End of Life Assistance (Scotland) Bill

Eileen Grant

I am not a healthcare professional but have been involved in voluntary support work with a mental health support group and also in voluntary advocacy work and counselling. I have also taught adults and found that the biggest part of the job was encouraging people to believe in their own worth. Having spent some considerable time over the last few months scrutinising the End of Life Assistance Bill and also sifting through the many submissions made by individuals and organisations, I am sending you my conclusions on the subject. I was glad when a special committee of experienced individuals was set up to examine this bill and hopeful that wisdom and justice would prevail in the long run.

I should state from the outset that my immediate reaction to this Bill was one of repugnance as I have a deeply felt belief in the worth and dignity of each and every human life. One of my principal objections to the sentiments behind this and similar bills is the suggestion that any human life is devoid of dignity because of the particular circumstances in which a person is living. All life is of value.

As the law in Scotland on assisted suicide is different from that in England and Wales; the recent guidelines issued by the DPP do not apply in Scotland. This Bill, if passed, would represent a new departure in our Scottish legal system and could create further divisions between the north and south of Britain. We could well end up with a form of “suicide tourism” on one or other side of the border. In reality, the current legal position in both Scotland and England allows for the exercise of compassion in individual cases where the fiscal authorities and courts may take mitigating circumstances and motives into account.

Although this Bill has been considerably watered down from its original intentions, it still offers an alarmingly broad scope and is very vague in places. I looked in vain for clarification on several points in both the Bill itself and the accompanying summary. Although the words “physician assisted suicide” are being employed by many advocates of the Bill, it seems rather obvious that what in fact could be on offer is “voluntary euthanasia” such has already been introduced into Holland, with appalling consequences. It would appear that at least three physicians would be involved, including a psychiatrist, but not necessarily the same three. The implication is that one of those physicians would ultimately be expected to administer the ‘means’ – again, this has been left very vague, both as to method and means. Nowhere in the Bill or its summary is it specified what means are envisaged: lethal drugs, as in Holland and elsewhere, or what?

“End of life assistance”, we are told, means assistance, including the provision or administration of appropriate means, to enable a person to die with dignity and a minimum of distress – throughout the Bill the word ‘death’ is
rarely used, substituting instead “end of life”. Language is important here; we should always be wary when a document uses euphemisms.

This Bill would offer ‘assisted’ death to people who are dependent on others and would include those with disabilities, both life threatening and non life-threatening, and many with relatively common conditions. Tens of thousands of seriously ill and disabled people throughout Scotland could be included in these categories.

If the person making a request is living in residential care, we learn, one of the witnesses should be an employee there if possible. The witnesses must sign a statement that the requesting person

- understands the nature of the request
- is making the request voluntarily
- is not acting under any undue influence

This is asking a lot of anyone. There are no built-in guarantees to ensure that the witnesses do in fact know the person well enough to witness to this. A professional carer could be put in a stressful position and might find his/her relationship with residents compromised.

Medical requirements for eligibility are that a person has been diagnosed as “terminally ill”, that is, he/she suffers from a progressive condition and a doctor has stated that he/she has no more than 6 months to live; or that he/she is “permanently physically incapacitated” and “finds life intolerable”. Medical prognosis, however, cannot be an exact science; and the manner in which the Bill defines “terminally ill” or “permanently physically incapacitated” is very vague and could cover a wide range of people who may have years of life ahead of them, while “finding life intolerable” is highly subjective and difficult to quantify. We can all find life intolerable at some stage or other of our lives; this is becoming increasingly common among young people, among whom suicide or attempted suicide is happening more frequently. To legalise “end of life assistance” would be sending out a very negative message at a time when young people need rather to hear messages about the value of all human life. An ‘intolerable’ existence cannot possibly be quantified: it must, at best, remain a most subjective thing, depending on circumstances, mood, support, sense of worth etc.

For the purposes of this Bill a person has the ‘capacity’ to make a request for end of life assistance if he/she is not suffering from any mental disorder which might affect the making of such a request and is capable of

(a) making a decision to request such assistance;
(b) communicating such a decision;
(c) understanding such a decision; and
(d) retaining the memory of such a decision,

“Mental disorder” here, according to the terms of the Mental Health (Scotland) Act 2003, means “mental illness, personality disorder or learning disability”. There are obvious dangers here: where, for instance, a person is
suffering from a reactive depression (presumably not uncommon where one has a terminal illness or is suffering considerable pain), rather than a clinical depression.

It would appear that far more rapid progress is anticipated in meeting a petitioner’s request than is usual in the NHS! The second formal request must be made no more than 30 days after the first. At this stage the requesting person and the designated practitioner must agree

(a) that end of life assistance is to be provided;
(b) who is to provide the end of life assistance;
(c) on the place where that assistance is to be provided; and
(d) on the means by which that assistance is to be provided.

The ‘who’, the ‘place’ and the ‘means’ are left extremely vague. For example, the place “must not be one to which the public has access at the time when the assistance is being provided” but could be a place to which the public normally has access. Does this mean a hospital or care home? It is not clear. There are obvious implications, however: if these “assisted deaths” are to take place in hospitals or care homes, many people may become even more reluctant to enter them. Will we have yet another fear to add to the growing list that currently includes lethal bugs?

The means will already have been agreed upon but again there is nothing in the Bill to suggest what the options might be. It cannot be administered within the first two days of approval of the second formal request but must be administered within 28 days or else the whole procedure must be begun again – might this lead to a certain degree of pressure? It does not allow much time for final consideration.

