

Compromise Medicalisation

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Introduction

In *Bioethics, Medicine and the Criminal Law*,¹ Margaret Brazier and Suzanne Ost ‘tell a story about the ways that the criminal process engages with medicine and bioethics’—a story designed to explore and ‘to explain the interaction between the three when they meet in the theatre of the courts, the legislature and public opinion’.²

In fact, Brazier and Ost tell several stories, two of which inspire this paper. The first is a story about the use of ‘medicalisation’ (‘compromise medicalisation’ as we will term it) as a strategy for dealing with bioethical conflicts that divide communities. So, for example, Brazier and Ost present the Abortion Act 1967 in this light;³ and, putting the point more generally, they suggest that ‘medicalisation plays a useful if often criticised role in mediating between the polarized extremes of bioethical debate...offer[ing] a way forward that is less than intellectually first class, but better than the practical alternatives.’⁴ The second story highlights the ‘kindly’⁵ treatment typically accorded by prosecutors, juries and judges to doctors who follow their conscience and try to do the right thing (even when this might fly in the face of the law)—for example, ‘doctors who seek to practise compassionately at the end, or beginning, of life, [or] who seek to honour their patients’ wishes....’⁶

Against the backcloth of these stories, we suggest that, when Parliament introduces a measure of ‘compromise medicalisation’, this does more than change the law; crucially, it

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¹ Margaret Brazier and Suzanne Ost, *Bioethics, Medicine and the Criminal Law Volume III: Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge: CUP, 2013).

² Ibid 255.

³ Ibid 194 and 198-199. Cf, too, Andrew Grubb, ‘Abortion Law in England: The Medicalization of a Crime’ (1990) 18 *J L M & E* 146.

⁴ Brazier and Ost (n 1) 262-263.

⁵ Ibid 15.

⁶ Ibid 5.

changes the responsibilities of both doctors and legal actors. Post-enactment, the medical profession, as a trusted third-party, is charged with safeguarding the terms of the compromise; and, where doctors fail to discharge their new responsibilities, it is quite wrong for those legal actors who play a leading role in the theatre of the criminal justice system to default to a kindly attitude.

This chapter is in three main parts. First, we identify three distinct types of ‘medicalisation’ before specifying the nature of the special responsibilities that go with ‘compromise medicalisation’. Secondly, looking back at nearly half a century’s experience with the explicit statutory medicalisation of abortion, we consider whether there is any evidence that doctors are *not* taking their special responsibilities seriously, and whether the key legal actors continue (inappropriately) to treat doctors kindly. Thirdly, learning from the experience with abortion, we focus on the possible medicalisation of assisted suicide, as proposed recently by Lord Falconer’s Assisted Dying Bill (ADB 2014). Our question, in short, is whether we can be confident that the medical profession (and, no less importantly, the leading legal actors) would hold the legislative line and safeguard the terms of the compromise. Or, are opponents of the Bill right to fear that this might be the thin end of an unauthorised wedge?

Our conclusions are as follows. First, our experience in relation to the medicalisation of abortion is that the terms of the compromise have not stuck. Secondly, this experience rightly gives a cause for concern to those who oppose the Falconer Bill. Thirdly, if ‘compromise medicalisation’ is the intended strategy of the Bill, then it needs to be made absolutely clear that the medical profession stands in the position of a trusted third party with a special responsibility to adhere to the terms of the compromise. Fourthly, because—if the Bill succeeds in changing the law—there is a distinct possibility that public opinion in relation to the ethics of assisted suicide might also change, there needs to be a strategy for keeping the law and practice in alignment with reasonable public views. Fifthly, where the original strategy is one of compromise medicalisation, it cannot be the medical profession that has the responsibility for keeping the law and practice aligned with public opinion. Finally, if the Falconer Bill survives the Parliamentary process, it will be a controversial but legitimate development of the law. We suggest that, if the terms of this latest exercise in compromise medicalisation are to be modified, a similar process should be engaged—that is to say, a process that requires nothing less than a positive act of parliamentary approval; and there

should certainly be no change in the practice of assisted dying without proper legislative authorisation.

