

Assisted Suicide (Scotland) Bill

Care Not Killing

Consultation Submission

Executive Summary

This Bill to legalise assisted suicide, following very shortly after one which was comprehensively rejected by Holyrood Parliamentarians, is as dangerous as its predecessor. It should be rejected because:

- Loose and relativistic terms such as ‘life-shortening condition’ mean that tens of thousands of seriously ill and disabled people throughout Scotland would be eligible
- Licensing doctors to kill would fundamentally alter the doctor-patient relationship
- The Bill fails to define the ‘means’ of suicide
- So-called safeguards are seriously defective with reporting and oversight provisions unenforceable even where they exist
- There are no penalties for contravention
- Doctors need not know or examine the patient
- No assessment by a psychiatrist is required
- Patients’ beliefs about their illness/condition cannot be objectively confirmed by the doctor
- The ‘savings’ clause protects all errors and omissions made ‘in good faith’
- There is no conscience clause for doctors, despite widespread medical opposition to assisted suicide

We thank the Scottish Parliament for this opportunity to comment, and now respond in detail to the Committee’s specific questions.

1. Do you agree with the general purpose of the Bill to make it permissible, in the circumstances provided for, to assist another to commit suicide?

No. This Bill, in both principle and practice, would be deleterious to public safety, to the practice of medicine and healthcare, and to the security of vulnerable people within society.

The Bill would be open to abuse and is also clearly being promoted as a ‘first step’. From the accompanying Policy Memorandum (PM): ‘the form of assisted suicide the Bill authorises will not be available to all those that the member would ideally wish to include... She would be confident that, once it has been seen to operate effectively for a number of years, there may be an opportunity for further developments in the law’ (PM 54).

The Bill’s proponents seek (PM 60) to play down public and parliamentary opposition to the Bill and its intentions, and point to polling of public opinion, but it must be emphasised that (i) 64% of individuals and 62% of organisations responding to the framers’ own 2012 consultation rejected a change in the law and (ii) the previous

attempt was defeated in Holyrood by a massive 85-16 in 2010.

2. Do you have any views on how the provisions in this Bill compare with those from the previous End of Life Assistance (Scotland) Bill?

This Bill is as dangerous as its predecessor, despite claims to the contrary.

3. The Bill precludes any criminal and civil liability for those providing assistance, providing the processes and requirements set out in the Bill have been adhered to. Do you wish to make any comment on this?

The Bill's loose and relativistic wording, the emphasis on precluding individuals from criminal or civil responsibility, and the absence of any penalties for abuse result in the Bill's containing no meaningful legal protections for Scotland's citizens. Its compatibility with Article 2 of the European Convention on Human Rights (ECHR) must be in question.

Notably, section 24 ('savings') removes culpability for 'incorrect' and 'inconsistent' actions 'in good faith' and contains no penalties for abuses or 'careless' errors, nor any suggestion of how such might be investigated.

4. The Bill outlines a three stage declaration and request process that would be required to be followed by an individual seeking assisted suicide. Do you have any comment on the process being proposed?

All aspects of this Bill are subordinated to the principle of making the securing of assisted suicide as easy and efficient as possible. We express particular concern about the following:

- The very completion of a declaration could potentially alter the entire future dialogue between patient and doctor as medical issues arise (PM 21)
- Only a passing reference is made to the content of a cancellation (7)
- There is no indication of how doctors would exclude pressure
- The witness is required to have known the individual 'for a period longer than that associated with the signing of the declaration' (schedule 1) – this could be mere minutes
- The declaration places no investigative obligation on the doctor, and subsection 4(3) effectively makes the doctor an accomplished witness
- Similarly, in the requests, the doctor need only confirm that the patient's understanding of the situation 'is not inconsistent with the facts currently known to me' (schedule 3)
- The short waiting periods exist simply to permit claims that 'no-one opts for an assisted suicide without careful consideration over an appropriate period'(PM 20). There is no counselling advised, alternative treatments considered or supportive care required to be given.

5. Do you have any comment on the provisions requiring that the person seeking assisted suicide must have a terminal or life-shortening illness, or a progressive condition which is either terminal or life-shortening?

Doctors are simply being asked to endorse the weight of patients' personal perceptions: 'The aim here is not to substitute the person's judgement about the quality of their own life with a medical opinion' (PM 31). This, however, dangerously subverts the very real need for a genuine doctor-patient dialogue.

Currently, health and social care professionals do all they can to enhance quality of life and do not see the termination of life as a solution to patients' health concerns. The Bill's vague wording gives wide scope for eligibility. Most progressive (PM 27) conditions will have a life-shortening effect; this need not be pronounced, as the framers chose not to include any prognosis-based time limit. Eligibility only requires that your life will conceivably be shorter than someone else's.

Legalising assisted suicide changes the culture surrounding care for sick and dying people, and would be a catastrophe in terms of how our society confronts illness and disability – not to mention devaluing suicide prevention efforts.

6. Are you satisfied with the eligibility requirements as regards age, capacity, and connection with Scotland as set out in the Bill?

Most children and young people seek to ameliorate their family's suffering. This was emphasised by opponents of Belgium's recent extension of euthanasia to children. We question whether 16 year olds might be subject to such emotional pressures.

