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# The Suicide Tourist Trap: Compromise Across Boundaries

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**Abstract** Amongst the latest, and ever-changing, pathways of death and dying, "suicide tourism" presents distinctive ethical, legal and practical challenges. The international media report that citizens from across the world are travelling or seeking to travel to Switzerland, where they hope to be helped to die. In this paper I aim to explore three issues associated with this phenomenon: how to define "suicide tourism" and "assisted suicide tourism", in which the suicidal individual is helped to travel to take up the option of assisted dying; the (il)legality of assisted suicide tourism, particularly in the English legal system where there has been considerable recent activity; and the ethical dimensions of the practice. I will suggest that the suicide tourist—and specifically any accomplice thereof—risks springing a legal trap, but that there is good reason to prefer a more tolerant policy, premised on compromise and ethical pluralism.

**Keywords** Suicide · Assisted suicide · Health tourism · Compromise · Pluralism

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## Introduction

Neither assisted suicide nor "health tourism" is a new phenomenon but their coincidence in the form of "suicide tourism" is, and it is one which merits careful appraisal. News reports from across the world carry stories of citizens embarking on final trips to Switzerland, where the permissive policy on assisted suicide is not (unlike other such policies operating in, for example, the Netherlands) restricted to residents. Amongst the myriad ethical and legal questions are familiar ones about the justifiability (or otherwise) of suicide and assisted suicide. However, in this paper I want to reflect on the distinct questions raised by travelling to take up the option available in Switzerland, and I am particularly interested in the position of someone who helps the suicidal person to make that trip. My intention is to focus most closely on the associated legal and ethical issues. I will establish that there are problems with the way(s) in which the law can be brought to bear on assisted suicide tourism, not least in England where the practice has received intense scrutiny, such that no one can currently say with certainty whether it is lawful or unlawful; there is, in other words, a suicide tourist trap, which might (one day) be sprung. Law can, I argue, do better than this, and I aim to demonstrate how a more permissive stance can be defended, from a broadly democratic position which accepts the reality and defensibility of ethical pluralism.

## What is Assisted Suicide Tourism?

In order to assess the legality and morality of assisted suicide tourism it is, of course, essential to define the concept. Unfortunately, this is no easy matter, since each of the three constitutive terms is open to interpretation and contest. A few illustrations of the problems should suffice (Huxtable 2007, 3–9). First, there is "suicide", which is heavily laden with normative baggage and thus susceptible to intense disputes. Is it only those self-inflicted deaths that are directly intended which should carry the label or should (merely?) foreseen death come into its purview? Similarly "assisted suicide" is a concept which, despite its common currency, confuses more than it clarifies. A popular account holds that this involves a suicidal person enlisting the help of another in dying, such that this assistant clearly plays a causal role in their death but it is the suicidal person him or herself who performs the final, fatal act (Kamisar 1997, 228–229). The boundaries between this activity and "voluntary euthanasia" can evidently be difficult to discern but there are other difficulties here, not least the extent of the putative assistant's participation and, indeed, the extent to which (intentional) inactivity is also covered (e.g. Kamm 1998, 29–30). Finally, questions attend the use of the term of "tourism"; Guido Pennings observes that the association with recreational travel indirectly devalues the desire motivating the journey, although he recognises that it is probably too late to change the label now (Pennings 2002).

Notwithstanding these (and other) difficulties, we still need a working definition in order to evaluate the phenomenon, so I will propose a broad concept, which should be capable of containing (but not camouflaging) the central issues. Allow me to stipulate that "suicide tourism" involves travel by a suicidal individual from one jurisdiction to another, in which s/he will (or is expected to) be assisted in their suicide by some other person/s. "Assisted suicide tourism" (hereafter AST) in turn encompasses assisting the suicidal individual to travel from one jurisdiction to another, in which s/he will (or is expected to) be assisted in their suicide by some other person/s. This working definition should suffice to stimulate, and hopefully not stifle, ongoing debates about the scope, legality and morality of the practice and its key components. We can assume for our present purposes that the jurisdiction in which the suicide ultimately takes place is more permissive of assisted suicide than the place of origin. However, it is not inconceivable that travel would occur in other circumstances, for example, between two permissive jurisdictions, or between two prohibitive jurisdictions.[1] Nevertheless, in line with reported practice, I wish to focus on movement from a prohibitive to a permissive jurisdiction.

