Assisted Suicide (Scotland) Bill

Scottish Council on Human Bioethics

The **Scottish Council on Human Bioethics** (SCHB) is an independent, non-partisan, non-religious registered Scottish charity composed of doctors, lawyers, biomedical scientists, ethicists and other professionals from disciplines associated with medical ethics.

The principles to which the Scottish Council on Human Bioethics subscribe are set out in the **United Nations Universal Declaration of Human Rights** which was adopted and proclaimed by the UN General Assembly resolution 217A (III) on the 10th of December 1948.

The SCHB's response can be shared internally with other Scottish Parliament policy teams who may be addressing the issues discussed. They may contact the SCHB again in the future and the SCHB gives permission to do so.

The SCHB is very grateful to the Scottish Parliament for this opportunity to respond to the consultation on the **Assisted Suicide (Scotland) Bill**. It welcomes the Scottish Parliament's intention to promote public consultation, understanding and discussion on this topic.

Question 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?

Scottish Council on Human Bioethics Response

Though the Scottish Council on Human Bioethics (SCHB) recognises the compassionate aims of those wanting to legalise assisted suicide in Scotland it is opposed to such legalisation. This is because:

1. Palliative care can address the suffering of a terminally ill person

Advocates of assisted suicide have suggested that it would enable persons who become terminally ill and find themselves in an unbearable situation, to not have to suffer a slow, drawn-out death.

In response to this, the SCHB notes that:

Physical suffering can be adequately alleviated in all but the most exceptional circumstances with up to 95% of patients having their pain and/or symptoms effectively relieved when treated by healthcare professionals with the relevant expertise.1,2 Experience shows that once people are comfortable and their fears

[1] Organisations such as the Hospice Movement reveal that suffering can be adequately alleviated in all but the most extreme cases. See also Pain Control - BBC - http://www.bbc.co.uk/religion/ethics/euthanasia/euth_pain_control.shtml; Using Opioids to Control Pain http://www.painlaw.org/opioids.html

concerning suffering have been addressed, they often change their minds about wanting to end their lives.3 Similarly, patients with an illness, such as motor neurone disease (a serious progressive neurological disorder), are often afraid of choking to death. But studies from the most experienced hospice units have demonstrated that, with appropriate palliative care, this virtually never happens. Thus, few patients request assisted suicide when their physical, emotional and spiritual needs are properly catered for with palliative care.

Moreover, even in the extremely rare cases where physical suffering does not fully respond to treatment there is the possibility of using artificial transient or (very occasionally) total permanent palliative sedation in patients to keep them asleep in order to address physical and/or mental distress.

In this regard, there will always be rare cases of patients whose symptoms cannot be completely controlled. These are often patients who have significant psychological and/or spiritual distress which they find difficult to resolve. Almost all patients with uncontrolled distress have elements of this kind of suffering which cannot be recognised as physical.

Some suffering may bring about self-realisation by the human person able to understand his or her worth and gain meaning in life (a common feeling many experience in their daily difficulties). This is also dignified and optimistic. It may, therefore, be possible to question whether the potential for this realisation should be ignored through the elimination of the person in the context of a pessimistic outlook.

It is, of course, important that patients with difficult symptoms are not promised complete relief since this is beyond the realm of medicine. But palliative care does not only include medical treatments since it endeavours to provide support and the right environment for patients to express and work through their distress.

2. It is wrong to suggest that any person can ever lose his or her inherent human dignity

Advocates of assisted suicide have suggested that individuals should be able to determine their own dignity and quality of life, unrestricted by the moral, cultural, religious, or personal beliefs of others. For example, it has been proposed that persons who fear that they will lose their dignity during the final stages of a terminal illness should be able to 'die with dignity' before these stages occur. This understanding reflects the concept of non-inherent dignity which can exist in degrees and can even be lost when a person is not treated properly.

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[2] When correctly used to relieve pain in a patient who is terminally ill, morphine should never cause death. By contrast it usually lengthens life and improves its quality. This is because the therapeutic dose of morphine, which relieves pain, is virtually always well below the toxic dose which ends life and because the relief from pain which it brings removes stress factors in the patient's condition. In addition, toxic doses risk causing increased agitation in some patients.

