

## Assisted Suicide (Scotland) Bill

### Society for the Protection of Unborn Children

#### The Present Bill and its Predecessor

This Bill differs from the previous version in that euthanasia is expressly excluded. However, the logic behind assisted suicide is the same as that behind euthanasia. Euthanasia legislation must be seen as an inevitable consequence of the acceptance of assisted suicide. Excluding euthanasia may increase the Bill's chances of passage, but it is likely that euthanasia legislation will eventually be sought, especially when difficult cases arise in which patients cannot complete their suicide and call upon others to intervene and complete the act.

As justification for this Bill, the Policy Memorandum uses the fact that "some doctors have ... administered deliberately higher doses than needed for pain management in order to bring the patient's suffering to an earlier end".<sup>1</sup> This is in fact euthanasia.

Even though the Bill requires that death must result from the "person's own deliberate act" [s18(3)], this is an area of some uncertainty. For example, would helping raise someone's weak hand to assist in bringing death-inducing drugs to their mouth constitute an external deliberate act and therefore euthanasia? The answer is likely yes. And indeed, the policy memorandum uses this specific example of assistance that may be provided by a facilitator.<sup>2</sup>

#### Criminal and Civil Liability

Protection from civil and criminal liability highlights a difficulty regarding vulnerable people. People contemplating suicide often see themselves as a burden, and there are some who would agree with them and wish for the burden to be removed. Pressure, manipulation, coercion, and compulsion are a real risk. Furthermore, some family members may also stand to gain financially from someone's death. This problem is not resolved by simply mandating a set of disqualifying relationships for witnesses, proxies and facilitators, as the Bill does. Coercion and pressure can readily be applied to encourage someone to undertake the steps required under the Bill, and that pressure can easily come from family members or others disqualified from direct assistance. Their indirect 'assistance' is protected from criminal and civil liability.

#### Preliminary Declaration and Request Process

A preliminary declaration can be made while someone is young and in good health. This develops a culture of assisted suicide by encouraging those not even contemplating it to have predetermined their response, regardless of how they might actually feel if a health crisis were to occur. Similarly, since the making of a preliminary declaration does not require capacity, someone with a mental health disorder could make one. This potentially means that an option for assisted suicide could be set in the mind of a very vulnerable person quite early in life and precondition their response to a health problem later in life.

The subsequent first request for assisted suicide can only occur after more than 7 days following the preliminary request, but may occur many years later. The second request must occur more than 14 days after the first, but again could be many years later. Each request requires endorsement by two medical practitioners. All of these steps may be seen

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<sup>1</sup> Policy Memorandum, para 6.

<sup>2</sup> Policy Memorandum, para 48.

as safeguards, yet they could all be streamlined with relative ease. No step is arduous or particularly restrictive.

The way the preliminary declaration and requests are arranged would allow for two extremes. First, a preliminary declaration could be made, followed by a first request 7 days later followed by a second request 14 days later, immediately followed by suicide. This is the quickest time frame permitted. Alternatively, a preliminary request could be made at age 16 for example, followed 10 years later by a first request, followed 30 years later by a second request, followed 14 days later by suicide. The large time gap between first and second request could mean that when it actually comes to the point of real vulnerability, someone could make their second request and be dead within a day, having not thought at all about assisted suicide for 30 years. This scenario highlights how unsafe any 'safeguards' really are.

#### Criteria for Illnesses and Conditions

This Bill requires diagnosis of an illness that is either terminal (with no time specification) or life-shortening, or a condition that is progressive and either terminal or life-shortening. In either case the qualifier "for the person" adds considerable subjectivity. Also, the person decides what makes their quality of life unacceptable and with no prospect of improvement.

This definition embraces a broad sweep of conditions, other than mental health disorders, including any number of genetic conditions that may foreshorten life, and at any stage of their development.

Likewise, those who have in fact suffered permanent physically incapacitating conditions could argue that there is evidence that their life will be foreshortened by that condition: for example, those with muscular dystrophy, multiple sclerosis, diabetes, dementia, various cancers, or cardiac disease. The removal of physically incapacitating conditions was an attempt to respond to critics of the previous Bill, viz. that it 'stigmatised some people as having lives not worth living'.<sup>3</sup> However, the problem remains just as pertinent, if not more so, with the current Bill. There are numerous illnesses and conditions that are both permanently physically incapacitating and life shortening.

The other key change from the previous Bill is removal of the requirement that the person finds their condition 'intolerable', and replacing it with finding their quality of life unacceptable. The latter is a lower standard than the former, lowering the bar considerably. Even though both are subjective, finding the circumstances unacceptable is much easier to argue than them being intolerable.

#### Age, Capacity, and Connection with Scotland

As before, this Bill assumes that a 16 year old has the ability in the circumstances to make a life and death decision. It is well-recognised that time and care is needed when coming to terms with a new and challenging medical condition. That people can gradually come to terms with life's circumstances after initially despairing is not an uncommon observation. How much more critical is such a phase for a 16 year old, with limited life experience and underdeveloped ability to make complex judgments regarding likely future scenarios. This Bill will put highly vulnerable young people at serious risk of suicide because the prospect of a meaningful life cannot yet be conceived.

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<sup>3</sup> Policy Memorandum, para 29.