The Special Responsibilities Associated With ‘Compromise Medicalisation’

Broadly speaking, the term ‘medicalisation’ signifies that a particular kind of decision or procedure is entrusted to the medical profession. However, we can differentiate between three particular instances of this phenomenon. First, there is ‘exclusionary medicalisation’. Here, in the belief that some decision or procedure is uniquely within the range of expertise of the medical profession and that it would be unsafe for other persons to make the decisions or to undertake the procedures, we entrust the matter exclusively to the former, excluding those who are not members of the profession from making the decisions or undertaking the procedures in question.⁷ Secondly, there is ‘evolutionary medicalisation’, entrusting to the medical profession the task of adjusting medical practice so that it, and the law that authorises it, aligns with public opinion and reasonable patient needs and expectations. Thirdly, there is ‘compromise medicalisation’, which entrusts the medical profession with granting patients access to an ethically controversial procedure but if, and only if, the terms and conditions set by the legislative compromise are satisfied. While there is much to be said about both exclusionary and evolutionary medicalisation, in this chapter our interest is in teasing out the special responsibilities that attach to ‘compromise medicalisation’.

To locate ‘compromise medicalisation’ in a larger regulatory context: where communities are divided about the ethics of some matter—for example, about the ethics of divorce, or using human embryos for medical research, or abortion or euthanasia—a compromise might be brokered. Against a restrictive background, a degree of relaxation is introduced. However, the permission is subject to carefully specified conditions (a list of approved reasons, grounds, purposes, and the like) together with an appropriate process for authorisation by independent and accountable persons (whether judges, the members of a regulatory agency, or doctors). Ex hypothesi, the medicalisation of such contested issues as abortion and assisted suicide is controversial, sensitive, and above all a compromise: for pro-choice advocates, the permission will be too narrow; for pro-life advocates, the permission will be too broad.⁸ Nevertheless, it is of the essence of democratic politics that the compromise sticks in

⁷ Cf Michael Thomson, ‘Abortion Law and Professional Boundaries’ (2013) 22 *S & L S* 191.

⁸ See Brazier and Ost (n 1) 103-4 (for the ‘uneasy compromise’ in relation to abortion) and Ch 5 (for the distorted shape of the law in relation to end-of-life issues).

practice; and, to this end, there are safeguards and limits that operate both ex ante and ex post. Ex ante, doctors are required conscientiously and in good faith to assess whether a relevant application falls within the terms of the permission; and ex post, they are required to report the acts that they have authorised.

Clearly, post-enactment, it is not for doctors to follow their convictions in the way that they might when participating in pre-enactment debates; rather, it is now their (possibly unwelcome) responsibility to ensure that the terms of the regulatory compromise are faithfully observed.⁹ To be sure, this might put some doctors in a position that strains their commitment to the compromise. Nevertheless, in their ex ante practice, doctors should act in a way that is compatible with their position as trusted third parties, neither stretching nor squeezing the sphere of legal permission in order to satisfy their pro-choice or pro-life inclinations. Similarly, it is important, too, that legal actors are compliant so that, in the event that a doctor is found to have wilfully departed from the compromise, the response should be to enforce the law.

Yet, there surely must be some margin for both doctors and judges where they are faced with particular cases that expose some lack of clarity in the legislative scheme or that have simply not been anticipated.¹⁰ Where doctors have in good faith sought to respect the spirit and intent of the compromise, a kindly response is appropriate. However, more difficult questions are raised where the medical profession takes it upon itself to adjust the compromise so as to align it with what is perceived to be changing public opinion. The concern is not that doctors might misread public opinion; the point is that, if the scheme is one of ‘compromise medicalisation’, doctors simply should not be engaging in this exercise. Of course, if the legislation contemplates the profession being entrusted with an ‘evolutionary’ role, then that is a different matter; this is not ‘compromise medicalisation’

⁹ Subject to any right of conscientious objection: see Abortion Act 1967, s 4 (as interpreted by *Janaway v Salford AHA* [1989] 1 AC 537 and *Greater Glasgow Health Board v Doogan* [2014] UKSC 68); and the Assisted Dying Bill 2014 (ADB 2014), s 5.