[3] Van Der Maas PJ, Van Delden JJM, Pijnenborg L, Looman CW. Euthanasia and other medical decisions concerning the end of life, Lancet, Vol. 338, 1991.

In response to this, the SCHB notes that:

An appropriate distinction should be made between inherent and non-inherent dignity. It is incorrect to suggest that any person can ever lose his or her inherent human dignity. Though inherent human dignity is not a scientific concept, it is something that everyone should always accept is present in everyone to an equal extent. This is in accordance with the **United Nations' Universal Declaration of Human Rights** which affirms in its preamble "the inherent dignity and…the equal and inalienable rights of all members of the human family" as "the foundation of freedom, justice and peace in the world".

This means that even when sick people become incontinent or cannot feed themselves and become dependent on the care of others, they do not lose their inherent human dignity.

Moreover, with assisted suicide, as opposed to suicide, another person must believe that it would be preferable for a person wishing to die not to continue living. Assisted suicide, is a reflection of the unacceptable belief by a person that another person has lost, or will lose, his or her inherent dignity to such an extent that his or her life is not worth living and should be ended.

Thus, if assisted suicide was legalised in Scotland, it would mean that society would accept that some individuals can actually lose their inherent human dignity and have lives which no longer have any worth, meaning or value.

It would also mean denying the inherent human dignity which is due to an individual in order for him or her to be legally killed. In other words, it would give the message that human dignity is only based on subjective choices and decisions and whether a life meets certain quality standards.

But no government should ever be prepared to go back to the abuses of humanity in the past in which inherent human dignity was not believed to be present in certain kinds of persons just because of their physical characteristics and that they could, therefore, be exploited or killed.

It should be noted that a society that does not believe in the inherent dignity of human life cannot offer any valid argument against murder. It is a society that has lost its trust in the intrinsic value and meaning of life and cannot comprehend why it should be endured; a society where the values of life have been completely undermined and where the killing of persons becomes acceptable.

This is in complete opposition to a responsible, benevolent and compassionate society which continues to affirm and defend the lives of all its members and the notion that every human life is full of value, meaning and richness even though persons may be aged, dependent on others or may have lost their autonomy.

3. Full and complete autonomy undermines the concept of inherent human dignity

Advocates of assisted suicide have suggested that a person's fear of disability and

dependency should enable him or her to die while he or she is still autonomous and that assisted suicide would enable self-determination to exist. In other words, that individuals have the right to take decisions concerning their own life and death situations in accordance with their own values and beliefs. These should not be imposed by a court, a physician or a family member. It is a question of freedom and equality in the face of death.
Thus, advocates of assisted suicide have suggested that nobody has the right to impose on the terminally-ill and the dying the obligation to live out their lives when they themselves have persistently expressed the wish to die.

In response to this, the SCHB notes that:

The recognition of every person's full, complete and total autonomy does not enable the concept of inherent human dignity nor, for that matter, an interactive society to exist. Instead, it would mean the fragmentation and atomisation of society whereby everybody would live as completely free and independent individuals.
But the very concept of inherent human dignity is dependent on persons having relationships with one another in an interactive society. It is not based on an individual's own personal subjective views.
Moreover, being dependent on others should never be associated with a loss of dignity. All are born dependent on others and many will die dependent on others. Being dependent on others is part of human nature and a characteristic of who a person is.

Historical precedent in the Netherlands demonstrates that progression to involuntary euthanasia requires only four accelerating factors: favourable public opinion, a handful of willing physicians, economic pressure and no convictions for those involved. If legislation allowing assisted suicide comes into effect, and political and economic interests are brought to bear, the generated momentum could prove overwhelming.

4. The concept of inherent human dignity cannot exist independently of others

Some supporters of assisted suicide have indicated that they should be able to choose whether or not they have lost their dignity and that this does not have any consequences on others.

