End of Life Assistance (Scotland) Bill

All Party Parliamentary Pro-Life Group

This submission is in response to the Call for Evidence on the Bill introduced into the Scottish Parliament by Margo MacDonald MSP. It is submitted on behalf of the Group, a cross-party group of MPs and Peers in the Westminster Parliament who uphold the dignity of human life from its beginning to natural death. We oppose the legalisation of euthanasia or physician assisted suicide.

Our comments on the specific questions posed in the Call for Evidence are as follows:

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

A1. There are two questions here, not one – whether “end of life assistance” (i.e. assisted suicide or euthanasia) should be legalised; and whether, if it were to be legalised, it should constitute a therapeutic option within health care.

On the first question, our answer is No. Legalisation of these practices is both unnecessary and dangerous. It is unnecessary because the high-quality palliative care services that exist north of the border with England are able to relieve the physiological and psychological suffering of serious illness in a way that would have been unimaginable 20 or 30 years ago and because the law as it stands is both robust enough to deter abuse and resilient enough to be applied sensitively to genuinely compassionate breaches.

Legalisation also raises serious issues of public safety. It is all very well to talk of putting safeguards in place to protect vulnerable people. But the safeguards that have been proposed, on which we comment in more detail in our answers to Questions 4 and 5 below, are based on a fundamental misunderstanding. They assume that persons who are minded to end their lives fall into one or other of two easily distinguished groups – people who have a settled desire to do so and who are approaching the matter in a rational and determined manner and others who are being pressured to do so or who lack mental capacity. This simplistic view is misguided. The Bill overlooks a much larger intermediate group of potential candidates for ‘end of life assistance’ – namely, people who do not have a settled wish to die but who may apply for assisted suicide or voluntary euthanasia either because they are depressed by their illness and the limitations to their lives that it brings or because they are conscious of the care burden they are placing on their families and they want to do ‘the decent thing’ by them. The present law protects such people from themselves. Nor should external coercion or pressure be ignored. The manipulation of elderly or sick family members can take subtle forms and be difficult to detect, and the Bill could unwittingly place a weapon in the hands of the unscrupulous. Consider, for example, the
situation of an applicant for ‘end of life assistance’ who has cleared all the hurdles but does not wish to implement the act at once. What is to prevent a relative anxious to inherit from applying subtle pressure to the successful applicant in the intervening period, safe in the knowledge that, with the application approved, there will be no police investigation? Licensing death in advance places those so licensed at risk.

On the second question, the Bill places doctors at the heart of the assessment process. Has any consideration been given to how the Bill could be implemented in circumstances where the majority of doctors in Scotland are unwilling to provide the ‘service’ requested? Ending, or helping to end, the lives of patients is not a recognised part of medicine and to most doctors these practices are abhorrent. The General Medical Council stated, in evidence to a House of Lords select committee five years ago, that:

“A change in the law to allow physician-assisted dying would have profound implications for the role and responsibilities of doctors and their relationships with patients. Acting with the primary intention to hasten a patient's death would be difficult to reconcile with the medical ethical principles of beneficence and non-maleficence”.

Yet the Bill contains no conscience clause to enable doctors who object to ‘end of life assistance’ to decline to participate. Is it envisaged that doctors should be compelled to do so? If not and the omission of a conscience clause is no more than an error, what arrangements are envisaged where such requests are declined – something that is likely to happen in the majority of cases?

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

Though it is recognised that 16 years is the age of majority in Scotland, it is nonetheless a very young age at which to license individuals to take decisions about whether they are going to commit suicide or ask their doctors to end their lives. Such decisions require maturity rather than mere chronological age.

It is not clear to us how the provisions in Sections 4(1)(b) and 4(3) will prevent persons from south of the border from taking advantage of the Bill if ever it were to become law – for example, by registering as temporary residents in Scotland.

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

A3. This is, without doubt, the most serious problem area with the Bill. Most attempts to legalise assisted suicide or voluntary euthanasia (for example, Lord Joffe’s Bills in England and Wales, the Oregon Death with Dignity Act and the Belgian Euthanasia Act) have been centred on terminal, or something close to terminal, illness. The Bill, however, goes well beyond these
boundaries, seeking as it does to legalise these practices not only for terminally ill people but also for anyone who “is permanently physically disabled to such an extent as not to be able to live independently”. A moment’s reflection shows that this category of eligibility covers a huge swathe of the population of Scotland, from people with recognised degenerative illnesses, such as Parkinson’s, multiple sclerosis or motor neurone disease, to others who are living with chronic conditions (such as heart disease) which are incurable but controlled by medication, to yet others who are disabled in one way or another – for example, through blindness, deafness or immobility – that makes them dependent on the support of others.

The Bill’s Explanatory Notes contain a revealing statement (Paragraph 22) – that “persons able to live independent lives without the need for assistance would not, regardless of their incapacity or degree of intolerability, qualify under the provision of this Bill”. The reciprocal of this statement is chilling – that, if your physical state obliges you to be dependent on others, you are considered a suitable candidate for having help to end your life. What sort of a message does this targeting of dependency send to sick and disabled people throughout Scotland?

