

Assisted Suicide (Scotland) Bill

Dignity in Dying

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?

Dignity in Dying campaigns for terminally ill, mentally competent adults to have the option of an assisted death subject to strict upfront safeguards. We believe that laws in Scotland and throughout the UK need to be changed to allow terminally ill people to choose the time and manner of their death and to offer greater protection to vulnerable people than the current laws, which turn a blind eye to those who travel overseas to die and which rarely (if ever) result in prosecution.

We support the aims of the Bill insofar as it would offer dying people choice, and allow honest conversations about assistance to die to happen (regardless of whether the individual goes on to formally request assistance to die). As a consequence, doctors could discuss all options with patients who raise the question of assistance to die, exploring reasons for requesting assistance and what palliative and supportive options are available. We view this as an important part of the range of conversations about end-of-life choices which we should be able to have. We support that the proposal embeds assistance to die within the current healthcare system. We do not, however, support assisted suicide for people with life-shortening conditions which are not yet terminal.

Dignity in Dying believes there is a clear distinction between assisted dying and assisted suicide. Assisted dying refers only to terminally ill, mentally competent adults and allows the dying patient, after meeting strict legal safeguards, to self-administer life-ending medication. The provisions in the Assisted Suicide (Scotland) Bill go beyond this, allowing assisted suicide for people who are not dying but have life-shortening conditions. We recognise that some people will face suffering as a result of such conditions, but we believe there is a legal and ethical difference between assisted suicide for those with life-shortening conditions on the one hand, who may have many years of life ahead of them and allowing a dying person the choice to control the time and manner of their death, when that death is imminent and unavoidable on the other. .

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?

We welcome the restriction of criteria so as no longer to allow people with a permanent disability (who are not also terminally ill) to have an assisted death. But we believe it should be further restricted just to those with a terminal illness and not those with life-shortening conditions (unless they have entered a terminal phase).

The provision in Section 18 (3), requiring the person him or herself to take the "deliberate act" to end their life is an improvement on the previous Bill, which was unclear on the nature of the assistance to be given at the time of death. We strongly welcome this change which makes clear that the Bill would not permit voluntary euthanasia.

We also welcome the removal of the upper time limit of 28 days between the first and second formal request that was proposed in the previous version of the Bill (see question 4).

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?

We agree with these provisions. We would welcome clarification on the extent of "Savings" (Section 24) – for example with regards to the responsibility of individuals for knowledge of mistakes of third parties, and to the extent of the savings for minor procedural errors. For the avoidance of doubt it might be helpful to create offences under the Bill e.g. if a person falsifies, conceals or destroys a declaration.

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?

Whilst we recognise the aim of the pre-registration process – namely in attempting to prevent pressure on the vulnerable under the assisted suicide law and giving reassurance to those who may wish to take up this option in the future – we think pre-registration is unnecessary. Where a person has a very short prognosis or faces a rapidly progressing terminal illnesses, an extra step to fulfil and the mandatory seven-day gap between pre-registration and the first request may prevent a dying person from exercising their rights.

Under Oregon's Death With Dignity Act, there is no pre-registration process but the patient is the first person to initiate a conversation about assisted dying with his or her doctor. Not having a formal process to start the conversation limits the number of steps that a person has to fulfil and it encourages an important benefit of an assisted dying law: the crucial discussion between patient and doctor of all possible treatment options.

We agree with the need for two requests separated by a time for reflection. This ensures the person has a clear and settled intention to die. The requirement that cancellations of requests be made in writing may, however, be a barrier to those who do change their minds. In addition, it may be more difficult to cancel a request in writing if the person has limited mobility etc.

We agree that there must be a minimum time between the first and second

requests (the “cooling off” period) as provided for in the Bill. We would prefer the maximum time limit between the second request and the final act of ingesting life-ending medication to be removed. The intention of such a limit – to ensure the person’s capacity – is good, but we are concerned that this time limit could have a pressuring effect on the person to take the medication before they were ready, so as to avoid having to repeat the process.

We recognise that the removal of the upper time limit of 28 days between the two formal requests (that was proposed in the previous Bill) lessens this risk, and welcome this change. Our preference, however, would be to have the life-ending medication delivered by a healthcare professional, who could ensure the patient still had capacity and had not revoked their decision.

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?

Dignity in Dying believes that only patients who are terminally ill should have access to assisted dying; we do not support assisted suicide for people who come under the wider definition of having a "life-shortening" illness.

