End of Life Assistance (Scotland) Bill

CARE for Scotland

Introduction to CARE

CARE is a Christian public affairs charity that campaigns, provides resources to Christian communities and undertakes caring work. We have 30,000 supporters throughout the UK and about 3,000 supporters drawn from all Christian denominations in Scotland. We are a member of the Care Not Killing Alliance and support their evidence to the Committee.

Answers to Specific Questions

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

CARE is opposed in principle to the proposal contained in this Bill. As a Christian organisation we hold to the Judaeo/Christian worldview which has underpinned Western civilisation for over 1,500 years. Within that framework of reference, we believe in the sanctity of human life which is a gift from, and created in the image of, God. Human beings are ultimately responsible to God for our stewardship of the life given to us and of the earth’s resources. The role of civil authorities is to be servants of God managing the governance of society. The civil authorities have a juridical role, standing in lieu of God’s ultimate judgement, to punish evil and promote the common good. We argue that the legalisation of euthanasia and assisted suicide, which run contrary to these principles, are unnecessary, unethical and pose a threat to public safety.

Euthanasia and assisted suicide are unnecessary because effective palliative care is available to ease the pain and distress associated with terminal and chronic illness. Evidence shows that in 95% of cases palliative care is available. Many people who express a wish for euthanasia or assisted suicide change their minds when palliative care is provided. In those cases where complete emotional and physical pain relief is not possible, it can be brought to manageable levels. As a last resort the option of sedation is available. The experience of the hospice movement has shown that restoration of dignity through creative care is possible for the vast majority. The challenge, therefore, is to extend palliative care services in Scotland rather than to introduce euthanasia and assisted suicide.

I have been to Oregon and spoken to those in favour of physician assisted suicide. In Oregon, patients do not have the benefit of the level of palliative care which exists in the UK. No hospice community program allows its staff to be involved in physician assisted suicide. No hospital in Oregon permits physician assisted suicide on its premises. There are no specialist in-patient palliative care beds and no rigorous 4 year training to become a palliative medicine specialist. This is not to demean the efforts of
inspirational doctors and nurses who are striving to improve standards of palliative care. But it is simply not true that Oregon provides any evidence that palliative care and physician assisted suicide could coexist.¹

Euthanasia and assisted suicide are unethical because they deny the presence of human dignity. Human dignity is the concept which underpins our human rights legislation. This concept is derived directly from our Judaeo/Christian worldview and is expressed also in the Hippocratic tradition in medicine. It is the recognition by society that all human beings are of value and have innate dignity. Being dependent on others for care does not remove dignity. A baby has no less dignity than an adult despite being totally dependant on his/her parents. Similarly a person with a terminal or chronic illness has no less dignity than a healthy person. Quality of life is not measured in terms of consumption or possession of material goods, physical capacity or health, but rather in terms of relationship with God and with other people.

Our individual human worth does not depend upon ability, gifts, or the quality of our life, but rather on our status as beings, made in God's image and likeness, and bearing the worth and value which He laid upon us …²

The central argument put forward in support of legalising euthanasia and assisted suicide is that of autonomy - the so called 'right to die'. However, there is no such right in international human rights treaties. Moreover, rights must be balanced with responsibilities. The European Court of Human Rights has consistently ruled that there is no right to die included in Article 2 (the right to life) of the Convention. Moreover, there is no right to determine the circumstances surrounding one’s death and the right not to receive inhumane and degrading treatment is unlikely to apply. Even if it does, this right would need to be balanced against the positive obligations on State Parties to take active measures to preserve life. We should not prioritise the autonomy of the few, no matter how vocal, over that of many others who might feel pressurised into ending their lives prematurely.

The legalisation of euthanasia and assisted suicide threaten public safety because they will put pressure on vulnerable people. The danger is that the so called ‘right to die’ becomes a ‘duty to die’. Some vulnerable people will feel pressurised into this option in order to avoid being a burden or because they lack effective social support. The experience of the US state of Oregon is pertinent. It is estimated that 11% of patients who opted for assisted suicide in Oregon took this option did so because they perceived themselves to be a financial pressure and another 6% did so because of lack of social support. At a time when we are facing significant cuts to public expenditure, do we really want to open up the possibility of people in Scotland feeling under pressure to end their lives prematurely for fear of being a financial, care or emotional burden on family or on wider society?

¹ Dr David Jeffrey in an address to the Scottish Parliament’s Cross Party Group on Palliative Care in February 2009.
We see no logical reason for medical practitioners to be involved in the administration of euthanasia or assisted suicide. We suspect that the author of the Bill has included physicians in the process in order to give a sense of legitimacy to what is a highly controversial proposal. However, the deliberate killing of a patient runs contrary to all principles of medicine which are to help and not to harm the patient. Since the time of Hippocrates (460-370BC), the deliberate killing of patients has been outlawed in medicine.