AST has recently involved travel to Zurich, Switzerland, where there operates an apparently unique policy. As is well known, various legal systems now permit a variety of actions intended to end the lives of seriously ill patients with their consent. However, in jurisdictions like the Netherlands, Belgium, Oregon, USA, and, previously, the Northern Territory of Australia, assisted suicide was—as a matter either of law or else of practice—only to be sought by a resident and performed by a doctor (cf. Coggon and Holm 2007). The Swiss policy is markedly different: Article 115 of the Penal Code only criminalises assistance in suicide that is motivated by "selfish" reasons, for example, for financial benefit. There is no other restriction in place, so it does not matter whether (or not) the assistant was a doctor—motivation, and that alone, determines criminality or innocence. It is easy to see how such a provision was (from the mid-1980 s) seized upon by local euthanasia groups and how it thereafter became possible for seriously unwell and suicidal individuals to seek help in dying, even if they resided in other jurisdictions and their assistant lacked medical qualifications (Hurst and Mauron 2003; Minelli 2007, 4).

Both the German and French-speaking wings of the Swiss euthanasia organisation *Exit* have distanced themselves from suicide tourism (Bosshard et al. 2003, 216), but *Dignitas*, a non-profit body founded by retired journalist and lawyer Ludwig Minelli in 1998, concluded that "there could not be any discrimination just because of the place of the residence of a person" (Minelli 2007, 3). Beginning

[1] Neither of these forms of travel can be dismissed as wholly unrealistic (e.g. Pennings 2002; Huxtable 2007, 56), although there is another form which looks much more remote: the situation in which someone seeks to move from a permissive to a prohibitive jurisdiction (provided there is someone in the latter jurisdiction willing, covertly, to help). The distinct questions raised by these sorts of travel are unfortunately beyond the scope of this paper.

with a German citizen in 1999, *Dignitas* has reportedly since facilitated more than 800 assisted suicides by non-Swiss nationals (Minelli 2007, 3).

Once contacted, the organisation provides background information (e.g. a brochure) and examines whether there are other ways of tackling or minimising the suicidal person's suffering, including through access to palliative care. For some people, information about and access to appropriate analgesics and other support will remove the desire to die, but where the desire endures there is the option of joining the organisation and seeking to avail oneself of *Dignitas*'s distinctive service. An applicant must submit a letter of request, along with a curriculum vitae and an up-to-date medical file, including information on the diagnosis, treatment and, if possible, prognosis of their condition. If *Dignitas* can locate a Swiss doctor willing to issue the lethal barbiturate prescription (which usually occurs within two months or so), then the applicant must obtain various legal documents (a birth certificate and the like) before the organisation will arrange the first meeting with the doctor. At this meeting—typically held another two months later—the doctor explores alternatives and seeks to ensure that the desire to die remains constant and is competently-formed, only after which will the prescription be issued. "This capacity is indispensable", explains Minelli, "and means that the person must be able to understand what shall be done and must also have the capacity to express himself, at least to answer questions by signs indicating 'yes' or 'no'" (Minelli 2007, 6).

*Dignitas* recommends that the applicant discusses their wishes with their loved ones, not only so that any opposition can be aired but also so that, if possible, a relative can be present at the end—usually in an apartment rented for the purpose. After consuming an anti-emetic (to prevent vomiting), the applicant is asked to confirm their wishes and, if determined, they sign a "Declaration of suicide" and the barbiturates are ingested. The final act is theirs, either through drinking a solution, injecting it through a gastric tube, or activating a pre-prepared infusion. Once death has occurred, the *Dignitas* escort will contact various authorities, who will investigate to ensure that no offence has been committed. Thereafter the body will be released, usually for cremation in Switzerland and subsequent burial in the applicant's home territory.