In response to this, the SCHB notes that:

In an interactive society, making a choice about the value of a life (even one's own) means making a decision about the value of other lives.
Legalising assisted suicide would mean that parliament, and therefore the whole of society, accepts that inherent dignity can be lost and that there is such a thing as a life unworthy of life.

Persons who consider that their lives are no longer worth living or believe that they have lost their dignity are, in a way, indirectly indicating that the lives of persons in similar or in worse medical situations than themselves are also not worth living and should be ended.

In the same way, persons who consider that their lives are no longer worth living or believe that they have lost their inherent dignity have to reject the worth, value and meaning that others, such as their family, friends and even society, are giving to their lives. To consciously deny and reject (without attenuating circumstances such as mental disorders) the value, meaning and worth given by others to one's own life can be considered as an extremely nihilistic, self-centred and insensitive behaviour.
Thus, personal opinions about worth, meaning and value of human life matter to the whole of society.

5. It is wrong to believe that opposition to assisted suicide is based on non-secular belief systems

It has been suggested that only those with religious or other non-secular beliefs are opposed to assisted suicide and that they should not be able to oppose those who believe, instead, in the autonomy of the individual to choose when to die.

In response to this, the SCHB notes that:

The belief in the inherent dignity and inviolability of human life is, in fact, based on international globally accepted secular principles such as:

- The **United Nations' Universal Declaration of Human Rights** which affirms in its preamble "the inherent dignity and…the equal and inalienable rights of all members of the human family" as "the foundation of freedom, justice and peace in the world".

At the national level in Europe, the **German Constitution** has presented the strongest example of the need to base the whole social and political order on the principle of human dignity which was prepared only a few years after the Second World War. This was done in order to avoid a return to the barbarous ideologies and practices which had recently taken place in Germany. Thus the first article of the German Constitution states:4

Human dignity is inviolable. To respect and protect it is the duty of all state authority.

Many other national constitutions5 also affirm this principle as the basis of legal systems with international legal instruments such as the **Council of Europe**

[4] See a detailed commentary on this article by Ernst Benda: «Die Würde des Menschen ist unantastbar», in Beiträge zur Rechtsanthropologie, ed. Ernst-Joachim Lampe, Stuttgart, Steiner Verlag, 1985, p. 23. In Roberto Andorno, The paradoxical notion of human dignity, http://www.revistapersona.com.ar/9Andorno.htm

[5] See Constitution of Belgium, art. 23; Constitution of Switzerland, art. 119 (concerning biotechnological interventions on human beings and nature); Constitution of Ireland, Preamble; Czech Republic Constitution, Preamble; Constitution of Spain, art. 10; Constitution of Sweden, art. 2; Constitution of Finland, art. 1; Constitution of Greece, art. 7.2; Constitution of Poland, Preamble, art. 30; Constitution of Lithuania, art. 21; Constitution of Slovenia, art. 34; Constitution of Russia, art. 21; Constitution of South Africa, Section 7.1 and Section 10; Constitution of Mexico, art. 3.1, 25; Constitution of Israel, art. 1; Constitution of Brazil, art. 1; etc. See a selection of legal texts which mention dignity explicitly, in Dignity, Ethics and Law, ed. J. Knox and M. Broberg, Copenhagen, Centre for Ethics and Law, 1999. In Roberto Andorno, The paradoxical notion of human dignity, http://www.revistapersona.com.ar/9Andorno.htm

Parliamentary Assembly Recommendation 1418 (1999) on the Protection of the human rights and dignity of the terminally ill and the dying6, which is the latest text on the issue, indicating in Article 9.c. that:

The Assembly therefore recommends that the Committee of Ministers encourage the member states of the Council of Europe to respect and protect the dignity of terminally ill or dying persons in all respects by upholding the prohibition against intentionally taking the life of terminally ill or dying persons, while:

> i. recognising that the right to life, especially with regards to a terminally ill or dying person, is guaranteed by member states, in accordance with Article 2 of the European Convention on Human Rights which states that "no one shall be deprived of his life intentionally";
>
> ii. recognising that a terminally ill or dying person's wish to die never constitutes any legal claim to die at the hand of another person;
>
> iii. recognising that a terminally ill or dying person's wish to die cannot of itself constitute a legal justification to carry out actions intended to bring about death.