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 main part of the assessment and approval procedure laid down in the Bill consists of a two-stage process in which an application is considered by a doctor (described as the “designated practitioner”) and a psychiatrist. On closer inspection, however, this process is not as rigorous as it may seem. The doctor who considers the first formal request for ‘end of life assistance’ must, under the terms of Section 8(2)(b) of the Bill, be the “designated practitioner” who considered the first request. The Bill does not, therefore, require an independent second medical opinion. If the “designated practitioner” has approved the first request, it is hardly likely that he or she will take a different view at the second stage, which under the terms of Section 8(1)(c) must follow between 15 and 30 days from the date on which the first request has been approved.

Similarly, there is no mandatory requirement for an independent second psychiatric opinion. Section 9(6) 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”. But, one might ask, what reason will the “designated practitioner” have to refer the second request to another psychiatrist than the one who acted in relation to the first? Indeed, since applicants are likely to have to ‘shop around’ for a practitioner who is willing to process an application for ‘end of life assistance’ (because it is likely that the majority of Scottish physicians will decline to do so), there must be a real risk that the chosen practitioner, who by definition will be comfortable with the request, will select a psychiatric opinion from someone who is like-minded.
Q5. Do you consider the level and nature of safeguards as set out in the Bill to be appropriate?

A5. No. The safeguards incorporated in the Bill are more apparent than real. The questions to be answered by the examining psychiatrist are whether the applicant “has capacity to make the request”, “is making the request voluntarily” and “is acting under any undue influence in making the request” (Section 9(3)). “Capacity” is defined (Section 9(4)) as “not suffering from any mental disorder which might affect the making of such a request”, while “mental disorder” is defined (Section 12) as having “the same meaning as in Section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003”.

A number of questions arise here. First, it is not clear from Section 328 of the Mental Health Act whether depression and despair are included within the term “personality disorder” referred to in the Act. These are common enough conditions in the population at large but particularly common among persons who are seriously ill. Their presence constitutes one of the main hazards of legislation such as this Bill is seeking to enact. Second, it is noted that the Mental Health Act does not regard addiction to drugs or alcohol as an indication of mental disorder. While this may perhaps be a fair enough exemption as far as concerns the purposes for which the Act was made, it is surely not appropriate that such addiction should be disregarded in a person who is seeking help to commit suicide or to have his or her life ended.

Third, one is entitled to ask: how is “making the request voluntarily” to be defined. A person who is seeking to end his or her life for the sake of others (for example, to remove a perceived care or financial burden) could be said to be making such a request “voluntarily”. He or she would not necessarily disclose to the examining psychiatrist the underlying motive for the request; and, even if disclosure were to be made, it could not be denied that the request was voluntary. What matters is, surely, that the request arises from a deep-seated and settled conviction rather than simply from a stated wish on the part of the applicant.

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

The language in which the Bill is expressed is misleading. It describes itself as an “end of life assistance” Bill. The phrase sounds reassuring, but one is entitled to ask: what sort of assistance? The assistance that the Bill is seeking to legalise is, in plain language, assistance to commit suicide or to be killed.

The Bill defines “end of life assistance” (Section 1(2)) in the most innocuous of terms – “assistance, including the provision or administration of appropriate means, to enable a person to die with dignity and a minimum of distress”. Who could possibly argue with such an objective? Yet there is an underlying and unfounded assumption here – namely, that if we are to die with dignity and avoid distress, we must have a change in the law to allow us to receive help to commit suicide or to have our lives ended for us by others. This is
nonsense. The clinical speciality of palliative care has precisely the objectives that the Bill is adopting for assisted suicide and euthanasia. The Bill’s definition of what it is seeking to legalise is founded on rhetoric rather than fact.

Again, what are “appropriate means”? The Bill does not enlighten the reader at any point on what acts a physician may or may not perform in implementing ‘end of life assistance’. In short, the Bill provides no sound basis for legislating.

That the Bill has already had a misleading effect may be seen from press reports of it, which generally describe it as seeking to legalise assisted suicide only. It needs to be recognised, however, that this Bill is seeking to legalise not only assisted suicide but also voluntary euthanasia. The experience of the few countries that have licensed this latter practice is far from reassuring. Yet the Bill’s Explanatory Notes (see Paragraphs 87-89) misleadingly compare its provisions with those of with Oregon’s Death with Dignity Act, under which only assisted suicide has been legalised. The difference in death rates resulting from the two practices is huge and the estimate of only 55 deaths annually in Scotland as a result of the Bill’s enactment is a considerable understatement. The Bill itself only once discloses its purpose of legalising voluntary euthanasia, and that obliquely¹. This is an important issue that needs to be probed thoroughly by the committee.

Jim Dobbin MP
Chair
All Party Parliamentary Pro-Life Group
April 2010

¹ Section 1(2) “In this Act “end of life assistance” means assistance, including the provision or administration of appropriate means, to enable a person to die with dignity and a minimum of distress” (our italics)