Introduction

This memorandum responds to the invitation to submit evidence on the above Bill. Dying Well is a cross-party group of members of both Houses of the Westminster Parliament who support investment in specialist palliative care and oppose the legalisation of euthanasia or assisted suicide. Further information about us may be found on our website www.dyingwell.org.uk. We believe that the answer to the suffering that serious illness often brings is not to kill the sufferer or provide assistance with suicide but to ensure that the high-quality specialist palliative care that already exists in parts of the UK is made available to all who need it.

We give answers below to the specific questions posed in the request for comment.

The Questions Posed

Q1. Do you agree a person should be able to request end of life assistance from a registered medical practitioner?

A1. This question highlights one of the Bill’s principal defects – its lack of clarity. The Bill defines ‘end of life assistance’ as “assistance, including the provision or administration of appropriate means, to enable a person to die with dignity and a minimum of distress” (Section 1(2)). Under the law as it stands, a patient is fully entitled to request such end of life assistance; for a doctor to refuse it would constitute negligence. This is, after all, one of the functions of palliative care. What this Bill is seeking to legalise, however, is not end of life assistance but ending life assistance – i.e. providing a patient with the means to end his or her life (physician-assisted suicide) or administering lethal drugs directly to a patient with the deliberate intention of ending his or her life (euthanasia).

It is not unusual for seriously ill people to say to their doctors that they want to ‘end it all’ when exhausted by inadequately controlled symptoms, demoralised by fear of being a burden, fearful of what lies ahead or depressed as part of the disease, through drug side effects or grieving for lost health. For a doctor to take such a request at its face value and to process what this Bill calls ‘end of life assistance’ risks signalling to the patient that suicide or euthanasia are sensible courses of action in the patient’s own circumstances and the doctor confirms that any efforts to improve quality of life should be abandoned. It would amount to a betrayal, however unintended, of the trust that patients place in doctors – that they will always act in the patient’s best interests and strive to improve quality of life even as disease progresses. This Bill responds to the demands of a very small number of highly determined and
strong-minded individuals, but it would put much larger numbers of less resolute and vulnerable seriously ill patients at risk.

Amongst doctors working in hospices and specialist palliative care, who work daily with patients facing death, over 97% oppose any legalisation of assisted suicide or euthanasia. There is also widespread opposition amongst the doctors as a whole, most of whom would be unwilling to provide such ‘services’ to their patients. Applicants would therefore have to go ‘doctor shopping’, as happens in the US State of Oregon, to find a compliant physician, whose assessment may well lack knowledge of the patient and objectivity. Whatever view the Scottish Parliament takes of what this Bill calls ‘end of life assistance’, it is not a role for the medical profession to perform.

Q2. Are you satisfied with the requirements for age and connection with Scotland as set out in the Bill?

As 16 years is the age of majority in Scotland, it is perhaps arguable that this should be the minimum age for requesting ‘end of life assistance’. However, although the legal age of majority is 16 years, it is a person’s emotional and mental development that affects thinking, as well as mental capacity, for decisions on seeking assisted suicide or euthanasia. Decision-making capacity in this context may be impaired by learning difficulties, or the effects of disease or medication, sometimes compounded by the turmoil of youth. We feel that chronological age is an inadequate safeguard.

The Bill states that an applicant for ‘end of life assistance’ must have been “registered with a medical practice in Scotland for a continuous period of at least 18 months” (Section 4(1) (b)), though this is qualified by the provision that “it is not necessary that the requesting person should have been registered with the same medical practice throughout the period” (Section 4(3)). The purpose of these sections seems to be to prevent ‘death tourism’ - for example, by persons from England crossing the border to avail themselves of the Bill’s provisions. The committee will wish to form a view of whether the Bill would prevent that from happening, since it does not require that the person must have been registered with an NHS practice. A private GP could have patients registered who only occasionally visit Scotland, if at all, but who may wish to avail themselves of the bill’s provisions at a future date.

Q3. Are you satisfied with the two categories of people who would qualify to be assisted under the terms of the Bill?

A3. The Bill offers assistance with suicide or euthanasia to anyone who “has been diagnosed as terminally ill and finds life intolerable” or “is permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable”. Terminal illness is defined as a “progressive condition” in which “death within six months in consequence of that condition can reasonably be expected” (Sections 4(2) and 4(4)).