By early 2009, *Dignitas* had assisted approximately 1,000 suicides in Zurich (Sawer 2009). The international media confirms that the organisation has a global membership; indeed, 79-year-old Australian Dr John Elliott made public his suicidal trip to Switzerland (on which he was accompanied by prominent euthanasia campaigner Dr Philip Nitschke) (Rothschild 2008; see also AAP 2008). Although the issues raised by AST therefore have international significance, it is—understandably given the geographical constraints—in Europe where AST has generated the most attention. A study conducted by the *BBC* in November 2008 found that there were some 725 British members (who were exceeded in number only by Swiss and German members) and that approximately 100 Britons had been helped to die (BBC 2008). The story of one such applicant, Daniel James, helps to shed further light on the practice and its legal and ethical ramifications.

Mr James, who was born in 1985, was a student and talented rugby player, who suffered serious spinal injury during training in March 2007 (Starmer 2008). Diagnosed as tetraplegic, he was found to be incurably paralysed from the chest down and, although he retained normal mobility and strength in his biceps and triceps, he was unable to move his legs, hands or fingers. In November 2007 Mr James returned home from hospital, where he made three failed suicide attempts before, in February 2008—one week after his final unsuccessful attempt—he approached *Dignitas*. Three months later a Swiss doctor agreed to issue a fatal barbiturate prescription and Mr James opted to meet with him three times over two days; in July he received an authorisation form and schedule, which confirmed that the assisted suicide was due to take place on 12 September 2008.

Mr James' parents and health professionals initially sought to discourage him from his plan but they came to accept that this was his determined decision. A British psychiatrist confirmed that Mr James was aware of his loved ones' opposition and that he knew he had the right to reverse his decision, but that he remained resolute and, as numerous assessments demonstrated, competent in so deciding. Mr James' parents arranged for carers and also helped him with his correspondence and his travel plans, in which they were themselves assisted by a family friend (who booked Mr James a return ticket in case he should change his mind). Accompanied by both his mother

and father, Mr James took the trip and, on the scheduled date, he was helped by a Swiss doctor to die. His body was returned to the UK, where post mortem blood analysis confirmed the presence of a fatal dose of barbiturates.

Regardless of one's perspective on the legality and morality of assisted suicide, it is impossible not to be moved by a story like that of Daniel James. Indeed, his plight raises numerous questions not only *in* ethics and law but also *about* the nature of ethics and law, particularly in a pluralistic setting. Is there—and should there be—anything unlawful in the behaviour of Mr James' parents and, indeed, their family friend? Could and should any culpability attach to a health professional, if they have supplied medical information in the knowledge that this forms part of the evidence used by *Dignitas* in judging whether to assist in suicide? Moreover, how should we proceed when we are presented with conflicting answers to questions like these? In the following sections I aim to argue that, at present, anyone involved in AST is at risk of springing a legal trap but that, in theory, a case can be made for allowing patients like Daniel James to move from a place of prohibition to a place of permission—provided that it is also a place of protection.

## (When) Is Assisted Suicide Tourism Un/Lawful?

Whether anyone engaging in AST would (in theory or in practice) fall foul of domestic law will, of course, depend on the domestic law in question. If, however, we assume that the domestic law is prohibitive of assisted suicide, then *prima facie* this suggests that the legal officials would or could adopt a negative view of the phenomenon. Remaining with Daniel James' story, it is instructive to examine the position in English law, not least because it has witnessed considerable legal activity on these issues.

Following the Suicide Act 1961, suicide is no longer a crime in England, although "complicity in suicide" is: anyone who "aids, abets, counsels or procures" suicide is liable to imprisonment for up to 14 years (ss. 1, 2). The crime has two components, the *mens rea* (or mental element) and the *actus reus* (the physical element). The mental element is essentially "intention"—the accomplice must have intended to assist the principal offender in committing the crime (admittedly an awkward phrase given that the decriminalisation of suicide means that, strictly speaking, there is no principal offender and, indeed, no one "commits" suicide). Intention has perplexed the judges almost as much as it has the philosophers and theologians (Huxtable 2007, 93). The position now appears to be that not only will evidence of a direct intention to assist suffice, but also *foresight* of the prohibited result as a virtually certain consequence of one's behaviour will be sufficient for a jury to infer that the intention was present (*Woollin* [1998] 4 All ER 103).

