

Assisted Suicide (Scotland) Bill

Free Church of Scotland

Introduction

We are grateful for the opportunity to submit written evidence on this Bill. We regret that the limit of 2000 words has been imposed, which makes it very difficult to express fully our objections to the Bill. We therefore crave the indulgence of the Committee if we go beyond the limit.

There is no question asked about the principles of the Bill, only “the general purpose”. This reflects the determination of the late Ms MacDonald in her Consultation to consult only on “the specifics of the process” rather than on the principles on which the Bill is based. This is a serious omission, as it was on the principles of the End of Life Assistance Bill that it was defeated at Stage 1 after exhaustive scrutiny. These principles have not changed and no amount of tinkering with the process will make the Bill acceptable. We will deal briefly with some of these principles in answering question 1.

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

We are intrigued by the phrase “general purpose”. On the face of it the Bill has a very specific purpose. However, perhaps unwittingly, the question shows that framing such a law may well have effects other than the specific purpose for which it was framed. We will return to this later (Q 11).

We oppose the purpose of the Bill for the following main reasons:

- Sanctity of human life. As a Christian Church we believe that human beings are made in God’s image and likeness and this gives an inherent dignity to each one of us. This demands that we treat human life with the utmost respect and this prohibits the deliberate ending of an innocent human life, including one’s own. It also prohibits assisting others to end their own lives. Our responsibility is to protect human life, especially at its weakest and most vulnerable, and our humanity is best shown in our mutual care for one another to reduce suffering and to give appropriate support right up to the end of life. This includes making palliative care available to all who would benefit from it. It does not demand that we attempt to prolong life indefinitely by burdensome treatment when no long-term benefit is achievable.
- Limitations on autonomy. The main principle on which the Bill is based is that of individual autonomy, which, it is claimed, gives us the right not only to choose the time and manner of our death but also to demand help to end our lives if we are unable to do so by ourselves. But our personal autonomy is already limited in many significant ways by legislation which is aimed at protecting ourselves and others. It is an

abuse of autonomy to claim not only that I have a right to take my own life when I find its quality unacceptable but also that I have a right to get someone else to help me end my life regardless of the effect this may have on others and on society in general. This extreme individualism is unrealistic and dangerous to society as a whole. Humans are relational, not autonomous beings. We have a duty of care for others in society, especially those who are vulnerable. People can exercise their autonomy to refuse treatment that they consider burdensome and uncertain in its benefits and this may shorten their lives. But this is not euthanasia.

- Quality of life. The concept of finding one's quality of life unacceptable seems to be based on loss of independence, control and dignity, and not only on the suffering of symptoms such as pain, which, in the vast majority of cases, can be relieved by palliative care. This is an insufficient basis for deciding a life is no longer worth living. None of us is completely independent. We are dependent on others to a greater or lesser extent throughout our lives as well being dependent on our environment, the creation of which we are a part. We believe that ultimately we are dependent on God himself. We support the concept and practice of 'independent living', which gives disabled individuals choice and control over the extent and manner in which they are supported. But this still involves a measure of dependence on others. It is as we learn to give and accept care that we realise our full humanity.

Although we may suffer a subjective loss of dignity due to loss of independence, loss of privacy and loss of control of bodily functions, we do not lose the inherent human dignity which we each possess as human beings. This inherent dignity does not depend on any capability or lack of it. Rather it is inherent to our humanity as made in God's image.

If we decide our quality of life is such that we no longer wish to live, this will inevitably have an effect on others in similar or worse situations and how they are viewed by society. We are in effect inviting society to believe that such lives are not worthy of life. We have a duty towards such people of protecting their inherent human dignity and right to life.

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 attempts to be clearer, simpler and more specific than its predecessor. Although some aspects are clarified, many ambiguities remain and it is no more acceptable as legislation than its predecessor.

- The change of title attempts to narrow the scope from "end of life assistance" to "assisted suicide". Also an attempt is made to distance assisted suicide from euthanasia. This is unsuccessful (see answer to Q 8).

- It is claimed that this Bill is better drafted than its predecessor. This, however, is debateable. This Bill is written in a way that is confusing because of frequent cross-references for clarification. Also many terms are used which require definition, as they are capable of various interpretations. For example, in Section 18 (3) the word “cause” requires some elaboration. In Section 19 the phrase “best endeavours” is used without definition or specification.
- The qualifying conditions claim to be narrower and more specific, in particular purporting to exclude people who are permanently physically incapacitated. However, as we shall endeavour to show, this is by no means as clear as is claimed (Q5).
- The three stage process, beginning with a preliminary declaration is different, and we will comment on this later (Q 4).
- The introduction of “licensed facilitators” is an attempt to distance medical practitioners from the act of suicide and, as we shall argue, is as unacceptable as the previous procedure (Q 7 & 9).
- The procedure to be followed during and after the assisted suicide is different and is poorly defined (Q 8, 9, 10).

