

Assisted Suicide (Scotland) Bill

The Scottish Youth Alliance

The Scottish Youth Alliance is a coalition of young people in Scotland seeking to promote human dignity. We work to empower young people to impact policy and culture by facilitating involvement and enabling them to make their voices heard at local and national levels.

We thank the committee for this opportunity to comment on the current Bill. While answering all of the committee's questions, our emphasis will be on the fundamental weaknesses in the general principles of the Bill.

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. The policy objectives as set out in the policy memorandum can be summarised as autonomy, compassion and control; we believe the Bill is fundamentally misdirected on all three counts.

In terms of autonomy, the Bill is aimed at people who wish to 'retain control of their lives to secure a dignified death at a time of their choosing'.¹ This is an illusion of autonomy as choosing the time of one's death is not to control life but to end it: there is no greater destroyer of autonomy than death. Furthermore, by placing any restrictions on assisted suicide the Bill contradicts even this limited understanding of autonomy.

The End of Life Assistance (Scotland) Bill Committee ("EOLA Committee") considered the issue 'in the context of preserving a balance between an individual's right to exercise autonomy and the interests of society as a whole' and concluded that 'the wider societal concerns should prevail'. We believe the same concerns should prevail against this latest Bill.

The Bill claims to be about allowing a 'good death' but is in fact about quality of life: having a life-shortening illness does not mean you are dying yet. The only reason for the Bill being limited to the terminal or life-shortening illnesses and conditions appears to be as an attempt to avoid the objection that the previous Bill 'inappropriately targeted disabled people.'² The reasons put forward in the current Bill, however remain the same: 'pain or discomfort', 'inability to experience or enjoy those things that previously gave their life meaning and which most of us take for granted', 'they may be paralysed or have limited mobility, they may need help with feeding and washing, everything they do may be painful, slow and frustrating.'³ All of these criteria apply to long-term conditions and illnesses and so it is of no surprise that many disabled people continue to feel threatened by the current proposals. If the only criterion for determining the value of someone's life is how close they are to death, then this is certainly not a compassionate response.

¹ Policy Memorandum, 3.

² Policy Memorandum, 13.

³ Policy Memorandum, 4.

Indeed, deliberate death can never be a compassionate response to human suffering. The inherent dignity of the human person (as recognised, for example, in the Universal Declaration on Human Rights) demands that everything be done to improve quality of life but prohibits deliberately hastening death.

The argument that the Bill would bring control is belied by the fact that current illegal practices as described in the policy memorandum include assisted suicide and euthanasia. The idea that all illegal euthanasia would cease if assisted suicide were legalised is more than questionable. The control such a law might bring would therefore be severely lacking in both depth and breadth. Moreover, studies in other countries that have brought in assisted suicide or euthanasia have shown reporting rates to be worryingly low.⁴

The incremental extension of legislation expected and envisaged in the policy memorandum is being seen in Belgium. For example, age restrictions have been lifted, and intensive care doctors are calling for the right to euthanize patients without their consent.⁵ Furthermore, the EOLA Committee found that 'There is no ambiguity in current Scots law in this area' and that 'Any call for clarity is, therefore, spurious.'⁶

We can only conclude that the general principles of the Bill are severely lacking and that its purpose, although well-meaning, is fundamentally mistaken.

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 fails to address most of the concerns of the EOLA Committee, and what has been changed appears to have been altered in an attempt to avoid previous opposition rather than to create a good piece of legislation.⁷

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?

Criminal and civil liability exists to protect the weak and vulnerable. No safeguard will ever be as effective as maintaining liability. This is particularly so when the 'savings' (section 24) limit liability yet further, and no penalties for abuses or 'careless' errors are given, 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?

The process would do nothing to prevent the influence of the subtle societal pressures that inevitably accompany the legalisation of assisted suicide. The doctor

⁴ E.g. 'Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases', *BMJ* 2010;341:c5174.

⁵ "'Piece" of mind: End of life in the intensive care unit Statement of the Belgian Society of Intensive Care Medicine', Jean-Louis Vincent, et al. *Journal of Critical Care* 1 February 2014 (volume 29 issue 1 Pages 174-175)

⁶ Stage 1 Report on the End of Life Assistance (Scotland) Bill, 256.

⁷ Cf. E.g. *Policy Memorandum*, 29 & 54.

is required to assess whether a request for assisted suicide is being made voluntarily and without external influence. This is far from being straightforward or reliable. It is necessary to ensure that an applicant is not acting as the result of internalised pressures, such as a sense of duty to remove him or herself as a care burden on the family or to avoid consuming in nursing home fees money that is 'needed' by children.

The process does not encourage the long-term accompaniment of the patient by the practitioner, ignoring the dignity of the patient and the necessary human relationships. Furthermore, there is no provision for the practitioner to cancel any stage in the process should new information come to light. The requirement that the second medical practitioner be identified by the first is meant to prevent 'shopping' for a supportive doctor in dubious cases, but it would seem likely that the patient would be referred to a supportive doctor anyway, so it would be no real safeguard. Moreover, individuals are free to seek initial endorsements from doctors outside of their own practice.