¹⁰ We cannot, in this chapter, elaborate on this ‘margin’. In place of literal or mechanical interpretation, we are advocating an intelligent purposivism that is sensitive to the context in which the compromise was struck (cf Roger Brownsword, *Rights, Regulation and the Technological Revolution* (Oxford: OUP, 2008) Ch 6). That said, it might be thought appropriate to try to constrain departure from the terms of the compromise by drafting appropriate guidance for the benefit of both doctors and key legal actors. We emphasise, however, that it is important that any such guidance should be subject to positive endorsement by Parliament: cf Alexandra Mullock, ‘Overlooking the Criminally Compassionate: What are the Implications of Prosecutorial Policy on Encouraging or Assisting Suicide?’ (2010) 18 *Med L Rev* 442.

and the profession's new guidance and practice might well be legitimate. However, in the absence of express authorisation, the profession's licence to act this way might be at best implicit (possibly with encouragement from, or at least acquiescence by, the relevant government department) and its scope might be uncertain—raising larger questions of transparency and accountability that go well beyond the particular interests of the pro-choice and pro-life lobbies.¹¹ Moreover, if the standard criminal justice response is to show a kindly attitude to those doctors who defend their actions—whether their initial decision or their subsequent administration of the relevant procedure or treatment—on the basis that it is broadly in line with general practice, then legal actors risk becoming complicit in unlicensed adjustment of the compromise.¹²

Ex post, it is the special responsibility of doctors to report their authorising actions. Reporting is no mere bureaucratic requirement. At a general level, reporting enables the impact of the compromise to be monitored¹³; and it provides an evidence base for any tweaking of, or more radical revision to, the compromise.¹⁴ At a specific level, reporting functions as a prompt for whatever checks and further inquiries need to be made as to the propriety of the doctors' actions. It follows that, even though reporting obligations might be viewed as tiresome, they are an important part of the compromise package. As Brazier and Ost recognise, these packages might not always be 'intellectually first class' but they almost always reflect a delicate balance; and it is of the essence of compromise medicalisation that the balance—that is to say, the balance struck between the opposed ethical views—is maintained.

¹¹ Cf the recent history in the United Kingdom of the regulation of human fertilisation and embryology (particularly the criticism of the regulatory agency).

¹² Cf Brazier and Ost (n 1) 103 and 116-117.

¹³ Although there are important questions to be asked about the identity of the monitoring body—is it to be Parliament or a government department or both (as envisaged by clause 9 of the ADB 2014)?

¹⁴ However, it will only be a useful evidence base for tweaking if it is publicly accessible, or at least accessible to Parliament: see, e.g., *R (Department of Health) v Information Commissioner* [2011] EWHC 1430 (Admin).

Abortion and ‘Medicalisation’

Although the common law recognised that, if a doctor undertook an abortion in good faith for the purpose of preserving the life of the mother, then they would not have acted unlawfully,¹⁵ the Abortion Act 1967 reset the framework for lawful terminations in a way that makes it an exemplar of ‘compromise medicalisation’.

At the time of the 1967 Act, there was much that was not anticipated—not least, the development of modern abortion techniques¹⁶ and the fact that there would be a significant change in the delivery mechanism for abortion services (i.e., from NHS to independent sector delivery). Most strikingly, in 1967, it would have been absurd to have suggested that the legislation licensed ‘abortion on demand’; this would have been a sell-out to the pro-choice group and no kind of compromise. At the time, the Act was a hesitant endorsement of ‘the position that abortion *could* be acceptable medical treatment’;¹⁷ and, it was recognised that a ‘great social responsibility’ had been placed by the law ‘on the shoulders of the medical profession’.¹⁸ Nearly fifty years later, the big picture looks very different; the landscape of abortions has been transformed.¹⁹ Nowadays, abortions have been normalised; from allowing that abortions *could* be acceptable in limited circumstances, in all but name, abortion on demand is available. While it can be argued that practice has simply evolved to reflect changes in public opinion,²⁰ and while this might be consistent with ‘evolutionary medicalisation’, it is deeply problematic relative to ‘compromise medicalisation’.

The normalisation of abortion is reflected in many ways, not least in the fact that, since 1967, there have been very few prosecutions under the Act and hardly any successful ones

¹⁵ *R v Bourne* [1939] 1 KB 687 (CCC).

¹⁶ See, e.g., Margaret Brazier, ‘Unfinished Feticide: a Legal Commentary’ (1990) 16 *JME* 68.

¹⁷ See Brazier and Ost (n 1) 116 (emphasis in original).

¹⁸ *R v Smith (John)* [1974] 1 All ER 376 (CA) 378f (Scarman LJ).

¹⁹ See Brazier and Ost (n 1) 116-117.

