

Assisted Suicide (Scotland) Bill

CARE for Scotland

Question 1

No. Assisted suicide is both unnecessary and unethical. It is unnecessary because the majority of terminal illnesses can be effectively treated or managed with the use of palliative care, which is effective in over 95% of cases. It is unethical in the sense that to describe a life with disability and a dependence on carers as lacking in basic human dignity is deeply flawed. The UN Declaration of Human Rights defines human dignity as inherent; people with debilitating terminal illnesses or conditions, therefore, have the same inherent human dignity as those who do not. In the same way as a baby who relies on its mother for care does not lack human dignity, so too someone with a terminal illness who requires help and assistance from others does not lose dignity.

The broad scope of the Bill is deeply alarming. People with the potential to live for decades could opt for assisted suicide under this legislation. Those with conditions such as diabetes, dementia, heart disease, renal failure, any form of cancer and stroke victims would qualify for assistance to end their lives under this Bill. There is no requirement that the patient's death is to be expected in the near future. Nor does the Bill require that there is objective evidence of serious physical suffering: it simply mentions an "unacceptable quality of life". As such the test which requires to be met in order to qualify for access to assisted suicide is based largely on the subjective judgement of the applicant as to the quality of his/her life. This raises considerable concerns regarding the possibility of people who are depressed (which is associated with terminal or chronic illness) being given assistance to end their lives rather than medication to overcome their depressive mood.

The focus of our efforts should be on continuing to improve and extend palliative and other medical care and on suicide prevention strategies. This is the truly compassionate way forward.

Question 2

The End of Life Assistance (Scotland) Bill was comprehensively defeated in a free vote at the Scottish Parliament in December 2010, by a margin of 85 votes to 16. Many groups voiced concerns about the content, wording and implications of the Bill. The vast majority of the concerns which were raised in relation to the previous Bill remain valid, and in some cases the proposed safeguards have been lessened.

There is no requirement in the current Bill for a psychiatric assessment of the qualifying individual before assistance to commit suicide is provided. Although the Bill states that no one who is suffering from a mental disorder can be considered to have capacity to consent to an assisted suicide, there is no mechanism in place to ensure that people suffering from depression or other mental illness are identified and prevented from gaining assistance to end their lives prematurely.

The inclusion of a time limit within which the act of suicide must take place raises the concern that once a person has been prescribed lethal drugs he/she will feel under pressure to complete the act of suicide. Experience in the US State of Oregon shows that on many occasions the lethal drugs are prescribed by a doctor but remain unused by the person who requested the prescription. By including in the Bill a time limit within which the act of suicide must take place those who are suffering from depression, mood swings or have doubts about the proposed act of suicide will feel under pressure to take their own lives within the time limit.

Question 3

There remains the possibility that a proxy may have a personal interest or some nefarious motivation for signing the documentation. This raises a serious concern that an individual who abuses his/her position of trust may be able to pressurise a person to commit suicide. In such a case it would be extremely difficult if the proxy or the licensed facilitator was charged with an offence to secure a conviction for murder or manslaughter.

Question 4

The pre-registration system is a flawed attempt at adding more effective safeguards to the proposal. The requirement for a single witness does nothing to alleviate concerns about the potential from undue influence being applied to a patient from those close to them; although the witness could not be a relative, he/she could be close personal friend or even a long term partner. Pre-registration would not protect the most vulnerable people from being placed under pressure to end their lives.

In 2010 MSPs expressed grave concerns about the evaluation of applicants. The new proposals do absolutely nothing to allay these fears. The removal of any kind of formal psychiatric assessment is staggering. General Practitioners do not have the specialist mental health training which would be required to determine whether or not a person is in a fit state of mind to request an assisted suicide. By removing the need for compulsory psychiatric assessment, there is potential for the state to assist in the suicide of mentally unwell patients who are simply not in a position to make informed decisions.

In our view, the involvement of two doctors is an illusionary safeguard which is likely to provide little protection to ensure that abuses do not occur. In practice it is likely that a small number of doctors who have a commitment to legalised assisted suicide are likely to approve most of the assisted suicide requests without any real scrutiny of the validity of applications. This has proven to be the case in other countries which have legalised assisted suicide

Question 5

The Policy memorandum which accompanies the Bill indicates that in the future the Bill may be extended to include those with other conditions. This is extremely worrying and indicates that should assisted suicide be legalised in any form it will lead to a slippery slope with assisted suicide being incrementally extended to apply to other groups of people. This has proven to

be the case with euthanasia in the Netherlands and Belgium.