The short waiting periods exist to permit claims that 'no-one opts for an assisted suicide without careful consideration over an appropriate period'⁸, but there is no counselling, consideration of alternative treatments, or support required. The witness is required to have known the individual 'for a period longer than that associated with the signing of the declaration' (schedule 1), but no minimum period is specified. Similarly, the doctor need only confirm that the patient's conclusion about her quality of life 'is not inconsistent with the facts currently known to me' (schedule 3): there is no investigative obligation on the medical practitioner, nor even any requirement that the patient's conclusion be reasonable. Furthermore, the very completion of a declaration could potentially alter the relationship between patient and practitioner.

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?

That such central terms are left undefined is extremely worrying. Specifically, the phrase 'terminal or life-shortening' is extremely broad in its scope and, combined with a broad interpretation of 'for the person', could cover a vast array of illnesses and conditions. Legalising assisted suicide in these cases would change the culture surrounding care for sick and dying people, and would be a catastrophe in terms of how our society confronts illness and disability.

The Bill in effect states that the lives of people with a qualifying illness or condition have no objective worth: their only value is the subjective worth held by the individual. Our feelings of self-worth and of what constitutes an acceptable quality of life fluctuate. The changes in quality of life associated with a terminal illness or progressive condition can be dramatic, but they are changes that many people come to terms with over time. The late Alison Davis was sure that the most compelling argument she could present against assisted suicide was her own experience: 'Had euthanasia or "assisted suicide" been legal I would have missed the best years of my life. And no one would ever have known that the future held such good times, and

⁸ *Policy Memorandum*, 20.

that the doctors were wrong in thinking I didn't have long to live.'⁹

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

In a matter of such gravity it would surely be prudent and responsible to err on the side of caution with regard to the maturity of applicants. The minimum age of just 16 for patients, witnesses and facilitators is simply too young. Regarding capacity, we are concerned that it is not a required element of the preliminary declaration and that its assessment is confused. Even at first and second requests, there is no mandated or recommended psychiatric (or indeed physical) assessment.

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

The Bill attempts to distance medical practitioners from the act of suicide, but if a doctor cures by prescribing life-saving drugs then he similarly kills by prescribing lethal ones: assisted suicide is killing. As the Solicitor General for Scotland made clear in his evidence to the EOLA Committee, the chain of causation is not broken by voluntary ingestion: supplying lethal drugs is sufficient causation.¹⁰ The Bill is expecting medical practitioners and pharmacists to cause patients' deaths. Doctors are no longer making clinical decisions but sociological ones, being asked to endorse the weight of patient's personal perceptions.¹¹ This dangerously subverts the very real need for a genuine doctor-patient relationship.

It is unlikely that the practitioner would have a detailed knowledge of the patient, making it difficult to be sure that the patient was not acting under duress. The so-called protection in the Bill would thus be no more than a formality: the 'best of my knowledge' may be very little knowledge indeed. This would be especially true of the second medical practitioner. The issue was raised by the EOLA Committee but has not been addressed.

There is no legislative protection of conscience, merely an anticipation that professional organisations might acknowledge ethical or faith-based objections in any revised guidelines or codes of practice.¹² This is a completely inadequate level of protection. It is further anticipated that medical practitioners and pharmacists would not exercise an opt-out but no evidence is given, and the position of professional bodies suggests otherwise.¹³

⁹ <https://www.spuc.org.uk/about/no-less-human/alison>

¹⁰ Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report*, 28 September 2010, Col 231.

¹¹ Cf. *Policy Memorandum*, 31: 'The aim here is not to substitute the person's judgement about the quality of their own life with a medical opinion.'

¹² *Policy Memorandum*, 39.

¹³ A change in the law is formally opposed by, among others, 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.

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

The Bill is silent on precisely what means of suicide are to be legalised. The Policy Memorandum envisages that a lethal dose of barbiturate or other drug would be prescribed and dispensed, but the Bill is open to other forms of killing, such as suffocation, carbon monoxide poisoning, hanging, shooting or assistance jumping over a cliff. This is an unacceptable lack of precision.

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

While there are of course many professions that are concerned with death in one way or another, there is no other profession whose primary purpose is to bring death. Any such facilitator would be worryingly vulnerable to the psychological effects of such a position. As with doctors, we must also consider the effect that the counsel of those predisposed to see assisted suicide as a positive choice will have on vulnerable people's decisions.

The lack of concrete limits to their role (can they hold the cup? lift the cup? pour the cup so long as the patient deliberately swallows?) risks tempting the facilitator to go just a little bit further when a patient is unable to himself. Similarly, the Bill has nothing to say about the additional assistance provided by other persons present.

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

The role of the police is ill-defined but is sure to stretch officers' time. The Bill has not answered any of the issues raised by the Association of Chief Police Officers in Scotland in response to the EOLA Bill. The Bill calls 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 would contradict the government's current efforts in suicide prevention. By promoting the idea that death is the appropriate response to a perceived lack of quality of life, the Bill would have consequences beyond those covered by the Bill. For this reason alone the Bill would be imprudent and dangerous.

In conclusion, this Bill is flawed both in principle and in detail. The Scottish Youth Alliance calls upon the Scottish Parliament to reject this Bill at the earliest opportunity.

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