

Assisted Suicide (Scotland) Bill

The Anscombe Bioethics Centre

The Anscombe Bioethics Centre is the oldest national bioethics centre in the United Kingdom, established in 1977. It exists to support healthcare professionals and the wider community in Great Britain and Ireland.

The Anscombe Centre engages with the moral questions arising in clinical practice and biomedical research. It brings to bear on those questions principles of natural law, virtue ethics, and the teaching of the Catholic Church, and seeks to develop the implications of that teaching for emerging fields of practice. It engages in scholarly dialogue with academics and practitioners of other traditions, and contributes to public policy debates such as the current debate on assisted suicide, as well as to debates and consultations within the Church.

Basic objections to draft Bill

In responding to the draft Bill on Assisted Suicide, the Centre will focus on the first consultation question, since we are strongly opposed to the general aim of the Bill. We believe that the Bill would entrench the view that the lives of those who are terminally ill or have a life-shortening illness, unlike the lives of other human beings, can sometimes have no value, or even perhaps a negative value. Thus we note the Bill's explicit invitation [section 8(3)(d)] to those requesting assisted suicide to declare that their quality of life is unacceptable, and for the certifying doctors to, in effect, agree with that judgement. The doctor is invited [section 9(2)(c)] to assess whether the conclusion that 'the person's quality of life is unacceptable' is 'not inconsistent with the facts then known to the practitioner'.

In other words, a doctor (who may be quite unknown to the patient and chosen simply as one of a minority of doctors prepared to be involved in certifying requests for assisted suicide) is being asked to make his/her own judgement on the 'quality' or worth of the patient's life – or at least, to explicitly decline to dissent from the patient's negative view of his/her own life.

Though we have cited some specific sections where this rationale is explicit, we do not think this fault can be remedied by changing the wording of the Bill or the forms it contains. The problem is with the basic rationale of the Bill itself. Even were the negative value judgement of the patient and negative value judgement of the practitioner not explicit on the surface of the Bill, they would be implicit in the way that the practitioner would respond differently to different suicidal requests.

Suicide and equality

All suicidal people want in some sense to die; that is, they find their life hard to bear, or believe that their death is otherwise desirable. If we allow assisted suicide for some (i.e. those with life-shortening conditions) but not for others, are we not endorsing the view that some people are right to want to die? Even leaving aside the urgent need of those who would 'qualify' for assistance in suicide under the proposed law, instead of qualifying to be affirmed and supported in living, it is not helpful to

others who are now, or may be in the future, suicidal themselves for society to endorse any person's choice to die. We note the suggestion in the draft Bill that the 'facilitator' will be providing 'reassurance' to the suicidal person as he/she acts out the decision to commit suicide. This is the absolute reverse of what is needed with all strong suicidality, which is urgent help and support for the person in reevaluating the worth of his/her life.

If physically-well suicidal people are supported in living, not assisted in dying, why not provide such support also to suicidal people with life-shortening conditions? Conversely, if we really believe 'assisted death' is a benefit to some people, why not provide this 'benefit' also to those who are incapable of killing themselves, but could be killed by others, whether voluntarily or (in the case of non-competents) non-voluntarily? True, the current bill is for assisted suicide, not euthanasia, but there is a logical progression from one to the other once the principle that some human lives may be deliberately ended as lacking value is officially admitted. Even if the law does not follow this logic to its final conclusion, the value judgments implicit in the law have the power to influence public attitudes and medical practice.

Alternatively, if assisted suicide is simply about patient choice, and not, as currently maintained in the draft Bill, about the value of the patient's life, why would the patient need to have a life-shortening condition (a rather broad category, which could include diabetics, for example) to qualify for it? Again, the way is open, if people follow this line of thought, to extending assisted suicide to those who are merely 'tired of life' (there are moves in this direction in the Netherlands and in Switzerland). In Oregon, both assisted suicide and other forms of suicide have risen in numbers since assisted suicide was legalised, while suicide has sometimes been offered to patients as a cheaper alternative to medical care.

It is important to consider the experience of all those jurisdictions that have legalized assisted suicide: that is, Switzerland, a handful of States in the United States, and also the Netherlands, Belgium, and Luxembourg (which allow both euthanasia and assisted suicide). Before taking the radical step of allowing professionals to supply lethal drugs to suicidal patients, Scottish Parliamentarians should consider all the available evidence from these five countries. Changes of this kind have an impact on the culture as a whole, irrespective of the details of the putative 'safeguards' within the legislation. There is evidence in a number of countries of further changes after the initial legislation, and such changes have generally been in the direction of an increase in numbers of prescriptions, an increase in the range or kinds of cases favourably considered, and a decrease in referral for psychological assessment. There is considerable evidence from the Netherlands and Belgium of widespread practice of hastening of death without request in the case of patients who cannot make a request, even though this practice goes well beyond what the law allows in those countries.

Patterns of care

Persistent requests for death are, of course, rare when dying people are properly cared for: hospice teams are experienced in supporting patients to a point where they are reconciled to their situation and able to use their last days to the full. However, once legalized, assisted suicide would inevitably, perhaps especially

outside the hospice setting, become a 'quick fix' for disposing of the more 'difficult' patients in response to the demands they make on care. Suicide is not a private choice: it very much affects the character of doctors, and their commitment to their patients' objective welfare. For example, if assisted suicide is legalized, doctors and indeed carers generally will no longer be able to appeal to the law against assisted suicide as a reason for not complying with requests from suicidal patients. They will inevitably come under pressure to be complicit in some way (for example, signpost the patient to pro-suicide doctors, or otherwise give information on how to access assisted suicide). And while the Bill makes provision for 'trained facilitators' to be involved in assisted suicide, serious questions arise about those who would be attracted to such activities, and the likelihood of such individuals raising any serious concerns about a client's wish to die, if this request retains the outward appearance of legality.

Conclusion

To conclude: we would argue that respect for a human being cannot be divorced from a valuing of his or her presence in the world. Assisted suicide confirms the suicidal person in his/her low estimate of the value of his/her life. No patient should be made to feel a burden – pressure which may be no less real for remaining subtle and/or unacknowledged – nor should society or those around the suicidal person concur with that person's judgment that life can lose all value when one is suffering or dependent on others. Society should continue to value the lives of all its members, including those who are currently distressed or demoralized by illness to a point where they do not see their own lives as worthwhile. In other words, the law should continue to uphold human dignity and equality by prohibiting assistance in suicide for all citizens alike.

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