Question 6

The suggested eligibility requirements are wholly inappropriate. The concept of capability is one which is extremely difficult to define. Using the definition of 'capacity' contained in the Bill, it is the case that a dependency on alcohol or drugs would not lead to a patient being considered to lack 'capacity'. Moreover, 'capacity' is not a static state in all cases. Rather 'capacity' can come and go, particularly during the early stages of dementia.

There is a high likelihood that applications for assisted suicide would be directed to a few GP practices or a single organisation.¹ There would be nothing to stop a person moving to the area and registering with a practice with the expressed intention of applying for an assisted suicide. There is nothing in the Bill which would prevent someone residing outside Scotland establishing an accommodation address within Scotland and registering with a medical practice in order to access assistance to end his/her life. Both 'death tourism' and the export of lethal drugs to other countries remain possible under this Bill.

Scots law has a tradition of protecting children up to and beyond the age of sixteen from making decisions which are manifestly against their interests. Indeed, the submission from the Royal College of Psychiatrists to the previous bill expressed a 'general reluctance to contemplate end of life assistance in young people'. Moreover, it seems somewhat inconsistent that the Scottish Parliament has agreed to introduce a 'Named Person' to for every young person up to the age of 18 and aftercare for care leavers up to the age of 25, whilst at the same time proposing that young people aged just 16 can access government-provided assistance to terminate their lives.

Rather than finding robust and objective criteria upon which to make an assessment, the Bill simply states that a qualifying person must find their 'quality of life is unacceptable'. The concept of 'intolerability' was one which was identified in the End of Life Assistance (Scotland) Bill Committee report as extremely difficult to define or prove. It is a subjective term which cannot be ascertained or measured and may be liable to fluctuate; a patient's attitude towards the tolerability of their condition is by no means fixed and is liable to change as an illness progresses. Indeed, for a patient, finding life intolerable may be the symptom of depression which could be treated, rather than an understandable response to a serious medical condition. The replacement of the term 'intolerable' with the even more subjective test of the person finding that their 'quality of life is unacceptable' is a matter of grave concern.

Question 7

CARE is of the view that it is not appropriate for medical practitioners to be involved in assisting patients to commit suicide. This action has no place in health care and runs contrary to all ethical principles of medicine (in particular the principle of do no harm) and the Hippocratic Oath. Although medical

¹ In the US State of Oregon nearly all of the assisted suicides are facilitated by one organisation, Compassion and Choices.

practitioners are not directly involved in administering lethal drugs, the Bill involves them in the process by approving applications for assisted suicide and prescribing lethal drugs. Similar concerns apply in relation to pharmacists who will be asked to dispense lethal drugs. We note that there is no conscience clause in the Bill for those who may wish not to participate in the assisted suicide process.

Question 8

There is no clarity in the Bill as to the means by which a person would be permitted to end his/her life. This raises the prospect of a variety of activities, which society would wish to discourage, becoming immune from criminal prosecution as long as they are associated with the suicide of a person who qualifies under the Bill.

Question 9

The Bill leaves it to the discretion of the Scottish Government whether to issue regulations relating to the training and activities of licensed facilitators. There is no requirement in the Bill that there be any form of training or that there be any regulatory system in place to oversee their activities. Without an effective and independent regulatory regime in place the opportunity for abuse to occur and go undetected remains a very real danger.

The Bill suggests that facilitators should remove any unused drugs from the qualifying person as soon as practicable after the expiry of the 14 day period. However, there is no requirement that these drugs, even if obtained, be returned to the source pharmacy. There does not seem to be any way of ensuring that unused drugs will not go missing.

Question 10

The Bill provides no compulsion for the police to investigate deaths. It provides no detail as to what action should be taken by a police officer once he/she has been informed that an assisted suicide has occurred. This is wholly inadequate in order to ensure that abuses do not go undetected and that prosecutions occur in cases where a facilitator has acted maliciously, negligently or without due regard to the appropriate procedures. There appears to be no effective after-death reporting mechanism.

Question 11

It is unclear as to who would sign the death certificate if a doctor is not involved in the administration of the lethal medication. On what basis would the doctor who signs the death certificate be able to certify that this was indeed a voluntary act if they were not involved in the administration of the lethal medication?

The monitoring of the private facilitator companies would need to be stringent and exhaustive in order to protect against abuses. The alternative is the frightening scenario where there would be little real supervision and regulation of the process with huge potential for abuse by rogue individuals.

CARE for Scotland Public Policy