Judicial ink-wells have also been exhausted in the quest to define the physical element(s) of accomplice liability, on which the 1961 offence rests. The main principles are that "aiding" and "abetting" require some agreement, encouragement or assistance being given before or at the time of the principal offence, while "counselling" involves consensus being reached prior to the offence and "procuring" means producing something, in advance, by endeavour (Huxtable 2007, 59). However, in the context of the 1961 offence, the judges believe that the phrase is best examined as a whole in determining whether or not a crime has been committed (*R (on the application of Purdy) v DPP & Another* [2008] EWHC 2565 (hereafter "*Purdy* no. 1"), para 5).

What is clear is that the English offence covers an "almost infinite" range of scenarios (*Purdy* no. 1, para 64). Cases that have led to conviction include instances of providing the pills, assisting in suffocation by holding pillows or securing plastic bags, and holding a shotgun in place (Huxtable 2007, 60–61). Although no central record is kept of these prosecutions, it seems there is an annual rate of one or two cases, which tend to result in conviction (*R (on the application of Purdy) v DPP & Others* [2009] EWCA Civ 92 (hereafter "*Purdy* no. 2"), para 19). However, the penalties imposed scarcely approach Parliament's maximum sentence; instead, they tend to be non-custodial or generally at the lower end of the sentencing scale, unless aggravating features (such as self-interested motives) are present (Huxtable 2007, 77–79).

In short, there is a considerable degree of flexibility in the English criminal law, which implies that the assistant in suicide tourism could well be culpable, although even then they might not serve any prison time. Consider the *mens rea*, intention: however

difficult the decision surely is for them, there must be relatives and friends who directly intend, through their actions, to help their loved one to travel to Switzerland in order to be assisted in suicide. Even if this is not so, English law suggests that (mere) foresight of their actions proving helpful in this way could suffice to satisfy the legal definition of intention. Indeed, there have been (controversial) cases in which failure to frustrate a suicidal relative's plan has been judged guilty (Huxtable 2004). The logic of such findings compels us to conclude that the mental element of the offence can be present in a case of AST.

The *actus reus* is also, apparently, not difficult to make out. There will certainly be some preparatory activities that will take place within the domestic state, such as making travel arrangements. The problem, of course, is that the final act of the (so-called) principal offender—the act of assisted suicide itself—is due to take place in another territory. Charles Foster, an English barrister, nevertheless cites judicial precedent which supports the conclusion "that the intended site of the suicide, and the lawfulness of the suicide in that jurisdiction, are irrelevant to the lawfulness of the aiding, abetting, counselling or procuring" in the state of origin (Foster 2004).

That would seem to be the end of the matter: as a matter of legal principle, AST clearly can amount to a criminal offence. However, the principles on which this proposition rest are by no means uncontroversial, particularly as the English lawmakers have elsewhere found it necessary to spell out that complicity in an act occurring outside the jurisdiction can be criminal (something they presumably would not need to do if the principles were clear).[2] Furthermore, the legal picture becomes much less distinct when we shift our focus from the criminal to the civil courts in England. In 2005 Mrs Z, who was 65 and suffering from the degenerative brain condition cerebella ataxia, sought her husband's help in obtaining assistance from *Dignitas*. Mr Z, like the remainder of the family, came to accept this decision, and he planned the trip, on which he intended to accompany his wife. At the time Mr Z was caring for his wife with support from his local authority. The authority came to learn of Mrs Z's plan and, deeming her a "vulnerable person" in line with the relevant legislation, it obtained a temporary injunction preventing her from travelling. A psychiatrist confirmed that Mrs Z was competent to make the decision she had reached and that she had done so freely. In the High Court, Hedley J discharged the injunction, explaining that the local authority's duty was to ensure that Mrs Z had made a competent, voluntary and informed decision; as this was indeed the case, the authority was not entitled to restrict her movement (*Re Z (Local Authority: Duty)* [2005] 1 WLR 959).

The message from Mrs Z's case appears to be in stark contrast to that on offer from the criminal lawyers. Hedley J, however, sought to preserve the appearance of consistency by claiming that it was not his job to clarify the criminal law (ibid, para 21). "The position of Mr Z", he commented, "is much less clear", although he added that it seemed "inevitable that by making arrangements and escorting Mrs Z on the flight, Mr Z will have contravened section 2(1)" (ibid, para 14). Tellingly, though, the final decision would lie with the prosecuting agencies, and ultimately the Director of Public Prosecutions (DPP) whose consent to prosecution is required by the 1961 statute (s. 2(4)). Although he remained anonymous, one can confidently conclude that no such prosecution was brought against Mr Z, simply because AST has never been the subject of prosecution in England.