²⁰ However, there is some evidence that there may be a divergence of views in respect of abortions carried out on the grounds of disability (pursuant to section 1(1)(d) of the Act): see, e.g., the findings of the UK Parliamentary Inquiry into Abortion on the Grounds of Disability (July 2013). It has also been suggested that the wider (so called ‘social’) ground for a lawful abortion (under section 1(1)(a) of the Act) may have been used by the medical profession to side-step the more restrictive grounds elsewhere in the Act: see, Department of Health, ‘Matching Department of Health Abortion Notifications and Data from the National Down’s Syndrome Cytogenetic Register & Recommendations for Improving Notification Compliance’ (London, May 2014), at 11.

against doctors.²¹ Reverend Jepson's well-publicised attempt to challenge the supremacy of medical decision-making ultimately failed,²² although the litigation may have had some impact on the medical approach to abortions based solely on the ground of disability.²³ The Jepson litigation also highlights the importance of the reporting provisions in the context of medical accountability.²⁴ In this regard, it is noteworthy that a recent Parliamentary Inquiry has expressed concern at 'the lack of transparency of decision-making in cases of fetal disability'.²⁵ Meanwhile the professional medical bodies have continued to resist any attempt to delimit or prescribe the scope of the disability ground.²⁶

More recently, we have seen media concern over abortions allegedly carried out on the basis of gender but reported by doctors as being on lawful grounds.²⁷ The subsequent Care Quality Commission Inspections,²⁸ the Department of Health Guidance²⁹ and the decision of the Director of Public Prosecutions (DPP) not to prosecute the individual doctors involved³⁰ revealed a number of potential issues regarding the bona fides of the decision making and notification process, as well as highlighting practical and evidential difficulties in mounting any legal challenge to medical decisions in this context. In particular, the absence of any clear medical guidance about the law was highlighted by the DPP,³¹ raising the question why it has

²¹ *R v Smith (John)* [1974] 1 All ER 376 (CA) is a rare example of a successful conviction.

²² *Jepson v Chief Constable of West Mercia Police Constabulary* [2003] EWHC 3318 (Admin).

²³ See the Royal College of Obstetricians and Gynaecologists (RCOG), *Guidance on Termination of Pregnancy for Fetal Abnormality in England, Scotland & Wales* (London, 2010) at 8.

²⁴ A failure to report can result in a summary conviction to a fine not exceeding level 5 on the standard scale.

²⁵ See UK Parliamentary Inquiry into Abortion on the Grounds of Disability, (July 2013), 4.

²⁶ RCOG (n 23)

²⁷ For example, <<http://www.telegraph.co.uk/news/uknews/crime/9794577/The-abortion-of-unwanted-girls-taking-place-in-the-UK.html>> accessed 6 November 2014.

²⁸ See, Department of Health, 'Guidance in relation to requirements of the Abortion Act 1967' (London, May 2014), 6-7.

²⁹ Letters from the Chief Medical Officer, Department of Health to Registered Medical Practitioners (23 February 2012 and 22 November 2013).

³⁰ DPP publishes fuller reasons for decision not to prosecute doctors over abortion (CPS, 7 October 2013) <http://www.cps.gov.uk/news/latest_news/dpp_abortion_case_fuller_reasons/> accessed 9 February 2015.

³¹ The Guidance (n 28) is intended to remedy that deficiency.

taken the medical profession and the Department of Health so long to rectify any ambiguity either in the law or in professional understanding of the statutory regime.

We can also learn from compliance with the reporting requirements laid down by the Act³² and subsequent regulations.³³ These requirements were put in place to provide some measure of ex post external scrutiny. There are two aspects to the statutory provisions that require separate consideration: (i) the method of recording abortion procedures; and (ii) external notification compliance. Both aspects have come under close scrutiny in recent years and the findings from the various investigations have revealed some worrying practices and trends. For example, the Care Quality Commission, carrying out inspections on a number of NHS abortion providers in 2012, found that a number of doctors were pre-signing the abortion record form HSA1 (ie before referral and assessment of the pregnant woman)³⁴ as well as signing these forms based solely on decisions/assessments made by other practitioners.³⁵ According to the Department of Health these practices call into ‘question whether doctors have acted in accordance with their legal obligations under the Abortion Act.’³⁶

Under the 1967 Act and the Abortion Regulations 1991, the registered medical practitioner who terminates a pregnancy must provide notification of the procedure to the relevant Chief Medical Officer (CMO).³⁷ Any person who ‘wilfully contravenes or wilfully fails to comply’ with these requirements is liable on summary conviction.³⁸ Although ‘wilfully’ is not defined, it seems that the provision has been interpreted as requiring a deliberate failure.³⁹ In recent years, both Parliament⁴⁰ and the Department of Health⁴¹ have highlighted notable

³² Abortion Act 1967, s 2.

