physiological disorder). In Oregon the patient must be terminally ill.

The assisted dying regimes in the Netherlands, Belgium and Oregon (http://wp.me/piyyG-9p) all contain a requirement related to the victim’s condition or level of suffering. (Switzerland is currently debating (http://wp.me/piyyG-aT) the adoption of a requirement that the victim be terminally ill.)

Although this issue is not addressed in the final policy, nor in the summary of consultation responses and the CPS response to them, the BBC is reporting (http://news.bbc.co.uk/1/hi/health/8536231.stm) that:

Mr Starmer made clear [presumably at the press conference] that other factors which remain in the guidance make it clear that it would not be appropriate to help someone who does not need assistance in actually committing suicide.

Without any restriction based on the victim’s condition or level of suffering, the guidance is more liberal in this respect than most assisted dying regimes. Perhaps the discriminatory impact of an explicit reference to the victim’s condition could have been avoided by consideration of the Dutch model which focuses instead on the individual’s suffering rather than their underlying condition.

To return to Factor 10 in the Final Guidance, the CPS have not provided an explanation of the impact of removing the factors relating to the victim’s condition, and the extent to which Factor 10 might mitigate such impact.
(11) the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication;

(12) the suspect gave encouragement or assistance to more than one victim who were not known to each other;

(13) the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;

(14) the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care;

(15) the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;

(16) the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.

Factors 11-16 are concerned to ensure that assistance in suicide remains an amateur activity carried out by inexperienced individuals without the assistance of professionals or amateur organisations (as in Switzerland). Factor 14 has been expanded to include all medical professionals caring for the victim rather than only those caring for the patient in a care/nursing home environment. While this is at least a logical distinction, the CPS provides no real explanation for their pro-amateur stance, simply stating:

On reflection, the CPS believes that the emphasis of this factor should be around any healthcare worker who has the victim in his or her care. The fact such a person encourages or assists the suicide of the victim, whilst acting in that capacity, should be a factor in favour of prosecution.

Unlike all of the other jurisdictions which permit assisted suicide (and in the Netherlands and Belgium, euthanasia as well), where the activity is carried out in whole or in part by physicians, the inclusion of these factors will discourage the involvement of physicians, unless the person assisted is fortunate enough to have someone with medical expertise amongst his or her family or close friends who is willing to provide expert assistance but who is not providing care in a professional capacity. The reasons for the privileged status of the reluctant amateur over the expert professional are unclear. Why is there a greater public interest in the prosecution of health care professionals if they are wholly motivated by compassion (Factor 6 in favour of prosecution; Factor 2 against prosecution)? If assisted suicide is thought to be incompatible with the professional role, surely this is a matter for the General Medical Council and the Nursing and Midwifery Council, rather than the DPP.

The advantages of medical involvement are manifold, and include a lower risk of botched suicides and suffering during the suicide or attempted suicide [R.S. Magnusson, Angels of Death – Exploring the Euthanasia Underground (Yale Univ. Press, 2002) 202-10; S. Jamison, ‘When Drugs Fail: Assisted Deaths and Not-So-Lethal Drugs’ in M.P. Battin & A.G. Lipman, eds., Drug Use in Assisted Suicide and Euthanasia (Informa Healthcare, 1996) 223-243 at 241] and the possibility of screening for possibly hitherto unknown mental disorders including depression.

Whether intentionally or not, these factors may keep the number of assisted suicides which take place entirely within the UK relatively low. There will still be an incentive to travel to a permissive jurisdiction such as Switzerland, when physically and financially possible, where such expertise is available. Those without supportive friends and family may commit suicide earlier than they would have wished, or travel to Switzerland when they are still able to do so on their own.
By strongly discouraging medical involvement, the guidelines place a heavy burden on supportive friends and family. If travelling to a permissive jurisdiction is not possible, for financial or health reasons, then the burden of assisting the suicide will fall on someone with no experience (Factor 12 in favour of prosecution) and no access to relevant information (Factor 11 in favour of prosecution). “Medical condition, body build, drug history and narcotic tolerance are all variables that must be factored in when developing a specific strategy to achieve death.” [Magnusson at 203]. Without this knowledge, and without access to appropriate medications, the guidelines are likely to result in assisted suicides which are more difficult, less successful and more stressful for the person assisted and his or her friends and family (including the suspect) than would be the case if medical expertise were permitted in some form.

Public interest factors tending against prosecution

A prosecution is less likely to be required if:

(1) the victim had reached a voluntary, clear, settled and informed decision to commit suicide;

(2) the suspect was wholly motivated by compassion;

(3) the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;

(4) the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;

(5) the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;

Factors (4) and (5) seem to encapsulate an idealised scenario that involves an unwilling ‘suspect’ and a determined ‘victim’. Again, no reasons for the inclusion of these factors are provided. What if the suspect is fully supportive of the victim’s decision, recognising that the victim has reached his or her own decision and agreeing that it is the right course of action for him or her in the circumstances? Does this make prosecution more in the public interest than if the suspect is ‘reluctant’ and sought to ‘dissuade’ the victim? Factor 4 envisages the decision to seek assisted suicide as an unwise or irrational decision from which the person should be dissuaded, or at least suggests that this is how the ideal suspect should react to the decision. The inclusion of these two factors seems to prescribe a certain kind of emotional reaction on the part of a family member or friend to the victim’s condition, for example, not accepting a terminal diagnosis, or wanting the person to remain alive as long as possible.

(6) the suspect reported the victim’s suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

Reporting of assisted suicides is in the public interest so that they can be properly investigated and recorded, and prosecuted when this is in the public interest.
This factor now includes ‘The suspect reported the assisted suicide to the police’ as recommended by me and presumably (no indication is given) other respondents.

Unlike the regimes in Oregon, Belgium and the Netherlands, no residency requirements have been included, although 36 consultation respondents suggested this, including me. In the absence of a requirement that the victim and suspect both be resident within England and Wales, individuals may travel to this jurisdiction in order to undertake an assisted suicide with significantly less chance of prosecution than there might be in their home jurisdiction, just as individuals travel to Switzerland for assisted suicides, and to Mexico to obtain veterinary euthanasia medications.