Let us deal first with the “finds life intolerable” criterion. The select committee examining Lord Joffe’s “Assisted Dying for the Terminally Ill” Bill in the
Westminster Parliament five years ago concluded that a similar criterion – that the applicant was “suffering unbearably” – was inadequate. The select committee’s conclusions apply equally to Margo MacDonald’s Bill as they did to Lord Joffe’s. Suffice it to say here that a criterion which cannot be objectively verified and which rests simply on a statement by the patient of how he or she feels provides no effective safeguard against abuse.

The clinical conditions that are specified as qualifications for the Bill’s ‘end of life assistance’ cover just about anyone who is moderately as well as seriously ill. Not only would the Bill be applicable to people who are thought to have a relatively short lifespan ahead of them. It would also cover anyone with a physical incapacity that makes them dependent on others. There can scarcely be a street in the land where there is not someone who has a physical disability that requires dependence on others. We are not talking here simply about people with long-term and progressive conditions such as multiple sclerosis or Parkinson’s disease. The Bill would encompass much more common conditions such as heart disease or diabetes, with which large numbers of people live with the help of medication; and it would also bring within its ambit others who are blind, deaf or wheelchair bound or otherwise dependent on others to live their lives. It is not possible to estimate with any precision just how many people in Scotland might find themselves as potential candidates for Mrs. MacDonald’s Bill, but the number must run into hundreds of thousands. The Bill’s Explanatory Notes opine that “in the first years the number of people requesting assisted [sic] will be low” and that “evidence from Oregon would suggest that in subsequent years the numbers of people receiving assisted deaths will not increase markedly” (Paragraph 91). But Oregon’s law is limited to assisted suicide and to terminal illness, whereas Mrs. MacDonald’s Bill seeks to legalise both assisted suicide and euthanasia and covers a much wider circle of clinical conditions than terminal illness. And, in any case, the number of terminally ill people receiving assisted suicide in Oregon has quadrupled in the 13 years since the law has been in force. It is no exaggeration to describe the Bill’s ambit as breathtaking.

The Bill’s definition of terminal illness (“death within six months can reasonably be expected”) is naïve. The committee may find it helpful to read what the select committee on Lord Joffe’s Bill was told by expert witnesses on the difficulties of accurate prognosis - “prognosticating may be better when somebody is within the last two or three weeks of their life...When they are six or eight months away from it, it is actually pretty desperately hopeless as an accurate factor”. Nor is diagnosis an infallible art. The select committee was told by the Royal College of Pathologists that post mortems regularly showed that around one in twenty diagnoses of terminal illness had been incorrect.

In summary, the Bill’s eligibility criteria are far too wide – they amount to legalising euthanasia for most moderate or serious clinical conditions. And they take no account of the difficulties, inaccuracies and errors involved in diagnosis and prognosis of terminal illness.

1 See House of Lords Report 86-I (Session 2004-05), Paragraphs 255-256.
2 House of Lords Report 86-I (Session 2004-05), Paragraphs 117-122
Q4. The Bill outlines a several stage consent and verification process that would be required to be followed for an eligible person to receive end of life assistance. Are you satisfied with this process?

A4. The adequacy of the consent and verification process depends on the extent to which it provides effective safeguards against abuse of the Bill’s provisions. Our answers to this question are therefore subsumed in our answers to Q5.

Q5. Do you consider the level and nature of safeguards as set out in the Bill to be appropriate?

A5. We do not consider the safeguards incorporated in the Bill to be adequate, for the following reasons:

(a) Though the Bill requires applicants for ‘end of life assistance’ to submit two formal requests, it requires that both requests are considered and adjudicated by the same registered medical practitioner. There is no provision therefore for an independent medical second opinion.

(b) The Bill does not require two independent psychiatric opinions. While it does not require that the same psychiatrist should adjudicate in both stages, it is to be expected that, unless an applicant should insist on an independent psychiatric second opinion, the registered medical practitioner who is leading the assessment process will refer to the same psychiatrist as for the first request. It is unacceptable that consideration of such a serious proposal as assisted suicide or euthanasia should be conducted on the basis of only one physician and one psychiatrist, neither of whom need know the patient well.

(c) The psychiatrist is required under the Bill to establish whether an applicant is suffering from mental disorder as defined in Section 328 of the Mental Health (Scotland) Act 2003. Under this definition, however, a number of circumstances are ruled out as possible indicators of mental disorder, including “dependency or use of drugs and alcohol”. If this Bill should be enacted, it would be possible for someone addicted to drugs or alcohol to be given the green light to end his or her life. Many seriously ill people will be taking drugs, such as opioids or steroids, that can have a serious effect on mood but fall outside the definition of mental disorder for the purposes of the Mental Health Act.

