I should say at the outset that I welcome the opportunity for Members of the Scottish Parliament to debate this important issue, and for members of the public to make their own views known. I have confined myself in what follows to addressing specific matters in the Bill itself, but would be happy to supply further information on the general area if that was deemed appropriate.

s. 2(1)(b): arguably, this gives an excessive amount of power to doctors, and may allow them to impose their own morality in deciding whether or not to allow the patient’s request. Giving this supreme gate-keeping role to doctors risks the kind of problems that arose initially in the interpretation of the Abortion Act 1967, which ultimately required that doctors were instructed by their professional bodies that they must refer to another doctor if their own morality was opposed to abortion. Perhaps the obligation to refer for a second opinion in such cases should be written into the Bill to avoid these problems arising. This would allow doctors to act according to their conscience, without precluding patients from accessing an assisted death. Perhaps this could be achieved by the inclusion of a ‘conscience clause’ which includes the specific requirement to refer on.

s.4(2)(b): I think that there could be serious problems surrounding the interpretation of what amounts to ‘independent living’. Again, given the authority handed to doctors by this Bill, this is presumably open to interpretation which could be based on personal attitudes. ‘Independent living’ does not seem to be susceptible of objective analysis. That being so, it might be preferable to omit this criterion altogether and simply rely on the individual’s belief that life is ‘intolerable’.

s. 6(1)(b): I think that a ‘valid and documented request’ should be broadly described; that is, it can be verbal or in writing, but must be properly recorded by the attending clinical staff. If patients are unable to sign a document, a witnessed verbal declaration, signed by witnesses and the attending physician should be sufficient evidence of intent. Otherwise, some people with particular kinds of disability would be unable to take advantage of the law. It should be noted that one of the major initial challenges to the Oregon Death with Dignity Act came from the disabled lobby who argued that some disabled people would be unable to avail themselves of the Act because of an inability to swallow the prescribed medicine. Similar objections could be raised to the need for requests to be in writing.

s.9(4): It might be worth specifically noting here that the mere presence of a mental illness does not necessarily (in law) mean that a person lacks competence. The definition of competence in this section seems to have been lifted more or less completely from the (English) case of Re C, in which
the court upheld the right of a man suffering from paranoid schizophrenia to refuse treatment that, in the view of his doctors, would be life-saving. Problematically, the explanatory notes to the Bill seem to go against this generally accepted proposition by specifically indicating that the term ‘mental disorder’, the existence of which would presumably preclude the individual from making a valid request for assistance, includes ‘mental illness’.

s.11(2): there is no obvious rationale for the request’s validity to expire after 28 days. Evidence from Oregon suggests that a number of people have chosen not to use the prescription for some time after it has been provided – in some cases this has been more than a year. The evidence suggests that some people are comforted by the mere knowledge that they can end their lie at a time of their choosing and may in fact live longer than if they were forced to take the medicine within a specified time limit. While it could be argued that this section doesn’t prevent people from re-starting the process, it seems an unnecessary restriction. The process is already complicated and this additional requirement may act as a disincentive for those who otherwise satisfy the necessary conditions to make further attempts. It is difficult to identify what harm would be prevented by this requirement.

In the explanatory notes to the Bill, it is said that article 11(6) requires the designated practitioner to be present ‘when end of life occurs.’ In general, I am unclear why this requirement is in the Bill, but specifically, the question must be answered as to what would happen if the ‘designated practitioner’ is incapacitated, or dies, or is otherwise unable to be present? Is it intended that the qualified patient’s right to receive an assisted death can be invalidated merely because of the unavailability of a third party?

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