These texts emphasise the universal and absolute nature of the concept of human dignity. They support the notion that no person (including oneself) can lose his or her inherent human dignity at any time in his or her life. To reject such a notion would not only seriously challenge the whole concept of inherent human dignity but would be an extremely serious precedent in a world that has fought so hard to endow all persons with the same inherent dignity. In addition, the concept of a person being able to lose human dignity would dangerously undermine the most fundamental principles embodied in these texts which form the foundations of civilised societies.

6. Assisted suicide would undermine the protection due to the most vulnerable persons of society

Having the option of assisted suicide is dangerous since it may be considered by many elderly and other vulnerable people who feel that they are a burden to family, carers and society or that their care may be eating up some of the inheritance which they wanted to pass on. A risk then exists that these vulnerable people may believe that a right to die is actually a duty to die.

This is reflected in a letter to **The Herald (12 February 2009)** by Dr. Alison Morton-Cooper who, as disabled person herself, indicated that: "Seen as a financial burden to society, friends and family, it is sometimes assumed that it is better, therefore, for us to shuffle out of sight - and mind - before it gets too uncomfortable for the rest of you."7

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[6] Council of Europe Parliamentary Assembly Recommendation 1418 (1999), Protection of the human rights and dignity of the terminally ill and the dying, http://assembly.coe.int/documents/adoptedtext/ta99/erec1418.htm

[7] Assisted suicide does nothing to bring about dignity in life which disabled people need, The Herald, 12 February 2009, http://www.theherald.co.uk/features/letters/display.var.2465080.0.assisted_suicide_does_nothing_to_bring_about_dignity_in_life_which_disabled_people_need.php

Vulnerable people need to hear that they are valued and unconditionally accepted by the community. They need to know that society is committed first and foremost to their well-being, even if this does involve expenditure of time and money. The manner in which the weakest and most vulnerable members of society are treated reflects the kind of society one is.

7. The request to die may not reflect the patient's real wishes

There is good evidence that a desire for death in terminally ill patients can vary with time and is closely associated with clinical depression which can often be addressed.8 The states of delirium and/or confusion are common in palliative care patients and are sometimes so subtle that they are difficult even for clinicians to recognise. It is impossible to be absolutely confident that a request for a life to be ended does not arise from a disordered state of mind.
In other words, whilst many people are competent to make decisions about their wish for assisted suicide, many will not be in such a situation. This could mean that a decision to end a person's life could be made by a second person such as a nominated proxy. The complexities arising from such conditions could lead to a serious abuse of power.

Furthermore, it has been noted that persons receiving palliative care often change their minds about their desire for assisted dying.9

8. Neither suicide nor assisted suicide should be seen as acceptable alternatives

The attempted suicide of an individual, such as a young person, is never seen as something to be encouraged in society. Instead, a lot of concern is raised as to the individual's state of mind and the fact that he or she may need psychological assistance or counselling. In other words, it would be completely unethical to help someone commit suicide in these circumstances. In the light of this, it is difficult to consider how any form of assisted suicide can be considered.

Conversely, if assisted suicide was ever decriminalised, a risk would then exist that the suicide of individuals, such as healthy young persons, would also be considered as acceptable to society at the very moment when the Scottish government is trying to reduce the very high suicide rates in some parts of the country with programmes such as **Chooselife** (www.chooselife.net).

Moreover, as soon as a second person is consciously involved in the suicide of a person and this is accepted by society, dangerous consequences as to the manner in which the whole of society considers the value, meaning and worth of human life are to be expected.

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[8] Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

[9] Van Der Maas PJ, Van Delden JJM, Pijnenborg L, Looman CW. Euthanasia and other medical decisions concerning the end of life, Lancet, Vol. 338, 1991.