³³ Abortion Regs 1991, SI 1991/499; Abortion (Amendment)(England) Regs 2002, SI 2002/887; Abortion (Amendment) (Wales) Regs 2002, SI 2002/2879.

³⁴ n28 at 6, para 10. See also Department of Health, Consultation: Procedures for the approval of independent sector places for the termination of pregnancy (London, November 2013).

³⁵ n 28.

³⁶ n 28.

³⁷ See specifically section 2(1)(b) Abortion Act 1967.

³⁸ Abortion Act 1967. s2(3).

³⁹ See, Department of Health, ‘Matching Department of Health Abortion Notifications and Data from the National Down’s Syndrome Cytogenetic Register & Recommendations for Improving Notification Compliance’ (London, May 2014).

⁴⁰ n 25 at 4.

discrepancies in data reporting (ie differences between the procedures carried out, recorded and notified to the CMO). The Royal College of Obstetricians and Gynaecologists (RCOG) were commissioned by the Department of Health to undertake a fact finding mission as a result of the discrepancies found in the data reporting. Of particular concern, is RCOG's suggestion that a possible explanation for the under-reporting of abortion procedures may be, not so much a 'wilful failure to comply with the law, but rather a lack of understanding of the statutory requirements, which in turn produced a lack of organisation and accountability.'⁴² Yet, not only has the medical profession had plenty of time to consider the statutory provisions, their own guidance requires doctors to be familiar and up to date with the guidelines and law relevant to their work.⁴³ It is also notable that the Department of Health chose to utilise the RCOG (who have a representative function for the medical profession) rather than a truly independent body to undertake the inquiry. Arguably, a highly deferential approach has been adopted by the Department to the medical profession both in terms of the process of investigation and the subsequent response to the discovery of the data reporting issue.

Pulling together these threads, we can see two very different perspectives on the compromise effected by the 1967 Act and subsequent practice. From one perspective, that of 'compromise medicalisation', the medical profession has failed to confine conduct and practice within the terms of the compromise. By contrast, from the perspective of 'evolutionary medicalisation', the medical profession has done pretty well in keeping practice in touch with public opinion (which is now much more comfortable with the idea of termination)⁴⁴ and making minimal demands on legislative time.⁴⁵ In other words, the verdict on the last fifty years might well be that the medical profession has failed to discharge the responsibilities that it was given by the 1967 compromise but, instead, has done rather well in discharging responsibilities that it was not given.

⁴¹ n 39.

⁴² n 39 at 11.

⁴³ General Medical Council, *Good Medical Practice* (London, 2013), domain 1, para 12.

⁴⁴ However, nb the caveat in note 20 above.

⁴⁵ Notably, the amendments made to the 1967 Act by s37 of the Human Fertilisation and Embryology Act, 1990.

Assisted Suicide and ‘Medicalisation’

Where secular views dominate end-of-life debates, the principal argument against relaxing the legal prohibition against assisted suicide is that there is too great a risk that unwilling and vulnerable persons will succumb to pressure to take steps to end their lives. Famously, this was the central objection expressed by Chief Justice Rehnquist in the leading US case of *Washington v Glucksburg*;⁴⁶ it is found, too, in the jurisprudence of the European Court of Human Rights, where national prohibitions against acts of assistance with suicide are protected by a margin of appreciation that gives particular weight to the potential vulnerability of the unwilling;⁴⁷ and the judgments in the Supreme Court hearing of the joint appeals of Nicklinson, Lamb, and Martin are full of references to this critical concern.⁴⁸

While pro-life supporters will not miss the opportunity to plead this concern, its real significance is that it must be taken extremely seriously by any *pro-choice* advocate—because, for such an advocate, the choice to be defended has value only so long as it is free and informed. Accordingly, if assisted suicide is to be ‘medicalised’, it is imperative that the compromise regime puts the condition of free and informed choice firmly in the foreground. To be sure, it is also important that the other qualifying conditions are carefully and clearly specified; but, without assurance that assistance will be given only where there has been a truly hard look at whether the relevant person’s choice is free and informed, no concession should be made.⁴⁹ In this light, what is striking about Lord Falconer’s Assisted Dying Bill is that it presents a proposal for medicalisation that seeks to give precisely the assurance that

⁴⁶ (1997) 521 US 702, esp at 731-732.