At this juncture the legal position in England still looks confused: as socio-legal scholars would argue, the law-as-stated is out of step with the law-in-action, since the former implies guilt for the assistant in suicide tourism, while the latter implies innocence. This is not to say that the police and prosecutors have entirely avoided the phenomenon: there have been numerous investigations in recent years, although none resulted in court proceedings (Huxtable 2007, 63–66). The trap nevertheless remained, seemingly awaiting someone to spring it. After numerous unanswered calls for clarification of the prosecution policy in this area, a Mrs Purdy, who was suffering from multiple sclerosis, challenged the DPP's failure to promulgate the policy in the Divisional Court, in 2008.

Like Mrs Z, Mrs Purdy was contemplating travelling to Switzerland with her husband's help, but she did not want him to spring the aforementioned trap.

[2] Examples include complicity in female circumcision which is undertaken outside the UK: see the Female Genital Mutilation Act 2003 and, for a related discussion of conspiracy and "sex tourism", Alldridge (1997).

The court ruled that the DPP was not obliged to clarify the policy on AST. Mrs Purdy's claim had been based on the Human Rights Act 1998, which incorporates the European Convention of Human Rights directly into English law. Article 8 of the Act protects the right to respect for private and family life, and it had underpinned one of the central arguments of Dianne Pretty, a patient with motor neurone disease, who had unsuccessfully argued that English law ought to permit assisted suicide within its boundaries (*R (on the application of Pretty) v DPP* [2002] 1 FLR 268). Despite failing to convince the highest English court, the House of Lords, Mrs Pretty had been offered a glimmer of hope when she took her plea before the judges in Strasbourg (No 2346/02 *Pretty v UK* (2002) 35 EHRR 1). They too rejected the case, respecting the discretion afforded to individual states to legislate on the matter, but they conceded that Mrs Pretty's article 8 rights might be engaged in principle. Mrs Purdy tried to claim that this meant her rights were also engaged, and specifically her right to know the DPP's policy.

Finding that there was no basis for preferring the European court's ruling, the Divisional Court followed the House of Lords and thereby denied that Mrs Purdy's rights were engaged. It did, however, decide to consider whether, if they had been engaged, there was any basis for limiting them (such as through failing to publish precise prosecution guidelines). Here too the judges found that the DPP was entitled to exercise discretion. Sufficiently clear (albeit general) guidance was available, in the form of the *Code for Crown Prosecutors* (Crown Prosecution Service 2004), and if there was to be any substantive change in the law, this could only be wrought by Parliament.

As such, despite plenty of legal activity, there was little in the way of substantial clarification. Significantly, however, this was not the end of the matter, and here we return to Daniel James' story. Only days after the ruling on Mrs Purdy's case, Keir Starmer—a noted human rights lawyer—became the new DPP. Prominent amongst his initial responsibilities was the potential case against Mr and Mrs James and their friend. Once again no prosecution was launched, but on this occasion the DPP chose to make public his reasons (Starmer 2008).

According to the Crown Prosecution Service Code, a decision to prosecute must comply with two criteria: an evidential test and a public interest test (Crown Prosecution Service 2004). In line with the foregoing analysis, the DPP seemed satisfied that there would be sufficient evidence to offer a "realistic prospect of conviction". Preparing the documents for *Dignitas*, making payments and travel plans, and accompanying Mr James appeared to satisfy the *actus reus* (Starmer 2008, para 25). He expressed the *mens rea* in terms of an "intention to do the acts which the individual ... knew to be capable of helping, supporting or assisting the suicide", and noted that Mr James' parents were engaged in some form of joint enterprise and that the family friend's actions were also undertaken "knowing the purpose of the visit" (Starmer 2008, para 23, 24, 27).

Prosecution is not an automatic certainty, even when the evidence is compelling, because it must also be in the "public interest" to proceed. It was on this basis that the DPP felt that the case foundered. Certainly the offence in question was serious, but the factors mitigating against prosecution were considerable: the likelihood of a serious penalty and of re-offence were small; the offence was not pre-meditated nor were the potential defendants "organisers" in the relevant senses; no pressure had been placed on Mr James and no advantage was obtained; the acts were more remote than "direct" assistance in suicide; and prosecution was unlikely to boost "community confidence" (Starmer 2008, para 28–36).