We define terminal illness as a progressive illness that is reasonably expected to lead to a person’s death within six months. This six month prognosis is the same criteria as used in Oregon, and is a feature of other pieces of legislation and public policy throughout the UK – for example personal independence payments for people with terminal illnesses under Section 82 of the Welfare Reform Act 2012. We acknowledge the difficulty in drawing a line between terminal illness and non-terminal life-shortening conditions, but we believe a line must be drawn and six months appears to be the best balance between ensuring public safety and preventing unnecessary suffering for dying people.

We are concerned that the requirement that the person considers their quality of life to be “unacceptable” is open to subjective interpretation (see point 7 below).

When someone is terminally ill and they have assistance to die, they control the manner and timing of a death that would otherwise be unbearable to them. This is not suicide – it is a means of controlling the timing and manner of their imminent death.

The general public appear to recognise the distinction between assisted dying and assisted suicide. British Social Attitudes surveys show that whilst an overwhelming majority of the public support a change in the law on assisted dying for terminally ill people, opinion is more split on a change in the law on assisted suicide for people who are not dying.

The experience of Oregon’s Death With Dignity Act, which has been in operation for 17 years, shows that a safe assisted dying law can be passed. Such a law, were it to be passed in Scotland or the rest of the UK, would

ensure that dying people could have open and honest conversations with their doctors about their death. It would prevent dying people from taking their own lives at home and potentially incriminating loved ones who assist them. A change in the law would mean that all dying people, not just those with the financial and logistical capabilities to go to Switzerland, could have access to an assisted death.

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

Whilst the Age of Legal Capacity (Scotland) Act 1991 and the Adults with Incapacity (Scotland) Act 2000 define “adult” as someone who has reached the age of 16 years, other laws applicable in Scotland continue to recognise the age of majority as 18. Dignity in Dying believes eligibility for assistance to die should be limited to those who have reached the age of 18.

We agree that only individuals with mental capacity should be eligible for assistance to end their life.

We agree that an individual must be registered with a medical practice in Scotland in order to request assistance to end their life.

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

Dignity in Dying believes that medical practitioners are best-placed to determine a person’s prognosis and assess a person’s mental capacity. We therefore agree that the first and second requests must be endorsed by medical practitioners.

As noted above, the importance of open and honest conversations between medical practitioners and their patients cannot be overstated. We believe that patients must be fully informed of all of their care options as well as having an assisted death – this is an important part of the Oregon process, meaning that many people do not take up the option of an assisted death where their needs may be better served by altering their care or care setting.

We are concerned that the first and second requests appear to require (at Section 9 (2) (c) and 11 (2) (c)) a medical practitioner to assess the patient’s quality of life. Such an assessment could, in our view, encroach on the medical practitioner’s professional independence. It would represent a shift from a more objective assessment (diagnosis and mental capacity) to a more subjective assessment of the person’s quality of life.

We agree with the role of pharmacists in dispensing the life-ending medication, though we would prefer the medication to be dispensed to another healthcare professional (see answers to questions 4 and 9).

We do believe a strong “conscience clause” is needed in legislation such as this, though we note that this could go beyond the legislative competence of

the Scottish Parliament insofar as it would engage with the regulation of the medical professions.

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

We agree with the Bill in differing from the Oregon model, where a life-ending medication is prescribed directly to the person, as this does not offer sufficient guarantee that the person continues to have mental capacity when they choose to take the final act.

We have commented at point 9 on the practicalities of the assistance given in order to help a person end his or her own life.

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

Dignity in Dying would prefer that assistance to die is provided within the context of healthcare professionals already known to the patient. A healthcare professional with proper training could check the person had not revoked their decision before providing medication, ensure it is taken correctly and be on hand in the unlikely event of complications.

Another area where the presence of a healthcare professional would be preferable is in the case of the "practical assistance" to be given by the licensed facilitator under Section 19 (a). Whilst preparing a medication for oral ingestion may be a comparatively simple task, in some cases a person may need to ingest the medication through the use of a feeding tube or intravenously, whether by hand or by syringe driver. In these cases, it would seem that the presence of a healthcare professional would be essential.

It is important that a licensed facilitator is provided with complete training to ensure they are able to provide the best assistance possible and welcome the provisions under Section 22 to allow the Scottish Ministers to set out full training, registration and standards requirements.

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

We agree with the role of the police as provided for in the Bill.

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

None.

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