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?

It is intriguing that Part 1, section 1, subsection (3) provides for circumstances in which the process of the Act has not been followed. This seems remarkably like the status quo. Since at present there is no specific crime of assisted suicide, prosecution is at the discretion of the COPFS and the court, in any case, would have complete discretion in finding that a crime had not been committed based on the evidence submitted to it. This shows that the Bill is unnecessary. The purpose of the law is to protect the vulnerable. It is doing this at the moment and should not be changed. This Bill would open the way for vulnerable people to be put at risk because assisted suicide would become socially acceptable and deemed a valid ‘treatment option’ to offer to people. Subtle internal and external pressure could be brought to bear on vulnerable people, especially in these financially straitened times. The current incidence of ‘elder abuse’ further heightens our concern about the potentially harmful effects of this Bill.

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?

The preliminary declaration

The purpose of this seems to be threefold: if done while the person is in good health, to lay down an early marker for those interested in assisted suicide as an option in some future situation; if done late, to provide a screening process

before the first request; to be a safeguard for those who are not interested in assisted suicide. We object strongly to the provision that it can be made from the age of 16 while in a state of good health. This opens the door to encouraging thoughts of suicide at a vulnerable age, as well as softening up society to accept suicide as an acceptable way out of problem situations. At a time when the Scottish Government is commendably trying to reduce the suicide rate, this is unacceptable. There seems to be no logical reason for anyone to make such a declaration until faced by the diagnosis of a possibly terminal illness. One week is far too short an interval between a preliminary declaration and a first request. Undue pressure would be just as likely to occur for a preliminary declaration as for an actual request, so it does not provide much of a safeguard.

The first and second requests

See answers to Q 5 and 7

The short 14 day time limit between the second request and the assisted suicide is purportedly to ensure that capacity is maintained. However, it could well give rise to extra pressure to go through with the suicide rather than await a natural end which might not be far away. Statistics from Oregon show that many lethal prescriptions and drugs are never used by the intended recipients. They are a 'back-up policy' – surely a very poor medical practice.

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?

- These two provisions are capable of wide interpretation, especially when qualified by “for the person”. “Life-shortening”, in particular, widens the range of illnesses and conditions to which this would apply. Whereas “terminal” would normally indicate a life-expectancy of days, weeks or months, “life-shortening” could apply to a situation where there were many years of life expectancy. Thus illnesses and conditions such as diabetes, some forms of heart disease and lung disease, Progressive Multiple Sclerosis, Motor Neurone Disease and, in some cases, tetraplegia would qualify in certain circumstances.
- The other provisions, which are not mentioned in the question, are that the person has an unacceptable quality of life and the person sees no prospect of improvement of quality of life. Since the foregoing provisions are fairly wide, these qualifying provisions assume an even greater importance. Thus persons with many years of life-expectancy could qualify if they saw no prospect of improvement and found their quality of life unacceptable. These are very subjective judgements which are impossible to falsify. These provisions leave the door wide open for incremental extension to conditions which at first sight are neither terminal nor severely life-shortening. It all depends on the person’s subjective view of quality of life and the readiness of the medical practitioners to acquiesce.

- The qualification of “condition” by “progressive” seems to have the purpose of excluding conditions which are not usually progressive, such as tetraplegia, while including conditions which are, such as Muscular Dystrophy. However, this is by no means clear. Disabled people have just as much to fear from this Bill as they did from the ELA Bill. The protestations of the Policy Memorandum 27-30 fail to convince.
- Medical assessment for mental illness such as depression should be mandatory.
- There should also be assessment of the level of palliative care and social support being given in order to have some objective measure of quality of life. The vast majority of people who receive good palliative care do not persist with requests for help to end their lives.

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

NO

Sixteen is too young an age to make such a momentous decision.

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

- The requirement that the preliminary declaration be recorded in the medical records of the person might, in the event of the endorsing practitioner not being in the person’s practice, involve the medical and other staff in an activity they might not be in favour of and to which they might have conscientious objections. The Bill makes no allowance for a conscience clause in such circumstances.
- The two medical practitioners endorsing the two requests have to judge capacity. This differs from the End of Life Assistance Bill in which it was a psychiatrist who would do this (Explanatory Notes 28). There is no mention of the necessity of examining the person for the possibility of mental illness such as depression, which might be present and yet not affect capacity, while causing suicidal thoughts. Such an examination would take some time and should not be glossed over. This is a serious defect.
- There is no mention of excluding the presence of undue pressure and ensuring that the request is entirely voluntary.
- The medical practitioners do not need to specify the illness or condition. This would seem to render a thorough examination of the person unnecessary and is wide open to abuse, especially since the medical practitioners do not seem to need to acquaint themselves fully with the person’s case. This is deplorable. Good medical practice is based not only on a thorough knowledge of disease and health, but on

good personal rapport with the patient and detailed assessment. This cannot be gained in a brief interview, however many case records are available. Since only a minority of doctors are in favour of any form of euthanasia, people would have to search for a suitable medical practitioner.