9. Distinction between acts and omission

The distinction between acts and omission argues that there is a difference between actively killing someone and refraining from an action that may save or preserve that person's life. For example, it is considered morally wrong to push someone into a river to his or her death but that a moral duty to leap into the river to save someone who is drowning may not exist.

However, in a medical context there is a moral duty for the physician to undertake what is reasonable to save and preserve life. If a certain lifesaving intervention was consciously not initiated by a physician in order to kill a patient, then this could be considered as murder. If, on the other hand, a physician follows good medical practice and addresses the best interests and well-being of the patient and does not initiate futile and burdensome interventions and this, as a side effect, shortens the patient's life, then no objections would normally be brought against the physician.
In other words, the critical distinction between murder and good palliative care is related to the physician's intention which is an extremely important concept in law.

10. Prohibiting assisted suicide acts as a deterrent to bypassing post-mortem review committees

Some countries which have legalised assisted suicide have changed their legislation in order to only examine the legality of an act of assisted suicide after the event has taken place by a post-mortem review committee.

In response to this, the SCHB notes that:

Once an illegal act of assisted suicide has taken place it is too late to redress the offence since the patient has died. Thus, it is preferable and more responsible that a prohibition on assisted suicide should be in place to deter any abuse or transgressions in this area.

Furthermre, by prohibiting assisted dying, it is possible to consider hard cases in which there is a measure of ambiguity, on a case by case basis, in an appropriate court of law and judged accordingly with a measure fairness and compassion where relevant.

Question 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?

Scottish Council on Human Bioethics Response

Justification for a change in the law

The SCHB notes the vague justification for developing a new Bill so soon after the last one was soundly defeated about three years ago. Ms. MacDonald made the point that she had received a 'volume of correspondence' and continuing public interest in the debate which made her believe that 'most people are convinced of the need for such legislation.' In our democratic society, it is extremely important that it is

proven that the majority of the Scottish people want the change. The SCHB would question Ms. MacDonald's evidence.

Ms. MacDonald quoted polling results as evidence of enduring public support but research carried out by the Market Researches Services in 2005 for the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill in England found that opinion polls purporting to show that a large majority of people would favour a change in the law are misleading. They are generally based on answers to 'yes/no or 'either/or' questions without any explanatory context and without other options such as good quality care being offered.
The results of polls are limited in value and cannot be accepted at face value as an authentic account of opinion within the UK. The research also observed that there is widespread ignorance or misunderstanding of the complex clinical, legal and ethical issues involved in changing the law. While there are minorities with strongly held views, one way or another, on the subject, many people are inclined to the concept of legal change when confronted with questions about offering a 'choice' with 'safeguards' to 'incurably ill' people who are 'in pain' or are suffering intolerably.

Ms. MacDonald also quoted the recent Commission on Assisted Dying chaired by Lord Falconer. But since most of the committee and the backers of this commission were known supporters of a change in the law it is hardly surprising that this biased piece of work has come out with the result that it has done. The SCHB is aware that many palliative care staff refused to be involved with it.

Of course, autonomy for patients is very important in clinical practice, as patients are very much at the heart of the decision making process. However, that does not mean that their decisions should always be implemented as there are other considerations, such as the needs and vulnerabilities of other patients, to be taken into account. Autonomy seems to be used as justification to give people what they want but this cannot always be the case if a civilised society is to survive.

The document

The new Bill would be modelled on the system in Oregon and Switzerland. Ms. MacDonald is convinced that the Oregon experience of assisted suicide is not problematic and does not disadvantage vulnerable people. However, the system in Oregon is not without its problems.
Many doctors in Oregon are not in favour of their assisted suicide law and will not support patients who request it. Patients have to go 'doctor shopping' to find one who will help. Moreover, the doctor who will assist may not often know the patients and is unlikely to be certain whether they are acting with full autonomy. Depression is not easily diagnosed with a limited consultation. In fact, when the law was first passed, one in three patients was referred for psychiatric assessment. However, in the last few years there have been practically none.

The kind of patient who requests assisted suicide tends to be a self determined person who wants to have control over the timing and manner of his or her death rather than for reasons of physical suffering. Many are concerned of becoming a burden to others. This may reflect a lack of disinterested solidarity and support in a family or society, which is the real pathology that may need to be addressed.