What does this decision contribute to our understanding of the boundaries between the permissible and the impermissible? Regrettably, it does not ultimately settle the question of criminality, although it does (I will shortly argue) move the law in the right direction. The uncertainty remains because this was only one decision on one case—it was not the policy that Mrs Purdy sought (cf. Coggon 2008). However, a more lenient legal approach can be glimpsed, even within the second ruling on Mrs Purdy's claim, which was issued by the Court of Appeal shortly after the DPP's decision on Daniel James' case. There too Mrs Purdy's case failed, for reasons broadly similar to those developed in the lower court. In that court there had been hints of a non-prosecution preference: certainly, Baker LJ's emphasis might be telling, when he suggested that in a case of AST "the factors in favour of prosecution ... might be important" but that the "factors against prosecution ... may be particularly important" (*Purdy* no. 1, para 79). There then

followed the DPP's statement, and it is immediately apparent that many of the mitigating circumstances to which he referred are likely to be present in most—perhaps all—cases of AST (and, indeed, in cases of assisted suicide occurring wholly within the jurisdiction's boundaries). These themes again surfaced in the Court of Appeal, particularly in what it labelled a "footnote", in which the court pointed out its power to dismiss prosecutions, issue lenient sentences and "question publicly the decision to prosecute" (*Purdy* no. 2, para 80). The court added that such powers are rarely exercised but it is difficult not to detect a judicial softening here. Indeed, Ward LJ had also, in the course of argument, observed that Mrs Purdy's legal advisers could draw on "ample material" in determining the likelihood of prosecution, not least the DPP's statement in relation to Daniel James (*Purdy* no. 2, para 78). At least one English newspaper concluded that prosecutions would "be extremely rare and have little chance of success" (de Bruxelles 2009, 23).

Nevertheless we cannot say with certainty that the trap has been removed. The prospect of prosecution and conviction must still remain, given the principles embedded within the law as it is stated and, indeed, given its uneven application in other contexts (Huxtable 2007, 62–77). England—arguably no less than any other apparently prohibitive jurisdiction—may lack a definitive legal answer but its attempts to grapple with the normative dimensions of AST indicate various ways in which a legal system could, should and should not respond to the phenomenon. The challenge lies in developing a legal response that rests on suitable legal and ethical values, and it is to this challenge I now turn.

## Should Assisted Suicide Tourism be Un/Lawful?

As a phenomenon, AST has a degree of novelty, hence its inclusion in this exploration of new pathways in death and dying. Despite its innovative aspects, AST nevertheless engages with problems of ethics, law and politics that carry a long history. To do justice fully to the issues would require a series of much longer treatises, which would seek to strike at the essential nature of law, policy-making and ethical discourse. I can only sketch such ideas here, although I will try to plot a way forward which should achieve the best balance between the competing arguments that surround the practice.

Roger Brownsword (1993) provides a useful way into these issues in his analysis of the "rationality" of the law governing contracts, although the model of law he develops need not be restricted to that area. Siding with Lon Fuller, Brownsword's claims derive from a basic definition of the legal enterprise, which sees law as essentially concerned with "subjecting human conduct to the governance of rules" (Fuller 1969, 162). For it to succeed in this purpose, he argues, law needs to obey three central principles of rationality: *formal*, *instrumental* and *substantive*. Formal rationality is fundamentally concerned with consistency in and between the rules: like good Aristotelians, lawyers should ensure that like cases are treated alike. Instrumental rationality is more a matter of guaranteeing that the means suit and serve the ends of the particular rules. As in many similar accounts of the "rule of law", the legal system will be instrumentally irrational if the policies are not matched in legal practice(s). Conflicting messages should not be tolerated and could, at worst, signal an absence of law.

