End of Life Assistance (Scotland) Bill

Association of Chief Police Officers in Scotland (ACPOS)

ACPOS acknowledges the complex ethical considerations surrounding this Bill and the considerable debate over the moral, religious and cultural aspects of it. It is not appropriate for the Scottish Police Service to enter the ethical debate or to provide opinion on whether or not a person should be able to request end of life assistance.

The question of the legality of the proposed measures is a matter for the Scottish Parliament, Crown Office and Procurator Fiscal Service. The way in which assistance could be provided, with the related medical and psychological considerations, is a matter for the medical profession. There are a number of criteria and conditions that need to be satisfied to enable the process to go on, central among them being the definition of “intolerable”. In the event the Bill becomes law, the Police Service would follow guidelines from the Lord Advocate in this respect.

The police currently investigate and report to the Procurator Fiscal all:

- Sudden or accidental deaths;
- Suicides;
- Deaths which have occurred in suspicious circumstances;
- Deaths for which a medical practitioner declines to issue a death certificate;
- Deaths arising at or in connection with employment; and
- Deaths in respect of which the Procurator Fiscal requests a report.

If the Bill is enacted there may be an increase in the overall number of investigations carried out by the police as a result of additional enquiries into deaths where End of Life Assistance has been provided. It must be borne in mind that any investigation into a suspicious death is likely to be protracted and resource intensive. The potential for an enquiry to be required for any death where there is any accusation or uncertainty over the meeting of the Bill’s eligibility conditions needs to be considered.

ACPOS would like to highlight the following points which relate to identified ambiguities, practical application and potential issues for the Police, if enacted:

Section 1 – Lawful to provide assistance under this Act

Section 1 stipulates that the Bill is intended to, “enable a person to die with dignity and a minimum of distress”. It may be desirable to more clearly differentiate between what could at present be interpreted as the provision of palliative care and the wish for End of Life Assistance; although it is acknowledged that this particular aspect must be covered when the
requesting person meets the designated medical practitioner (Section 7(1)(b)) and the psychiatrist (Section 9(2)).

Section 3 – Revocability of request for assistance

Section 3(1) states that: "end of life assistance may not be provided if, at any time, the requesting person gives notice, however informal, to the designated practitioner that the requesting person no longer wishes it". Clarification is needed on the notifying methods and supervision of designated practitioners in these circumstances. In a situation where the requesting person requires the assistance of another person to end their life the Bill only requires the designated practitioner to be present "...at the end of the requesting person’s life..." (Section 11(6)).

For a person unable to self-administer the means of end of life assistance it would be necessary for the designated practitioner to be present throughout the process in order for them to have the opportunity to be "notified" by the requesting person right up to the point where the method of ending life is put into irreversible process. Up to this point it can still theoretically be stopped.

Does the Bill foresee the need for a second independent witness to be present during administration of assistance to end life, to verify that no such notification was given and that end of life assistance was lawfully rendered? If there was a subsequent allegation of impropriety in the process, the presence of a witness would simplify the subsequent investigation and protect the position of the designated medical practitioner.

Section 4 – Eligibility requirements

This section requires that the requesting person “finds life intolerable”. Concern is raised at the lack of a definition of “intolerable” in this context. The requesting person and designated medical practitioner may have different interpretations. It is suggested that this should be clarified.

Section 5 - Requirements relating to designated practitioners and psychiatrists

This section details the requirements relating to designated practitioners and psychiatrists. Currently this relates, as defined in Section 2, to a “registered medical practitioner to whom a first formal request has been made by the requesting person”. Concerns are raised at the limited details contained within Section 7, which provides the mandatory subjects to discuss with the designated medical practitioner when considering the first formal request.

It is not clear how such a limited assessment would determine that the requesting person is not under external pressure to request assistance. In addition, clarity is needed as to how medical practitioners would record this and subsequent involvement and who will monitor nationally. Should assistance be provided in contravention of Section 5, it follows that an offence
has been committed. Concern is raised over the ability to prove such an offence should an enquiry become necessary.