Question 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?

Scottish Council on Human Bioethics Response

Criminal and civil liability for the providing of assisted suicide should not be suspended. Instead assisted suicide should continue to be regarded as culpable homicide in Scotland.
Moreover, precluding any criminal and civil liability for those providing assisted suicide may provide an inappropriate inducement to individuals who may be reluctant to assist in the suicide.

The Bill would enable Scottish society to accept that certain lives are not worth living and should be ended. This kind of thinking, however, should never be tolerated in a civilised society in which every human life is inherently valuable and worthy of life. The equal and inalienable worth and value of every human life is the very basis of civilised society.

Advocates of assisted suicide have suggested that, at present, it appears to be extensively practised in secret and that it is this reality that carries the greatest potential for abuse. They indicate that the pressures that can influence end-of-life decisions will be more pernicious if exercised in the dark and that the gap between law and practice must be reconciled if respect for the rule of law is to be maintained.

In response to this, the SCHB notes that:

It is not because something, which is illegal and unethical, such as murder, is practised in secret that the law should be changed. If this happened it would completely undermine the rule of law in a country.

Question 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?

Scottish Council on Human Bioethics Response

The SCHB believes that any pre-registration declaration document from a patient for assisted suicide is inappropriate and dangerous because it may enable vulnerable people to be pressurised to consider assisted suicide.

Question 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?

Scottish Council on Human Bioethics Response

The SCHB believes that the suggested eligibility requirements are inappropriate. It would be difficult to decide who would meet the criteria. How is a terminal illness or condition defined? The margins between terminal and chronic illnesses are becoming

blurred. Cancer in many cases is becoming a chronic illness though the patient may ultimately die from it. But certain 'chronic' illnesses such as diabetes can be life limiting. In fact chronic illnesses can be more distressing for patients as they may be ill for a longer time.

Questions can also be asked about patients who are terminally ill, such as with motor neurone disease, but who cannot take the medication. Self-administration of any lethal drug would be impossible to any person who needs complete assistance. This demonstrates that any legalisation of assisted suicide would inevitably lead to demands for full blown euthanasia by some members of the public.

For whom, exactly, is this proposed Bill being considered? It seems to be for the kind of person who would currently go to Switzerland – self determined people who know their own mind. They would still have to end their lives before they may be ready to do so as they would have to take the medication themselves and not wait until it is too late. Most people who have advanced illness are not in that category - they are vulnerable and frightened and would be worried about the existence of such a Bill.

For a terminally ill patient, finding life intolerable can be a temporary situation and, with time, can eventually believe that life has meaning. Waiting two weeks between assessments is too short to allow these patients to move on from difficult feelings. There are various stages of the acceptance of the dying process. Some of the negative processes need to be experienced by persons before they can accept their condition. These feelings may adversely influence the patients when making decisions if they have not matured through the natural process. They may then make decisions which are not autonomous. How do witnesses, who may not know the patient well, discern that they are not under any influence? Or indeed a doctor who is asked to be involved if the patient's own doctor opts out?

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

Scottish Council on Human Bioethics Response

The SCHB is not satisfied with the eligibility requirement as regards age, capacity, and connection. These are all open to potential abuse.

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

Scottish Council on Human Bioethics Response

Assisted Suicide should not be considered as a medical procedure

It is often suggested that assisted suicide should be considered as a medical procedure supported by health care professionals.

In response to this, the SCHB notes that:

Assisted suicide actually undermines the meaning of medicine which has always

been to cure and care but not to harm or kill patients.

Research demonstrates that most sustained demands for assisted suicide are actually considered by persons suffering from existential problems or because they have such an extreme concept of control and independence that they are prepared to deny their own inherent human dignity to get what they want.10

In other words, the argument in favour of assisted suicide is more about control than medicine. This is reflected in that most physicians are opposed to this practice.11

Assisted suicide would undermine the relationships of health care professionals with their patients.