A cursory glance back at the policies and practices surrounding AST in England demonstrates the degree to which the law can fail to satisfy the demands imposed by these principles. What we must then consider is how the law can be brought into line with the dictates of substantive rationality, which, for Brownsword, means tethering it to some justifying norm(s) or value(s). In AST, at least, this quest for guiding values is bound to be fraught. Even within the boundaries of one territory, there will be deeply rooted division over the permissibility of assisted suicide. On the one side are the permissive arguments, premised on respect for autonomy and an obligation to respond to suffering; on the other lie appeals to the inviolability of life and fears of embarking on a slippery slope to unjustifiable (or at least more questionable) killings. The (voluminous) literature suggests that none of these positions is quite capable of completing the ethical jigsaw puzzle—but they nevertheless offer glimpses of important moral features (Huxtable 2007). Indeed, there is sufficient merit in these competing values that it seems unlikely that a wholly new end-of-life ethic could be devised, let alone command a supportive consensus. Assuming that there is something worth preserving here, I

believe that it is time to look beyond the stalemate to which these various arguments bring us. Ethical complexity and uncertainty is widespread and, thus far, irresolvable, even once we eradicate misunderstandings; yet, at the same time, the confused legal position in England and the legal vacuum it creates exemplify the need for answers (and not just in that jurisdiction). These circumstances suggest that a compromise policy offers the best way forward.

Although he does not deal directly with assisted suicide and euthanasia, Martin Benjamin has mounted a robust case for the value of compromise as a means of tackling bioethical dilemmas. He locates his arguments in a pluralist position, in which he recognises that "some important values, principles, rights, duties, and conceptions of the good are incapable of being combined into a single, fully consistent, comprehensive moral framework" (Benjamin 1994, 266–267). Given the aforementioned ethical complexity, there is certainly good reason to adopt Benjamin's stance in relation to assisted suicide (at least). No one can claim to have the last word in relation to the prohibition on, or permission of, assisted suicide, but efforts can be usefully directed to splitting the difference between the two, for example, by eschewing talk of justification and replacing it with the language of excuse. Indeed, the resulting compromise is likely to resemble the sort of the law that is already in place in England: the practice is marked out as criminal but the crime is neither ranked as heinous as murder nor administered in a punitive fashion. I have defended this idea elsewhere, along with a bundle of other rules and policies which make up the middle ground on euthanasia (Huxtable 2007, 141–174). What I mainly want to explore here is the move from purely internal rules and practices like these to those which have a longer reach.

There are various options available to the jurisdiction whose citizens are embarking on AST (or, indeed, any other form of "health" tourism), which Pennings helpfully describes as *coerced conformity*, *international harmonisation* and *inter-state ethical pluralism* (Pennings 2002). Coerced conformity can be ensured by restricting particular benefits and services to residents and by preventing residents from leaving to take up options available elsewhere, including through the use of criminal sanctions. Many permissive euthanasia policies have indeed been restricted to citizens, hence the novelty of the Swiss situation and the difficulties it has presented for other jurisdictions. However, we are most interested in the freedom (or not) to travel to take up such services and an outright restriction thereon immediately seems at odds with the pluralistic, compromising spirit. Put simply, the ethical arguments for and against assisted suicide remain suspended in a fine balance. If we continue to presume that the originating state is broadly prohibitive, then that must constitute a considerable victory for opponents of the practice. Such a position necessarily excludes the proponents, including those who would themselves wish to take up the option if available. As assisted suicide is indeed available elsewhere (subject to the satisfaction of certain criteria) it seems unduly heavy-handed of the jurisdiction of origin to seek to prevent or penalise those who seek to take up the offer.

Indeed, we arguably get no better answers by relocating the problem at the international level. For one thing, as I noted earlier, a consensus position will be difficult to articulate and secure: one can readily detect efforts to accommodate local preferences in various trans-national attempts to safeguard (so-called) "universal" human rights. Moreover, even if an agreement can be reached in principle, then there will undoubtedly still be people who will lose out, despite them sincerely holding to views that are no less susceptible to reasonable challenge than those held by the victors.