⁴⁷ See *Pretty v United Kingdom* (2002) 35 EHRR 1, [74].

⁴⁸ *R (on the application of Nicklinson and another) v Ministry of Justice; R (on the application of AM) (AP) v The DPP* [2014] UKSC 38, [2014] 3 WLR 200. See, for just a few of the many examples, [85]-[89], [172], [228]-[229], and [349]-[351] (esp [350] where Lord Kerr points out a devastating disconnection between permitting assistance for those who are unable to assist themselves and increasing the vulnerability of those who are able to assist themselves).

⁴⁹ Cf the argument in Roger Brownsword, Penney Lewis, and Genevra Richardson, ‘Prospective Legal Immunity and Assistance With Dying’ (2012) 23 *King’s LJ* 181.

those who are vulnerable will not be tricked or coerced or otherwise pressurised into seeking assistance that they do not actually wish to have.⁵⁰

At the core of the Bill is the requirement that the person who seeks assistance has a clear and settled intention to end their life. By restricting permissible assistance to cases where the person has been diagnosed as terminally ill and with a life expectation of no more than six months,⁵¹ the Bill invites the obvious criticism that it misses too many of the target cases (such as that of the late Tony Nicklinson);⁵² but, of course, this restriction increases the plausibility of the claim that only those persons who really do want to end their lives will be assisted. However, the key assurance in the Bill is given by the provision that requires an independent doctor (together with the person's attending physician) to countersign the person's statutory form declaration but to do so only if satisfied that the person 'has a clear and settled intention to end their own life which has been reached voluntarily, on an informed basis and without coercion or duress.'⁵³ This introduces a very particular kind of special responsibility for the medical profession.

When, in July 2014, the Falconer Bill was presented to the House of Lords for its second reading, there was a long and impassioned debate, drawing out all shades of opinion. However, with a strong signal from the Supreme Court in *Nicklinson* that a declaration of incompatibility is hanging over the legislative prohibition on assisted suicide unless Parliament takes a hard look at the issues,⁵⁴ it was no surprise that it was unanimously agreed that the Bill should proceed to the next stage. Moreover, there are significant supportive statements in *Nicklinson*, recognising the good sense of an *ex ante* inquiry into the state of mind of a person who seeks assistance.⁵⁵ Nevertheless, a compromise of the kind proposed by the Falconer Bill presents major challenges for both the criminal justice system and for the medical profession.

⁵⁰ In this chapter, our references are to the Bill as it stood as at November 30, 2014.

⁵¹ ADB 2014, ss 2 and 3(3)(a).

⁵² See *R (on the application of Nicklinson) v Ministry of Justice* [2012] EWHC 2381 (Admin).

⁵³ ADB 2014, s 3(3)(c).

⁵⁴ The legislative provisions are in s 2 of the Suicide Act 1961 as repealed and re-enacted by s 59(2) of the Coroners and Justice Act 2009. For some of the relevant remarks in the Nicklinson appeal, see [2014] UKSC 38, [113]-[118], [190], and [293].

⁵⁵ See [2014] UKSC 38, [108] (Lord Neuberger), [186] (Lord Mance), and [314]-[316] (Lady Hale).

First, if the only lawful acts of assistance are those permitted by the compromise, then there is no reason why the criminal justice system should look kindly on doctors who give unlawful acts of assistance, albeit on compassionate grounds. We can be quite sure that there will be many such cases that fall outside the authorised ambit of assistance but which invite a merciful act; and, no doubt, there will be pressure to extend the sphere of permitted acts of assistance. Yet, as Brazier and Ost chronicle in their discussion of end-of-life cases, the record of the criminal justice system is to find any number of ways of looking kindly on doctors (such as Cox⁵⁶ and Moor⁵⁷) who, on compassionate grounds, ease the passing of their patients.⁵⁸ The question is whether, following a medicalised compromise, with very strict limits, the leading legal actors would see the unlawful acts of doctors in a different light. If not, the opponents of the Bill would have a reasonable ground *ex ante* for concern and correction and *ex post* for complaint.

