The DPP’s new interim guidance on assisted suicide prosecutions (http://wp.me/piyyG-9m) sets out a list of public interest factors in favour of and against prosecution. I reproduce them here, with some initial reactions.

The public interest factors in favour of prosecution are set out below.

1. The victim was under 18 years of age.
2. The victim’s capacity to reach an informed decision was adversely affected by a recognised mental illness or learning difficulty.
3. The victim did not have a clear, settled and informed wish to commit suicide; for example, the victim’s history suggests that his or her wish to commit suicide was temporary or subject to change.
4. The victim did not indicate unequivocally to the suspect that he or she wished to commit suicide.
5. The victim did not ask personally on his or her own initiative for the assistance of the suspect.

These first five factors are relatively non-contentious, focusing on the validity of the victim’s consent and the requirement of a request from the victim.

6. 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.
This factor relates to the extent of suffering experienced by the victim. ‘No possibility of recovery’ is a difficult standard to meet given the inherent difficulties associated with medical prognosis. What will constitute a ‘recovery’? Will it be a cure, remission, or an improvement in the victim’s condition?

In Oregon, assisted suicide is restricted to those with a terminal illness, which is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.” In the Netherlands and Belgium, a certain level of suffering is required. In the Netherlands, the “attending physician . . . must have been satisfied that the patient’s suffering was unbearable, and that there was no prospect of improvement”. In Belgium, the “patient [must be] in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident”.

(7) The suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that they or a person closely connected to them stood to gain in some way from the death of the victim.
(8) The suspect persuaded, pressured or maliciously encouraged the victim to commit suicide, or exercised improper influence in the victim’s decision to do so; and did not take reasonable steps to ensure that any other person did not do so.

Factors (7) and (8) 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 consent).

(9) The victim was physically able to undertake the act that constituted the assistance him or herself.
(10) The suspect was not the spouse, partner or a close relative or a close personal friend of the victim.
(11) The suspect was unknown to the victim and assisted by providing specific information via, for example, a website or publication, to the victim to assist him or her in committing suicide.
(12) The suspect gave 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 their assistance.
(14) The suspect was paid to care for the victim in a care/nursing home environment.
(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 a member of an organisation or group, the principal purpose of which is to provide a physical environment [whether for payment or not] in which to allow another to commit suicide.

Factors (9) to (16) seem 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). 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, here the involvement of a physician will remain unusual, unless the victim is fortunate enough to have someone with medical expertise amongst his or her family or close friends who is willing to provide expert assistance. This is likely to keep the number of assisted suicides which take place entirely within the UK relatively low. There will still be an incentive to travel to Switzerland, when physically and financially possible, where such expertise is available.

The public interest factors against prosecution are set out below.
“Some public interest factors set out below appear in both lists, because their presence or absence is either a factor in favour of or against prosecution, to be taken into consideration in each case.”

Where the factors appear in both lists, I have commented on them above.

(1) The victim had a clear, settled and informed wish to commit suicide.
(2) The victim indicated unequivocally to the suspect that he or she wished to commit suicide.
(3) The victim asked personally on his or her own initiative for the assistance of the suspect.
(4) 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.
(5) The suspect was wholly motivated by compassion.
(6) The suspect was the spouse, partner or a close relative or a close personal friend of the victim, within the context of a long-term and supportive relationship.
(7) The actions of the suspect, although sufficient to come within the definition of the offence, were of only minor assistance or influence, or the assistance which the suspect provided was as a consequence of his or her usual lawful employment.

Clearly assistance which is more proximate to the suicide than travel arrangements, such as providing medication, writing a prescription, or other technical or practical assistance with the act of suicide itself are unlikely to constitute ‘minor assistance’. Taking someone to Switzerland will be less likely to attract prosecution than providing more proximate assistance within the UK. The final clause of this factor may relate, for example, to someone who assists a suicide by dispensing medication which has been prescribed, or by prescribing medication for another purpose which is subsequently used in a suicide.

(8) The victim was physically unable to undertake the act that constituted the assistance him or herself.
(9) The suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide.
(10) The victim has considered and pursued to a reasonable extent recognised treatment and care options.

This is an interesting factor. It goes some way to providing a palliative filter. A palliative filter (debated but not included in the Belgian legislation) is a requirement that the patient be provided with advice by a palliative care team prior to consideration of a request for assisted suicide. Lord Joffe included a variant on such a filter in his Assisted Dying for the Terminally Ill Bill (http://www.publications.parliament.uk/pa/ld200506/ldbills/036/06036.1-4.html#j002) and it was...
discussed in the Select Committee’s Report on the Bill (http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8610.htm#a56).

(11) The victim had previously attempted to commit suicide and was likely to try to do so again.
(12) The actions of the suspect may be characterised as reluctant assistance in the face of a determined wish on the part of the victim to commit suicide.
(13) The suspect fully assisted the police in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing assistance.

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