Introduction

This brief paper offers commentary on the January 2010 Bill put before the Scottish Parliament. The objective is to raise points for discussion or of concern with respect to the drafting of the Bill before it comes before the Scottish Parliament. The fact that we have contributed to the consultation should not be construed as evidence that either or both of us approves or disapproves of either assisted suicide or euthanasia; that is a broader and distinct question which we believe requires a different approach from that adopted in the present consultation. Further, while the views expressed herein reflect our agreed personal opinions, they do not necessarily reflect any wider views or opinions of colleagues in the Law School or University.

Comments on specific provisions

S.1. We note the emphasis in this section and throughout the Bill to a ‘person’ who provides assistance in dying. The implication, backed by s.11(6) of the Bill, is that there is no requirement that a medically qualified practitioner carry out the final act of assistance. So far as we know, this is the first Bill in the UK that has attempted to go beyond physician assisted suicide (PAS).

There are two major consequences:

   a) It means the Bill will almost certainly fail;
   b) It has to be accepted that this is not just an extension of the Oregon legislation or Lord Joffe’s Bill presented in the House of Lords but represents largely uncharted territory for any jurisdiction. As such, it is a leap into the unknown and has to be treated with exceptional care.

S.1(2) We believe the sub section to be seriously flawed in that it defines assistance as ‘including the provision or administration of appropriate means’. At the very least, this implies that the two procedures are to be morally and legally interchangeable without further ado. In fact, it is almost universally held that assisted suicide and euthanasia are distinguished by the fact that assistance in dying is provided in the former and administered in the latter. The breadth of the Bill is, thus, extended even further than appears on the surface in that it legalises euthanasia ab initio. It is imperative that this is made clear rather than having to be sought within the text.

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1 We draw attention to the position under Swiss law where, as we understand, it is not a criminal offence for a person to assist another in dying so long as the motive is altruistic. For comment see O Guillod and A Schmidt, ‘Assisted Suicide under Swiss Law’ (2005) 12(1) European Journal of Health Law 25. A copy can be provided on request.
While we believe that this is far more than the public – or parliament – is likely to accept, we suggest that, at a minimum, s.1(2) is amended along the lines:

\[\text{\'}In this Act, end of life assistance includes:}\]

\[\begin{align*}
a) & \text{the provision of appropriate means or } \\
b) & \text{in the event of the requesting person being physically unable to utilise such means, the administration of appropriate means so as to enable ....'}\end{align*}\]

This, in our view, would serve to limit potential distortion of the Bill’s intentions – say, into the field of mercy killing – but would, simultaneously, address one of the most difficult problems in the area – that is, the management of the patient with incapacitating neuromuscular disease.

In respect of the final line of s.1(2), we caution against the inclusion of the terminology of ‘die with dignity’ in this Bill or any subsequent Act. There are two reasons for this. First, the expression ‘dignity’ is notoriously difficult to define and could lead to considerable legal uncertainty. It adds little or nothing to the Bill as it stands. Second, if the reference to ‘dignity’ is a synonym for respecting an individual’s choice to die then it is unnecessary and redundant given the general thrust of the Bill. If a broader notion of dignity is intended then this could be open to wide-ranging interpretation and confusion. We suggest it is sufficient to say: ‘.... enable a person to end his or her life in accordance with ss. 4 and 11 below.’

S. 2. The section refers to ‘medical practitioner’ but there are two minor concerns with this:

\[\begin{align*}
a) & \text{There is no mention of experience;} \\
b) & \text{The law will shortly require that registered medical practitioners must also be licensed if they are engaged in patient care.}\end{align*}\]

We suggest alternative wording: “Registered medical practitioner of at least five years’ standing and holding a current licence to practise.”

S. 3. We believe that consideration should be given to the possibility that temporary and valid revocation can be given to someone other than the designated practitioner in the event that the designated practitioner is not available. We appreciate that s/he must be present at the ultimate act of assistance but they may not be available at an earlier point in time when the patient might wish to revoke their request for assistance. On a practical point, what happens if the practitioner dies or is otherwise indisposed? Is there a case for a nominated deputy in the event that the practitioner becomes incapacitated?