Clarity is also needed over what is meant by a designated practitioner or person acting as a witness having “another interest in that death” (Sections 5(1)(c) and 6(4)(c)). It is felt that this phrase may be open to a variety of interpretations and requires further explanation.

Section 6 – Requirements relating to the first formal request

This section (and also Section 10) refers to the requirement for the requesting person to sign formal requests. This appears overly prescriptive and does not provide for a requesting person to demonstrate their consent in any other way. A person can clearly have capacity to determine that they wish to make such a request but may not be physically able to sign. This appears to be contrary to the provision of Section 9(4), which addresses the possibility of a person being denied access to end of life assistance through an inability to communicate directly.

Section 9 – Consideration of capacity etc. by psychiatrist

This section refers to the term “mental disorder”. This phrase is defined by the Mental Health (Care and Treatment) Act (Scotland) 2003 as “any mental health, personality disorder or learning disability however caused or manifested”. The conscious decision to end one’s own life where a person has the personal capacity to do so and undertakes such actions as to bring this about is suicide. The Scottish Association for Mental Health categorises “suicidal thoughts and feelings” as a mental health problem, which would suggest that this then falls within the definition of a mental disorder.

Section 9(4) of the Bill states, “…a person has capacity to make a request for end of life assistance if that person is not suffering from any mental disorder which might affect the making of such a request...” There is lack of clarity over the purpose of this sub section, particularly through use of the word “might”. It could be interpreted that there is an automatic preclusion, preventing a person with any mental disorder from qualifying for end of life assistance. However, an alternative interpretation is that a requesting person with a particular mental disorder, despite in all other respects having capacity, may be precluded from receiving end of life assistance if it could be argued that such a mental disorder has the potential to result in a lack of capacity, or has caused lack of capacity in another person.

If the purpose of the Bill is to avoid this automatic or inferred preclusion, an alternative drafting of Section 9(4) might be:

For the purposes of this Act a person has capacity to make a request for end of life assistance if they are deemed by the psychiatrist to be 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,

but a person is not to be regarded as lacking capacity:

(e) by reason only of suffering from a mental disorder or;
(f) by reason only of a lack or deficiency in a faculty of communication
    if that lack or deficiency can be made good by human or
    mechanical aid (whether of an interpretative nature or otherwise).

This would separate the considerations for assessing capacity from the
presence or absence of a mental disorder.

In addition Section 9 replicates that of Section 5 regarding assessment.
Similar concerns are raised with regards to the ability of a psychiatrist to
assess and identify that a requesting person is not under external pressure to
request assistance.

Section 10 – Agreement on provision of assistance

The Bill does not specify what methods are available for ending the life of the
requesting person. Without clarification this may be problematic in the event
of an enquiry. The only reference to this point appears in Section 10
specifying that the requesting person and designated practitioner must agree
on the means by which assistance is to be provided. It is suggested that
consideration is given to providing further detail around method, means and
recording.

Section 11 - Requirements relating to the actual provision of assistance

Section 11(6) requires the designated practitioner to be present at the end of
the requesting person’s life. There is ambiguity in the wording of this section
over whether the designated practitioner is required to be present only at the
point of death or throughout the process of the actual provision of assistance
to end life. There should also be clarity over the role of the designated
practitioner to pronounce life extinct and certify the process complete.

Insurance implications

No provision is made within the Bill regarding existing life insurance policies.
At present, insurance companies would not normally pay out benefits when an
insured person commits suicide. If end of life assistance is interpreted by
insurers as suicide this will have implications for requesting persons and their
families. Clarification with representatives of the insurance industry may be of
value.

Conclusion
If the Bill is enacted and police investigations are initiated under its provisions, this would have a significant impact for the police service. Each stage of the process would have to be evidenced as having been lawfully undertaken. Therefore, there is a need for clarity over definitions, recording, monitoring and accountability, which ACPOS considers is not fully met in the current draft.

In addition protracted enquiries into deaths result in additional trauma for the bereaved. Forensic examination and evidential requirements can necessitate delays in release of the remains for burial or cremation.

Finally it may be worth considering independent judicial oversight of the proposed process to assist with ensuring any criteria are fulfilled prior to the provision of any assistance to end life.

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