- There is no mention in the Bill of the acts of prescribing and dispensing or supplying the “drug, other substance or means” by which the person is to end his or her life. This would be a serious departure from the traditional roles of medical practitioners and pharmacists and would require changes in the professional guidelines for these professions. This we oppose strongly, as the role of these professions should never be to bring about death deliberately and should always be to care and treat appropriately until the natural end of life. The Policy Memorandum (38-40) and the Explanatory Notes (38-39) treat this in a rather cavalier fashion, considering that the Royal College of General Practitioners opposes a change in the law. This is not a merely technical or procedural matter, but affects the nature of the profession and the doctor-patient relationship.
- There is no mention in any of the documents of a death certificate, who should complete it or what should be entered as cause of death. There is no mention of collection of statistics of assisted suicide. There is no mention of monitoring or of a review mechanism. Would these be left to Government directives, to be worked out later?

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

- This seems deliberately to remain unspecified in the Bill (Policy Memorandum 38-40 and Explanatory Notes 38-39). So it could be by prescribed oral barbiturates or other drugs; by an inert gas like helium, self-administered by means of a supplied mask or hood; or by the use of some sort of apparatus through which the person could self-administer a lethal drug intravenously. The list could go on – depending on human ingenuity. This is a serious defect, as some means might be undetectable and this could open the door to abuse. Again there seems to be an attempt to distance health professionals from the act of suicide, because some of these means would not require the involvement of a doctor and would therefore be more difficult to supervise and police.
- These means increasingly approach the euthanasia side of the spectrum of “assisted dying”, where more and more is done by the person supplying the means. For instance, someone who cannot swallow and is being fed through a tube could have a bottle of a lethal drug prepared and set up so that the person could self-administer it by opening a valve. If his or her hands were very weak, assistance would be needed, so that it becomes a joint operation, possibly with most of the strength coming from the assistant. Or it could be triggered through

a computer by a slight finger movement or the blink of an eye. This shows how difficult it can be to differentiate between euthanasia and assisted suicide.

- If a person fulfils the requirements of having a life-shortening or terminal illness or condition, etc, but is unable to perform the act directly causing death, the person might go to law on the basis of unfair discrimination and denial of 'rights', if assisted suicide is admitted as a 'right' under certain ill-defined circumstances. Once the principle is legalised in one form, it is possible that it may be extended to include euthanasia. This is another reason to reject the Bill.

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

- Sixteen is too young an age for this onerous responsibility.
- The role of the licensed facilitators may clash with the role of health professionals delivering care for the terminally ill person. It is unlikely that the facilitator would have the all-round training and skills necessary to deliver such care. What about the conscientious objections of these care attendants who have to be present to the end of the person's life?
- The psychological effects on the facilitators could be deleterious to their well-being.
- There is no requirement for the facilitator to keep records, or even to be present at the moment of death. This confirms that this Bill is poorly drafted.
- There is no mention of the place or premises in which assisted suicide may be carried out. We would object strongly if this were allowed in NHS premises.

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

The only role of the police specified is as recipients of the report from the facilitator of the assisted suicide or attempted assisted suicide. The Policy Memorandum (49) states that it is for the police to make any investigation they consider necessary and to report to the procurator fiscal if they have any grounds for believing that the correct procedure had not been followed. So on a verbal report from a facilitator, the police could just record the report and forget it. Why should they investigate it as a routine? This seems another attempt to make this a routine matter, not a monumental change in society's dealing with life and death issues.

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

Cost implications

Because we oppose the Bill in principle, we oppose the use of public money both to set up the licensing structure for facilitators and also to meet any charges on the NHS. The Financial Memorandum (28) argues that it is difficult to calculate the overall financial effect, although there may be some savings in individual cases depending on how long they would have lived if they had not undergone assisted suicide. Section 29 emphasises that cost-saving is not a purpose of the Bill, but it is all too easy to see this becoming a factor if this Bill were to become law, thus putting even more vulnerable people at risk.

Possibility of extension in the future

According to Paragraph 54 of the Memorandum the sponsor of the Bill “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 that would offer hope to other categories of people seeking assistance to die.” This would suggest that the Bill is seen as a first step towards wider access to assisted dying, possibly to include euthanasia, which some campaign groups favour.

Conclusion

This Bill is wrong in principle and is poorly drafted. The proposed safeguards give no confidence that vulnerable lives will be protected. The Bill should therefore be rejected.

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