(d) The psychiatrist is also required to establish whether an application for ‘end of life assistance’ “is making the request voluntarily” or “is acting under any undue influence” (Section 9(3) (b) and (c)). While psychiatric examination may perhaps be able to establish the presence or otherwise of external coercion or pressure, it is less likely to be able to identify instances where an applicant is acting voluntarily in a formal sense but is being motivated by internal and undisclosed pressures, such as feelings of guilt at being a care burden, either to their family or to society as a whole, or a desire to die in order to avoid eroding an
inheritance that had been intended for younger family members. Such feelings are common among elderly and seriously-ill people who express a wish to end their lives, sometimes seeking reassurance that they are of worth and are valued by others.

(e) The Bill requires that, where an applicant is a resident of a care home, "one of the witnesses [to the application] must, where practicable, be an employee of the service designated by a manager of the service as a person who knows the requesting person well" (Section 6(3)(a)). This provision offers scope for the manager of a care home to exercise manipulation in the expectation of a bequest, either for themselves or a third party – the disqualifications referred to in Section 6(5) refer only to persons who “know” (as distinct from expect) that they would benefit from the applicant’s death.

(f) The whole process set out in the Bill has an air of almost-indecent haste about it. The Bill requires that the second formal request be made “at least 15 and not more than 30 clear days” after the first has been approved. This fast-track timetable may perhaps suit a small minority of strong-minded applicants who are determined to go through with ending their lives. But it risks pressuring a much larger number of less resolute people into going ahead with a life-or-death project on which they may retain mixed feelings. If the Bill should ever come to be enacted, it should provide ample time for applicants to reflect on what they are doing and to pull back. A 15-30 day interval between the two stages of application is incompatible with this. It does not allow for the process of adaptation to illness that occurs as patients grieve for loss of health, particularly when illness has been an unexpected shock.

The so-called safeguards in the Bill are largely illusory; it is in effect death on demand. There is no independent second opinion, the definition of mental disorder ignores the effect of drugs and disease on mood and decision making, vulnerable care home residents are not protected from manipulation, and the timetable allows little space for reflection.

Q6. Do you have any other considerations on the Bill not included in answers to the above questions?

There seems to be a widespread perception in the media that Mrs MacDonald’s Bill is seeking to legalise assisted suicide. That is, of course, one of its purposes. But the committee should recognise that it has another, more serious, purpose – to legalise euthanasia. As the Westminster select committee recognized from its taking of evidence from expert witnesses in Oregon and The Netherlands, the impact of euthanasia in terms of premature deaths is very much greater than that of assisted suicide. In Holland, according to the select committee’s report, of the 3,800 deaths a year from euthanasia or assisted suicide over 90% were from the latter; and deaths from euthanasia accounted for around 1 in 40 of all deaths. In Oregon, where only

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3 See House of Lords Report 86-I (Session 2004-05), Paragraphs 243-246
assisted suicide had been legalised, the death rate from this source was around 1 in 650. Mrs MacDonald’s Bill, which seeks to legalise both practices, is modelled on that of The Netherlands, not Oregon. The committee should be in no doubt, therefore, of the impact of its enactment.

It is necessary to consider also the cultural impact of the Bill, if it were to be enacted, on Scottish society. The law as it stands send a clear message – that as a society we disapprove of killing or of aiding and abetting self-harm. This message is underpinned by the strenuous efforts, such as emergency 999 responses and ‘suicide watches’, that are taken to discourage and frustrate attempts at suicide, almost invariably by persons who have found life intolerable. This Bill, for all its window-dressing of compassion and personal choice, sends a completely different signal – that, if you are seriously ill or disabled and dependent on others, you may be better off dead and we should consider helping you on your way.

The law as its stands is firm in its protection of the vulnerable – of people who might be manipulated or otherwise influenced by others to end their lives or of those who might opt to ‘end it all’, not because that is what they want, but because they are anxious to spare others the burden of supporting them. But the law also shows compassion. It often does not prosecute where there is evidence that the deceased was completely determined and acting of his or her own free will and that any assistance given was reluctant and not motivated by personal gain. This Bill, however, seeks something else. It is an attempt to create a tick-in-the-box facility through which people who feel they want to end their lives and others who are inclined to help them on their way can do so without serious soul-searching. Breaking the law in extremis is one thing; creating a facility to sidestep the law is something else. This Bill is dangerous for the people of Scotland and should be rejected.

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