S.4. ss.1(a) Scots law has a tradition of protecting children up to and beyond the age of 16 from decisions that are manifestly against their interests. Thus, for example, while a child has capacity to enter a contract between 16 and 18, this is can be struck down up to the age of 21 if it is
shown to be against his or her interests. Similarly, while the law provides that a child under 16 who understands a medical treatment can give valid consent to that treatment, it does not provide for an automatic right to refuse treatment. Although the arguments are balanced finely on both sides around the need to respect and protect the evolving capacity of the child, it is clearly the case that Scots law can and does intervene to protect children from harmful decisions. On this basis, we suggest that there are strong reasons to argue that the Bill should only apply to those of 18 and over.²

If we are to deviate from the threshold of 18 then we suggest that it would be consistent to reflect the concept of understanding as per the Age of Legal Capacity (S) Act 1991, s.2(4). The difficulty here is how anyone can possibly understand death since no-one can tell us what it involves.³ This having been said, it is, we admit, not an issue that has prevented other jurisdictions adopting legislation on assisted dying. As a final point, and inconsistent though it may be, if the recommendation is to follow the approach of the 1991 Act then it might be prudent to incorporate a minimum age – e.g. 14 - below which authorisation was impossible as a further protective measure for minors.

ss.2(b) We suggest the desirability of a firm rider here on the following lines: ‘The fact that one’s financial resources were, as a result, being compromised would not be allowed as a measure of intolerability.’

ss.(3) We question the inclusion of a restricted 6-month window of opportunity before death if the test is indeed to be intolerability. Surely the real concern is for those who are suffering over the longer-term and who wish to end their pain or other measure of intolerability. We suggest that the reference be to “progressive, fatal condition which cannot be halted”. If the concern is to build in some form of protection mechanism to avoid abuse or expanded use of end of life assistance, then we would point to s.9(2) which requires that full discussions be undertaken about alternative options including palliative care.

For various reasons, mainly semantic, we further suggest that the concept of ‘unbearable suffering’ should replace ‘intolerability’ on the grounds that something that is intolerable, cannot, by definition, be tolerated whereas ‘unbearable suffering’ more accurately reflects the subjective experience of the patient and his/her choice to end that suffering. Note that the appellate English courts have consistently questioned the value of the concept of ‘intolerability’ in cases involving withholding/withdrawal of care.⁴

S. 5(2)(a) Mainly for the avoidance of doubt, we believe that this provision should read ‘only if that person or the requesting person knows of ..’

S. 6(1) There is considerable controversy over how long an advance decision should remain in force due to changes of circumstances etc. Any comparable

² When adulthood is attained: Age of Majority (Scotland) Act 1969, s.1(1).
³ For judicial recognition of this problem, albeit in a different context, see McKay v Essex AHA [1982] 2 All ER 771, Court of Appeal.
concern over time in respect of assisted dying should be mollified, however, by s.11(2), (3) which make it clear that assistance must be provided before the expiry of 28 days from the notification of the approval of the second request. Any remaining doubt centres on how long a request can remain valid before the designated practitioner takes action and this is not clear from s.2. It is to be noted that the time bar relates only to the time between the approval of the second formal request and the provision of assistance in dying (s.11(2)).

A further issue relating to this 28 day time factor is the question of the need for a cooling-off period. If a patient changes his or her mind at the last minute must they begin the process all over again or could the law allow an extension of this period? Such a provision could help to avoid charges of coercion. Equally, returning to our first point, this period should not be too long lest it undermine the original decision. We propose that a one-off extension of 28 days, overseen by the designated practitioner and the psychiatrist, should be included.

S.9 What is to be the definition of a ‘psychiatrist’ for the purposes of the Act? Presumably this would be a registered medical practitioner who is registered as a psychiatrist in the GMC’s specialist register. Even so, there are different types of psychiatrist just as there are different types of pathologist and there is no mention of experience. This is such an important area that it seems to us that there must be very firm evidence of expertise in the field. We suggest something like:

For the purposes of the Act, a psychiatrist is a registered medical practitioner having a current licence to practise who has (a) been registered as a psychiatrist in the GMC’s specialist register for at least 5 years and (b) is certified by the Scottish Ministers as having particular expertise in the field of suicide and assistance in dying.