The who must not be a relative or anyone likely to benefit. So whom does this leave? Although not stated in so many words, it would suggest that the person who both provides and administers the means of death is expected to be a medical practitioner. It cannot be the “designated practitioner” who has been involved up until now but he or she would be required by law to be present. In fact, throughout, the word “provide” is used rather than “administer”, although the explanatory notes use the words “regardless of who administers the means to bring about the end of life” but this area is again vague.

This would suggest, I contend, that what this Bill seeks to make lawful in Scotland is, in fact, “voluntary euthanasia” rather than assisted suicide.

Scottish Catholic Parliamentary Officer John Deighan came in for some angry criticism recently from Ms MacDonald when he suggested that her Bill would offer a cheaper alternative to palliative care. Included, however, in the explanatory notes accompanying the Bill is a “Financial Memorandum” which examines the possible costs involved. They assume a figure of some 55 assisted deaths a year (based on figures from countries where this is already happening) and base financial considerations on this. So, we are informed:
• There will be minimal if any costs incurred by the Scottish Administration – good news for the tax payer!
• There are not expected to be any direct costs upon local authorities. The main burdens will fall upon local Health Boards – already overburdened
• It is envisaged that the Scottish Government could prioritise any campaign on this Bill within existing public information budgets (budgets are already under threat).
• **The costs required to deliver an assisted death will be minimal and will inevitably be less than those associated with providing ongoing medication and care.**
  “Given that requests will be made to GPs, the bulk of the work in relation to assisted dying will fall upon those in practice.” – The BMA in Scotland have already stated their total opposition to physician assisted suicide, voluntary or involuntary euthanasia. They have also expressed fears that the doctor-patient relationship would be compromised if doctors were to be seen as willing to ‘help’ their patients die under any circumstances.
• “It will fall upon the registered medical practitioners to counsel the person and advise them of available alternatives including palliative care. This nature of work is already part of a registered medical practitioner’s work, particularly when treating persons with severe depression and suicidal tendencies.” And of course, doctors have plenty of time on their hands! There is also the increasing possibility that the doctor consulted will not know the patient well, if at all. Already, we hear, people “shop around” in Ohio for amenable doctors. (Incidentally, is there a hidden proposal to dispense doctors from their oaths?) Personally, I would not go near a doctor if I knew he was willing to kill me.
• “There will be some costs incurred by individuals requesting an assisted death.” What those costs would amount to is not specified.

The burden will fall on many other people. Relations are no longer to be officially involved; instead medical practitioners, psychiatrists, nurses or care workers will be expected to become involved, demanding of them not only additional time but also pressurising them to compromise principles they may hold and possibly causing distress, anxiety and even a wish to leave their employment. There are no guarantees that relatives will not put pressure on the sick or disabled person to make the request. There is also the risk that relatives, officially excluded from the process, might, either before or after death has occurred, seek legal action against the healthcare professionals. Litigation is already a fast growing branch of our legal system.

There is also the “slippery slope” syndrome. We are assured that various safeguards will guard against any abuses and that the regulations will be stringently followed. We’ve heard all this before: when David Steel’s Abortion Act became law in the Sixties we were assured that it would provide only for a minority, with very strict guidelines on eligibility. Less than fifty years on we now have abortion on demand, often for very trivial reasons. We have already seen how the original proposals for this Bill have been amended; should the
Bill become law these further criteria might well be re-introduced. How long before a right to die” becomes a “duty to die”?

Healthcare workers and campaigners for expanded palliative care have expressed distress and even anger at the suggestion that the only way for some people to “die with dignity” is to be killed before their time is due. It is an irony that the Scottish Government is already committed to Palliative Care Action Plan and proposes to “place a statutory duty on NHS Boards to provide high-quality palliative care for all on the basis of need”. We should give credit for this and work to ensure that it becomes a reality. With the appointment of four Nurse Consultants in children’s palliative care in Scotland we have a good example before us for expansion into adult palliative care.

There is, I have noticed, a worrying trend developing in our society which is almost a form of subliminal conditioning: there are regular news items commenting on the increasing burden being placed on our resources because of the increasing numbers of elderly or sick requiring care. People are living too long; soon we will have too many elderly people and not enough carers for them. Dramas and soaps on television have featured “assisted suicides” where we are invited to sympathise with the people doing the “assisting” and rarely are these people brought to book. Again I would question: when will a “right to die” become a “duty to die”? It is the stuff of science fiction but we have many instances of science fiction becoming science fact.

I believe that every single human life has innate dignity and is worthwhile and that to apply a kind of “quality control” to human life would be wholly wrong. To state officially that perhaps some lives are worth less than others is wholly abhorrent to me. I admit that it is not enough simply to state that “suicide is wrong” or that suffering can be offered up, or some such pious suggestion. People need to be convinced that their lives, however dreadful or tedious or worthless or ‘intolerable’ they may seem to be, are worthwhile and that they still have a viable, valuable role to play. We have many, many fine examples of people who demonstrate this in lives others might dismiss as valueless. An expansion of palliative care, easily accessible counselling and, above all, of us, professional and private, being willing to spend more time simply listening to vulnerable people’s concerns and fears, are what we need, rather than legalising any form of euthanasia. Socrates, we are told, willingly drank his cup of hemlock; his was still a legal execution.

Examples where such legislation has already been introduced indicate that it is impossible to prevent abuses from occurring and that there will always be attempts to expand the remit of such laws. This is an issue that will affect us all: either very soon or in the future when we are growing old, less able and fearing to be a ‘burden’ on those we love. That is why I passionately believe that this dreadful Bill and others like it must be thrown out. I trust that you, as individuals who work for the good of society in Scotland will reach the same conclusions. I thank you for your attention.

Eileen Grant