Rather than seek to enforce a blanket prohibition on travel or aim to instate international ethical uniformity, a compromise allows the home state to afford its citizens a measure of freedom, whilst also cleaving to a bigger bundle of overlapping and sometimes contradictory values. "Tolerance towards people with different moral positions, who express their disagreement in a peaceful manner, should be a characteristic of pluralistic society" writes Pennings (2002, 340). As one might expect, Benjamin and Pennings both adopt a democratic stance, in which there is a base line of tolerance, mutual respect and freedom (cf. Charlesworth 2005, 15–16). However, respecting such freedom in no way commits the state to pioneering autonomy at all costs; in other words, allowing AST need not mark the first step in the direction of allowing assisted suicide back home. Just as importantly, it also does not mean that the exits are carelessly flung open. Rather, in keeping with the idea that there are persuasive arguments on both sides of

the euthanasia divide, the jurisdiction of origin is entitled to ensure that there is suitable protection in place for its travelling citizens. At the very least, the home state should be free to guarantee that the permissive policies operating in the place of departure reasonably conform to their justifying principles i.e. respect for autonomy and the eradication of suffering.[3] Indeed, it does not seem overly heavy-handed for the originating state to insist on its own assessment(s), much as occurred in the English case of Mrs Z (whose mental competence was assessed and confirmed before she could depart). Even a staunch pluralist would surely accept that the move between prohibition and permission is best taken under protection.

I hope at least to have mounted a *prima facie* defence of allowing AST. The position is bound to be challenged and, without wishing to pre-empt too much how this interesting debate might develop, I will conclude by briefly addressing three possible objections, which are concerned with injustice, integrity and irrationality. The injustice objection will basically claim that AST will unfairly be the preserve of the wealthy. Here I defer to Pennings who notes that this sort of argument is often selectively employed and also misdirected: if we are really concerned about (social) injustice, then we should seek to tackle this across the board. Furthermore, it is also arguably unjust to deny someone with the means to travel the right to do so, particularly when their wishes are also being denied at home.[4] Secondly, compromise might be seen as an affront to integrity and conscience. As a pluralist, Benjamin sees no major difficulty here and WF May (2003) neatly conveys the central point, when he talks of "the rough landscape of policy-making in which one may need to compromise, not in the sense of defecting from duty but honoring [sic] duties which are multiple". Finally, it might be thought that I have abandoned any claim to consistency, such that I cannot coherently side with Brownsword's criteria for sound law. In answer to this, I would seek to differentiate between the levels inherent in Brownsword's model: it is at the level of ethical defensibility (or "substantive rationality") that I think we can re-assess any apparent inconsistencies in the rules that a formal and instrumental analysis reveal. Put differently, I think it better to swap the trap I have identified for the tightrope to which Benjamin refers in his defence of locating the middle ground between conflicting values: "One will, in walking such a tightrope, be responding to both sets of duties while fully doing justice to neither. The resulting ambivalence is part of the price we must pay to avoid the dehumanization of simple consistency in an unavoidably complex situation" (Benjamin 1994, 277).

## Conclusion

Despite its merits, any attempt to compromise is bound to come under attack, since (by definition) both sides not only make gains but also incur losses. Allowing AST nevertheless strikes the best balance between the reasonable but unavoidably conflicting positions usually adopted on the ethics of assisted suicide. More work is undoubtedly required in spelling out the conditions in which such a compromise is defensible and under which people should be free to travel. Equally, new accounts of the value of life will be offered, and new answers to perennial questions about assisted suicide and euthanasia will become available. Travelling to take up the option of assistance in suicide in another jurisdiction occupies, if you will, a new frontier in these ongoing developments. I hope to have shown why it can be right for a jurisdiction to allow its citizens to travel in this way, for reasons which Pennings succinctly captures: "It is preferable within a pluralistic society, when reasonable people disagree on the acceptability of a certain course of action, to look for a legal compromise that takes into account the positions of different moral communities and to avoid as much as possible radical prohibitions" (Pennings 2002, 341). The suicide trap should be removed; in its place should appear a tightrope, strung between firmly erected ethical poles, which we must learn to walk with care.

[3] In this regard it will be essential to monitor developments in relation to *Dignitas*, as there have been reports of investigations into profit-making (Sawer 2009) plus more general calls for tighter regulation of the assistance offered and greater transparency in the organisation's activities (Boyes 2008).

[4] There is undoubtedly more to say here, not least because the option does still seem to be limited to e.g. those who are still sufficiently well to travel and arguably also to those who can draw on help to travel. There will always be people who will lose (or miss) out in some way, particularly under a policy premised on compromise, but (for now) I will leave it to others to assess whether this is appropriate or just.

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