Regarding capacity, we are concerned that it is not (PM 22) a required element at preliminary declaration.

Even at first and second requests, there is no mandated or recommended psychological (or indeed physical) assessment. It is deemed sufficient (12) that the individual has not already been diagnosed with a mental disorder and has some powers of communicating decision.

Regarding connection with Scotland, the revised Bill actually removes the 2010 Bill's requirement that an individual should have been registered with a Scottish practice for at least 18 months prior to initiating the process.

7. Do you have any comment on the roles of medical practitioners and pharmacists as provided for in the Bill?

The Bill removes responsibility from doctors, repeatedly absolving them from blame with no prescribed checks and no penalties. Doctors are no longer making clinical decisions but sociological ones, and are expected to rubber stamp.

There is no conscience clause in the Bill, and while the framers muse (PM 39) on anticipated professional guideline changes to allow for opt-outs, this is preceded (PM 38) by a very clear expectation that pharmacists will dispense any medicine prescribed for the purpose of suicide.

There is an expectation (PM 39) that doctors would not want an opt-out. What is the evidence base for this? Healthcare professionals have consistently opposed legalising assisted suicide, as uncontrollable, unethical and unnecessary. A change in the law is formally opposed by the British Medical Association, the Association for Palliative Medicine, the British Geriatric Society, the World Medical Association and the Royal Colleges of Physicians and General Practitioners. Medical opposition has been frequently reaffirmed as with the the BMA in 2012 and the RCGP in 2011 and 2014, when 77% of respondents favoured maintaining collegiate opposition. The RCGP's consultation is the most recent to survey Scottish doctors on this issue, and their analysis of reasons for opposing change should be read

carefully by Parliamentarians scrutinising this Bill.

The main problem in licensing doctors to end the lives of their patients is doctors who are predisposed to say 'yes'. It is claimed (PM 32) that by requiring that the first doctor identify the second, there can be no 'shopping around', but individuals are free to seek endorsements from doctors outside of their own practice, who are not required to examine them and who having endorsed a request are unlikely to seek support from someone who would say no.

8. Do you have any comment on the means by which a person would be permitted to end his/her life under the Bill?

No means are prescribed or suggested in the Bill, which speaks very generally of 'any drug or other substance or means dispensed or otherwise supplied for the suicide'(19(c)). The words 'means... otherwise supplied' are extremely broad in scope and could arguably include the whole range of 'means' that are already employed in Scotland to commit suicide (see the 'Scottish Suicide Information Database Report 2012' listing which includes hanging, strangulation & suffocation, poisoning, jumping or falling from a high place, drowning and submersion, firearm etc.)

9. Do you have any comment on the role of licensed facilitators as provided for in the Bill?

It is hard to imagine how any licensing authority would approach training for such an all-encompassing role. 19(c) requires that the facilitator be present at the suicide, yet section 20 allows for a report to be made to the police by a facilitator who 'knows or believes' (emphasis added) that a suicide has been committed or attempted. This is surely contradictory.

It is clear from schedule 3 that by the time of second request, the individual will have 'arranged to have the services of a licensed facilitator'. We do not know the extent to which a particular facilitator may have counselled the individual: as with doctors, we must consider the effect that the counsel of those predisposed to see assisted suicide as a positive choice will have on vulnerable people's decisions.

PM 43 makes clear that while a family member could not be the designated facilitator, 'there is nothing to prevent other persons from also providing assistance'. The Bill has nothing to say about this additional assistance provided by family members.

The proponents claim (PM 14 and 42) that they have eliminated any chance of the Bill's being used to justify euthanasia and the Bill states (18(1)) that 'Nothing in this Act authorises anyone to do anything that itself causes another person's death', yet section 19 follows this vague wording by charging facilitators 'to provide, before, during and after the act of suicide (or attempted suicide) by the person for whom the facilitator is acting, such practical assistance as the person reasonably requests', and the Delegated Powers Memorandum envisages (3) 'for example holding a cup for someone who might otherwise be unable to drink the necessary drugs from it'. Statistics from the Netherlands are broken down into instances of euthanasia, assisted suicide and 'combinations' – this Bill clearly invites the last.

10. Do you have any comment on the role of the police as provided for in the Bill?

The police are granted no role. This is woefully inadequate, and we question again compliance with Article 2 of the ECHR. The Bill calls (20) for facilitators to report assisted suicides – completed and attempted – to the police, but they are not required to confirm that procedures have been properly followed. Reporting and oversight provisions are not enforceable.

11. Do you have any comment to make about the Bill not already covered in your answers to the questions above?

The Bill's so-called safeguards assume that those who will request assisted suicide will know their own minds beyond doubt. This is a false assumption. In today's individualistic society the pressures on sick, disabled and elderly people to avoid placing 'unfair burdens' on others are very great. Maintaining the law's protection of this silent and vulnerable majority is more important than giving choices to a minority of strong-minded and highly resolute people.

This Bill is flawed both in principle and in detail. Care Not Killing calls upon the Scottish Parliament to reject this Bill at the earliest opportunity.

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