S.9(4) A central question in this area of legal reform relates to how given the very wide definition of mental disorder provided by the 2003 Act, a person who is suffering such pain that life is intolerable is not, as a consequence, suffering from a mental disorder which might affect the making of a request under the Act? However, this is a problem that crops up throughout the euthanasia debate and it has not proved to be insurmountable in other jurisdictions. What is important is that it opens up the possibility of considerable subjectivity on the part of psychiatrists and this is of major importance in view of the free movement of doctors in the EU. You could get a very different answer to a request for assistance from a Dutch rather than a Scottish psychiatrist - but our recommendation above as to definition might address this concern adequately.

S.9(6) Closer to home, we question very strongly the wisdom of the inclusion of this provision which states that ‘the psychiatrist who acts in relation to the second formal request need not be the psychiatrist who acted in relation to the first formal request’. The purpose of this is unclear. It could easily lead to the difficult situation where the two psychiatrists disagree. What is to happen
then? How will disputes be resolved and where does this leave the requesting person? If it is some form of protective mechanism then we suggest it should be a requirement that two separate psychiatrists be involved. If two are to be involved then some dispute resolution mechanism is required as an integral part of the Bill.

**S.10** We think it very important to include the following additional provision as sub sec 10(1)(e):

> (e) who is to be present at the time the assistance is provided, with the proviso that the nominations are solely at the discretion of the requesting person.

In this respect, for the avoidance of doubt, we suggest an addition to s.11:

Sub sec 11(7). The fact that a person has or may have a pecuniary or other material interest in the death of the requesting person will not prohibit his or her nomination under s.10(1)(e).

Absent such a provision, the propriety of the presence of close relatives, who might well figure in the requesting person’s will, might be questioned

**S.11(6)** This provision takes us back to our comments at the very beginning of this paper: arguably the most disturbing part of the Bill is that it confirms that we are dealing with more than PAS. Not only does it extend assisted suicide to euthanasia but it also reduces the role of the doctor almost to that of counsellor – the only medical requirement as to the actual assistance is that a medical practitioner must be present when the deed is done. Is the Bill deliberately setting up a trade of euthanasist? This may, of course, be a good thing insofar as it might satisfy those doctors who have a conscientious objection to ending life. Nonetheless, there are many members of the public who would see this as an unacceptable extension of PAS and the preamble to the actual assistance involves the doctor to such an extent that it is a remarkable conscience that would be happy to go through the complex administrative process but would feel salved by not actually delivering the fatal dose. We can see tenable arguments on both sides:

*In favour of the role of the euthanasist*

- This sends a clear message that active assistance in dying by way of assisted suicide is not the proper role of the medical profession
- This might remove opposition from the medical profession on both ethical and professional grounds
- There is some precedent for this non-medical role from the experience of Switzerland; if the Bill were to succeed, the position in Scotland might be an improvement in respect of safeguards in that, at least, a medical practitioner would have to be present.

*Against the role of the euthanasist*

- Who would be trained to take on this role? What qualification would be required and how would it be policed?
• Will the removal of the medical profession from the final act undermine trust in the legislation?
• Does this blur the distinction between mercy killing and assisted suicide to an unacceptable degree?

Finally, since the explanatory notes refer specifically to trauma as a possible eligibility requirement (at para 22), we wonder whether the Bill should contain a disclaimer along the lines: ‘The application of s.1 of this Act will represent a novus actus interveniens for the purposes of the criminal law relating to homicide.’ We confess to being divided on this point. One of us believes that assistance in dying should normally be considered as a new intervening act that breaks any causal link of liability for the person who brought about the original trauma. The counter argument is along the lines that a person whose criminal activity has been such as to render a person’s life intolerable should not escape the consequences if the victim bows to the intolerability of the situation into which he or she has been forced. A possible compromise is to consider whether there should be a rebuttable presumption that the casual chain will be broken by assistance in dying and that this can be overturned by prosecution services on good grounds shown.

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