Secondly, for the medical profession, the challenge is not quite like that facing doctors after the Abortion Act 1967, when terminations needed to be legitimated by reference to the particular statutory grounds. It is not a matter of exercising restraint in stretching or squeezing the limiting conditions. Rather, the challenge is to prove the doubters wrong: to demonstrate that the profession is capable of making robust judgments about whether a person who seeks assistance does so on a free and informed basis. Even though free and informed consent is the fulcrum of modern medical law, and even though, in their daily clinical practice, doctors seemingly make judgments with complete confidence about the free and informed decisions of their patients, some might question whether—at any rate, in the context of assisted suicide—doctors are the best persons to make such judgments. So, for example, in her incisive speech in *Nicklinson*, Lady Hale says that, while it might not always be easy to make such judgments, this is what judges in the Court of Protection or the Family Division are sometimes required to do;⁵⁹ and, moreover, it is something that those judges are

⁵⁶ To be sure, Dr Cox was actually convicted of attempted murder although his subsequent treatment via sentencing and the GMC can certainly be regarded as ‘kindly’:

<http://news.bbc.co.uk/1/hi/health/background_briefings/euthanasia/331255.stm> accessed 26 January 2015

⁵⁷ (unreported) Newcastle Crown Court 11/5/1999 <<http://news.bbc.co.uk/1/hi/health/343257.stm>> accessed 26 January 2015.

⁵⁸ Brazier and Ost (n 1) 140-143.

⁵⁹ *Nickinson* (n 48) [314].

required to do in cases that involve ‘sensitive life and death questions’.⁶⁰ That said, Lady Hale does not insist that it is only judges who are equipped for such a task: what matters is that the judgment is made by persons who are ‘sufficiently neutral and independent of anyone involved with the applicant, and skilled at assessing evidence and competing arguments’.⁶¹ If the Falconer Bill completes its legislative passage, it will be a surprise if its ‘medicalising’ strategy is abandoned—doctors surely must be responsible, at the very least, for confirming the terminal diagnosis. However, it will not be a complete surprise if the task of determining that the applicant is acting on a free and informed basis is not left to doctors alone.⁶²

Conclusion

In the United Kingdom, we have lived for half a century with the medicalisation of abortions; by contrast, the medicalisation of assisted suicide is still an unknown quantity. However, the lessons of the former are relevant to the debates that currently rage around the latter.

The key lesson is this. Brazier and Ost’s ‘medicalisation’ implies that the terms of the compromise should be strictly observed by the professions—primarily by the doctors but also by the key legal actors in the theatre of the criminal justice system. To put it bluntly, the medical profession is entrusted with holding the line; and the legal actors are charged with ensuring that the doctors discharge their special responsibilities. However, the world does not stand still; public opinion, technologies, and economies change; and, in practice, the ‘medicalisation’ of abortions has proved anything but conservative. In practice, we have had ‘evolutionary medicalisation’. Viewed retrospectively, this might seem to be no bad thing: it has enabled doctors and lawyers to go with the flow of public opinion; and it has meant that there is no great gap between the law and public opinion. However, viewed prospectively, at the time of the 1967 compromise, these developments would seem to be quite unacceptable: the terms of the compromise are not respected and the norms are changed without the medical profession being held to account.

⁶⁰ Ibid [315].

⁶¹ Ibid [315].

⁶² Cf Brownsword, Lewis and Richardson (n 49). Significantly, at the Committee Stage of the Bill, Lord Falconer conceded that doctors alone might not be able to deal with all the relevant questions (see the Committee Stage of ADB 2014, column 1880-1881).

As the latest attempt to change the law on assisted suicide runs its course, we again face the challenge of finding a way of facilitating the compromise (which also means, respecting the compromise) but also finding a mechanism *ex post* for reflecting whatever changes in public opinion might take place. The obvious answer is that we need both ‘sunset’ and ‘sunshine’ so that, after a specified period of years, the compromise legislation is brought to Parliament to be openly reviewed and then renewed or revised by *positive act*.⁶³ Of course, for the opponents of the Bill, no guarantee can be given that the terms of the compromise will never be changed—in this sense the Falconer Bill might prove to be the thin end of the wedge. However, in the interests of transparency, accountability, democracy, and the integrity of the compromise, it will not do to leave any adjustment of the law either to unauthorised medical discretion or to low visibility governmental ‘guidance’ or codes of practice. Any adjustment to the compromise needs the positive imprimatur of Parliament.

⁶³ Cf the provision in ADB 2014, s 13(4).