Advocates of assisted suicide have suggested that curing disease and bringing about death are not mutually exclusive roles, the intention in both cases being the relief of suffering. It is further argued that the primary role of the physician is to care for his or her patient, which must therefore entail respecting their autonomous wish to die.

In response to this, the SCHB notes that:

Crossing the boundary between acknowledging that death is inevitable and taking active steps to bring about death changes fundamentally the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society.

Some physicians may become hardened to death and to causing death and start considering their patients as disposable, particularly when they are old, terminally ill, or disabled. Legalising assisted suicide would give persons, such as physicians, power that could be too easily abused, and a responsibility that they should not be entitled to have. In very rare cases, physicians such as Harold Shipman12 may actually feel empowered in being able to provoke death.
Because of these very rare cases, however, many vulnerable groups of people may start to doubt the real intentions of their doctors. Indeed, a number of legal changes have taken place in response to Shipman, in order to protect the vulnerable from such people.

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

Scottish Council on Human Bioethics Response

The SCHB does not believe that the filming of the death will add to the safeguards and is entirely undignified. How many people would like to have such a public death?

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[10] Linda Ganzini, et. al., Physicians' Experiences with the Oregon Death with Dignity Act, The New England Journal of Medicine, Vol 342, February 2000.

[11] BMA maintains opposition to assisted dying, http://bma.org.uk/news-views-analysis/news/2013/november/bma-steps-up-opposition-to-assisted-dying [Accessed on 2 April 2014]

[12] Harold Shipman: The killer doctor, BBC News, 13 January 2004, http://news.bbc.co.uk/1/hi/uk/3391897.stm

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

Scottish Council on Human Bioethics Response

The SCHB believes that the suggested process is inappropriate and dangerous. To charge anyone with the task of assisting with the killing of someone, be it execution or assisted suicide, is completely undignified, inhumane and cruel. It is an intolerable psychological burden to place on facilitators, and there is no appropriate justification for allowing such use of individuals. When it comes to those who prescribe and prepare the lethal dose, the current definitions of participation are ambiguous at best. This participation will be the source of great distress to some individuals and would even be open to legal challenges.

Moreover, if the Bill precludes civil and criminal liabilities for those providing assisted suicide, this could have serious repercussions on the manner in which it may be possible to bring eventual abuses to the courts.

The facilitator stays with the patient throughout the process and may film the death, but returns any medication not used within a specified period. Does that mean the facilitator moves in with the patient until he decides when to take it? If the presence of the facilitator is required during the act of taking the medication then he or she would need to be continually present. But what is to stop the patient waking up in the small hours and swallowing the medicine on his or her own? Does this not put pressure on the patient to take it when the facilitator appears at the door with the drugs?

If this person were a physician and should volunteer or declare themselves as a specialist suicide facilitator, would any other patients want to attend his or her practice for treatment? They may be afraid or confused in opening their heart to someone prepared to consider suicide as an acceptable option or help to kill patients if they get depressed and contemplate or plan suicide! The medical practice of any physician with those views would necessarily become limited! They may end up just facilitating death and be isolated from balanced medical views! Will there be practical classes on how to cause the smoothest death?

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

Scottish Council on Human Bioethics Response

Each time a person dies or attempts suicide but does not die, this must be reported to the police. It would then be for the police to make any investigation they consider necessary.

Moreover, if suspicions do arise, this may (1) take a long time to investigate, (2) be distressing to the police officers examining the procedures and (3) produce inconclusive results since only the licensed facilitator would be present.

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

Scottish Council on Human Bioethics Response

The SCHB believes that any governmental support for assisted suicide would completely undermine its campaign to reduce the number of suicides in Scotland. It would also undermine the government's position that all human life has inherent human dignity which is vital for a civilised society to exist.

The SCHB is of the opinion that if Scottish society accepts assisted suicide it would also mean that it would accept that some lives are unworthy of life which completely undermines any notion of equality between individuals in society. Suffering and dying persons would begin to be considered as having less or even no worth in society and, therefore, would be seen as having a duty to die quickly.

Scottish Council on Human Bioethics