The conditions requiring a link to Scotland have been considerably weakened. Previously someone had to be registered with a medical practice for a continuous period of 18 months. This no longer holds. According to the minimal legal requirements of the Bill, someone could enter Scotland, register with a medical practice, make a declaration and requests then receive assisted suicide all within 3 weeks.

Regarding capacity, this Bill requires that the person not be suffering from any mental disorder. The term 'mental disorder' is unlikely to include depression.<sup>4</sup> Therefore, someone who fits the criteria set by this Bill may in fact be depressed and seek assisted suicide because of untreated depression. Moreover, the fact that no psychiatric assessment is required, unlike in the previous version of the Bill, adds risk for vulnerable depressed people.

#### Role of Health Professionals

This Bill places considerable power in the hands of medical professionals. The underlying assumption is that all will adhere to the same high standards. But this is not necessarily the case. In a Belgian study for example, 32% of cases reported by physicians involved euthanasia without explicit request<sup>5</sup>, an illegal activity. In any case, only about one half of cases were even reported.<sup>6</sup>

In Oregon, 61% of the 271 lethal prescriptions from 2001 to 2007 were written by just 20 physicians.<sup>7</sup> The few doctors who are prepared to do this work are likely to become the well-known suicide doctors. The requirement that a second doctor be involved and known to the first, rather than acting as a protective measure as stated<sup>8</sup> will instead help establish a group of like-minded doctors.

The other critical issue here is the need to allow for conscientious objection. The Bill makes no allowance for doctors who are required to participate at many levels. Moreover, the Bill's drafters imply the necessary involvement of Pharmacists by stating that they "would be expected to dispense the 'medicine'".<sup>9</sup> Health professionals must be permitted to exercise their universal rights of conscience not to participate at any level. It is not enough to expect that peak bodies will amend their guidelines to ensure conscientious objection. The rights of conscience should be guaranteed by legislation.

#### The Act of Suicide

The Bill makes no stipulation about the means by which suicide can occur. This vacuum leaves the means wide open to the imagination. It could be by any choice of drugs, mixture, or indeed any means at all. There is no requirement that drugs be prescribed by a medical practitioner.

This laxity risks encouraging experimentation. One could envisage circumstances in which suicide attempts leave individuals in even more seriously compromised health.

<sup>4</sup> Lindsay D. G. Thomson, The Mental Health (Care and Treatment) (Scotland) Act 2003: legislation for mentally disordered offenders, *The Psychiatrist* (2006) 30: 423-429. doi: 10.1192/pb.30.11.423 See <http://pb.rcpsych.org/cgi/content/full/30/11/423>

<sup>5</sup> Chambaere K *et al*, Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey. *Canadian Medical Association Journal*, 182(9):895-901, June 15, 2010.

<sup>6</sup> Smets T *et al*, Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases. *British Medical Journal*, 341:5174, 2010.

<sup>7</sup> See [http://www.oregonlive.com/opinion/index.ssf/2010/03/cornering\\_the\\_market\\_on\\_physic.html](http://www.oregonlive.com/opinion/index.ssf/2010/03/cornering_the_market_on_physic.html)

<sup>8</sup> Policy Memorandum, para 32.

<sup>9</sup> Policy Memorandum, para 38.

Alternatively, means may be chosen that are thought to work quickly and painlessly, but instead lead to an unpleasant and painful death, leaving everyone involved deeply traumatised. In Oregon for example, several botched suicides have been reported under the Act<sup>10</sup>, but the real number is unknown because of poor reporting. This Bill permits circumstances of death where no one with any medical expertise need be present.

#### Licensed Facilitators

While the Bill makes allowance for the licensing of facilitators, nowhere is it specified that they must be involved. Moreover, the Policy Memorandum envisions that others present may assist with the suicide.<sup>11</sup> However, it is also possible that a patient may, if they so wish, be entirely alone for the act of suicide.

Licensed facilitators, if present, could be as young as 16. The law is permitting teenagers to become involved in assisting suicides.

The Bill requires facilitators to remove suicide substances or means within 14 days of the second request if they have not been used. This requirement is impractical - the means of suicide could easily be kept from a facilitator.

#### Role of police

As noted, facilitators are not expressly required to be present, so not every suicide will be reported to police. Likewise, if someone were to suicide alone, their death would not be notified to police - presumably until someone found them.

#### Other Matters

There are no requirements in the Bill for any reporting mechanisms to the parliament or to any public authority. The Bill also does not make any requirement for independent review of the processes authorised by the Bill. Assisted suicide is an issue of such gravity that such lack of oversight is unacceptable.

One of the most serious problems associated with assisted suicide legislation is that once the key principle - that the state must protect innocent human life - is surrendered, it becomes impossible to contain the law from further change. This is because there is no enduring basis for retaining either the access criteria or the particular limitations or safeguards.

#### Conclusion

This Bill is just as deeply problematic as its predecessor and should be withdrawn. The vulnerable disabled, sick, and frail in Scotland will be far better served by an ethos of caring, compassionate, and humane medicine using modern evidence-based treatments, and/or provided with quality palliative care when necessary.

### **SPUC Scotland Society for the Protection of Unborn Children**

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<sup>10</sup> Disability Rights Education & Defense Fund. Some Oregon Assisted Suicide Abuses and Complications. See [www.dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/](http://www.dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/) For further information about botched suicides and complications see <http://www.patientsrightscouncil.org/site/oregon-ten-years/>

<sup>11</sup> Policy Memorandum, para 43.