

abortion suggests that providing regulated and medically safe provision is better than driving the situation underground, putting people at further risk of harm and criminalising those who, often for good motives, seek to help people in need.

The second pragmatic argument is based on the suggestion that though a majority of people want to have access to assisted suicide, only a minority will ever choose to exercise their right to end their life (as data from Oregon and the Netherlands suggests). Knowing that assisted suicide is available may often reduce the anxiety of dying people. Fear of pain and other symptoms may be mitigated by the knowledge that there is another way out, if it all gets too much. The possibility of controlling death can be life-enhancing.

A national survey by Clive Seale (2006) reveals that, in some cases, British doctors already hasten the death of their patients in different ways. The data shows that physician-assisted deaths are very rare: none of his respondents had assisted the suicide of patients, and only 0.16 per cent had performed voluntary euthanasia and 0.33 per cent non-voluntary euthanasia. This suggests that the disability rights community's suspicions of doctors are misplaced. However, nearly a third (32.8 per cent) of respondents had alleviated symptoms with possible life shortening effects (the so-called doctrine of double effect, where doctors knowingly prescribe pain-relief drugs which have the side effect of hastening death), and a similar proportion (30.3 per cent) had made decisions not to treat end stage conditions, knowing that this would hasten an inevitable death. Doctors did not think that a new law would make much difference to their palliative care philosophy.

Safeguards in assisted suicide legislation

If assisted suicide were to be legalised, appropriate safeguards would be necessary to protect vulnerable people and prevent abuse. These would govern eligibility for assistance to die, the decision making process around death, and the broader cultural and social context within which assisted suicide was made available.

First, disabled people and terminally ill people need to have access to independent living and the full range of support services. Choices about death should not be made because life has been made unbearable through lack of choices and control. Moreover, palliative care is not currently available in many parts of the country. Palliative medicine can reduce pain and suffering at the end of life: assisted suicide is not an alternative to palliative care, but an addition to it. Some countries where assisted suicide is permitted have not made a commitment to palliative care, which makes it more likely for dying people to choose to end their lives prematurely, from fear of preventable pain and suffering. The broader cultural context is also important, because assisted suicide should not be promoted via negative images of disability and dying. Some of the advocacy around assisted suicide has stigmatised dependency and disability, and encouraged people to think that disability is a fate worse than death. Assisted suicide should be viewed as a last resort for a minority of people with terminal illness, not the expected and preferred option when faced with difficulty and disability.

Second, promoting autonomy should be balanced with protection, even if this verges on paternalism. Questions of definition need close attention in developing regulation of assisted suicide. The distinction between 'people with terminal illness' and 'terminally ill people' is very important, and not easy to specify. It is an important principle that the qualification for assisted suicide is the end stage of incurable disease accompanied by unbearable suffering. Simply being a disabled person is not a reason to be permitted assisted suicide. To broaden the eligible class too widely might be to put disabled people at risk in the way that critics fear.

Moreover, it is normal to fear disability and death, and it is often traumatic to incur or be diagnosed with incurable impairment or terminal illness. For example, Disability Awareness in Action quote Dr Ian Basnett, a quadriplegic, as saying of the period after the accident which left him quadriplegic, 'I was ventilator dependent for a while and at times said to people "I wish I was dead!" I am now extraordinarily glad no one acted on that and assisted suicide was not legal' (Hurst, n.d.). Experience shows that the initial anger and distress at diagnosis often gives way to a more balanced and accepting attitude over time. Therefore, people who have recently developed or been diagnosed with impairment or terminal illness should be prevented from exercising the choice of assisted suicide. There should be a short-term infringement of autonomy for newly disabled people, until they come to terms with their situation. Understanding the complex fears and yearnings of those who desire euthanasia is important (Wood Mak and Elwyn, 2005).

Moreover, even people in the eligible category may not always be able to make a rational decision to request death. For example, depression and other mental illness could cloud judgement and may prevent a person with terminal illness making a competent decision to request death. The right to request assisted suicide should depend on the mental competence of the person with terminal illness. Disabled people may become depressed at pain and restriction, and express desire to die. For example, Alison Davis (2004) discusses a phase in her life when this was the case for her. She fears that had it been legal, she would have requested assistance and suggests that most requests for death stem from depression.

Any request for assisted suicide should be subject to calm and careful scrutiny from both medical and legal professionals. Once a request has been made and approved, there should be a 'cooling-off period' for the person to consider their situation, at the end of which they should have to confirm once more that they understand the consequences of their decision and want to go ahead with assisted suicide.

Assisted suicide should only ever be available in very restricted circumstances: the end stage of terminal, incurable illness, when suffering becomes unbearable. Legalisation and regulation should be carefully framed, to ensure that the 'slippery slope' which opponents fear cannot occur.