The Bill makes clear that the doctor may be involved in ‘administering’ the ‘end of life assistance’. It is assumed that this would be a cocktail of drugs or an injection, but it could be a bullet to the head or any other means deemed ‘appropriate’ under the terms of the Bill. Nor does the Bill say where the proposed end of life assistance would be administered. Would it occur in GP’s surgeries, hospitals or hospices? If so, what would be the effect of such activity on other patients?

In her original consultation, Margo MacDonald made reference to a series of ‘high profile’ cases, such as that of Daniel James - the 23 year old who went to Dignitas just 18 months after rugby accident left him quadriplegic. Yet it is precisely just such cases which show the limitations of the ‘autonomy’ argument. The real danger is that ill-informed ‘patient autonomy’ can easily be allowed to trump professional medical opinion based on many years of clinical experience. Rather than assist with suicide or engage in actively killing their patients, the responsibility of health professionals is to provide the best care available and to help people to come through the initial shock and despair often associated with such accidents.

We note that there is no conscience clause on the face to the Bill. Whilst the author of the Bill has claimed that doctors would not be forced to participate, the absence of a conscience clause raises concerns that doctors may come under pressure to participate in administering or facilitating euthanasia or assisted suicide in contravention to their conscience and the Hippocratic Oath. Patient choice is an increasingly overt aspect of modern medicine. Some doctors may find it difficult to resist a persistent demand of euthanasia or assisted suicide even if granting or facilitating this goes against their better judgement. Without the protection of a conscience clause on the face of the Bill, doctors who refuse to accede to such demands may be subject to complaints being made to the GMC regarding their conduct or to legal action.

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

CARE is of the view that the age limit of 16 is far too low. Many young people suffer from low self esteem or depression, particularly if associated with a terminal or chronic illness. They may not be in a position to make a fully informed judgement about their prognosis or options for quality of life. Other factors such as family circumstances or relationship breakdowns may affect their deliberations. We note also that the parents of children aged 16 upwards might have no input into, or knowledge of, their child’s intentions. The
potential for considerable negative psychological consequences for the parents and siblings of young people who access euthanasia or assisted suicide under the Bill’s proposals is immense.

We are concerned about the potential for euthanasia tourism should this Bill become law. Upon diagnosis of a terminal or chronic condition, there would be nothing to prevent people from anywhere in the UK or overseas from moving to Scotland and registering with a GP 18 months before seeking assistance to end their lives.

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

The Bill proposes euthanasia as an option not just for those with terminal illness but also for those suffering from “progressive irreversible conditions” and who are “permanently physically incapacitated to such an extent as not to be able to live independently”. We are of the view that the scope of the Bill is very wide and would incorporate those suffering from a vast range of medical conditions. It includes a whole range of non-terminal but treatable conditions. For example, it includes someone suffering from Macular Degeneration which although treatable is not reversible. Yet how many of us would say to our loved one that just because your vision is deteriorating your life is not worth living. Other conditions which would be covered by the Bill include insulin-dependent diabetes, heart of lung disease, arthritis and anyone with a disability.

It is difficult to predict life expectancy of someone suffering from a terminal illness with any accuracy. In individual cases people may live for many months or even years after having been given a prognosis of having 6 months or less to live. Indeed the accuracy or inaccuracy of such predictions has been a prominent feature of Scottish political debate during the past year. We suggest that to allow those given such a prognosis access to euthanasia or assisted suicide is mistaken and may prevent many people from enjoying some to the most cherished and precious times with loved ones who have a terminal illness.

The Bill outlines a two-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?

CARE has major concerns about the process documented in the Bill. We note that the doctor involved in providing the end of life assistance is expected to be the same doctor who made the initial assessment. Unlike in the case of abortion, there is no provision for a second doctor to approve the application for ‘end of life assistance’. A psychiatrist is to be involved, but he/she has no power to veto the provision of ‘end of life assistance’. The psychiatric assessment may be little more than a tick box exercise aimed at providing reassurance that the person is not suffering from an immediately evident mental illness or depression. However, such an assessment may be difficult to make in two short consultations. We are mindful of the potential for abuse,
should a second opinion by an independent doctor not be necessary. Since the case of Harold Shipman the medical profession has taken great strides to ensure greater supervision and opportunities for peer review in General Practice. The proposals in this Bill seem to run counter to that trend.

We have major reservations over the timescale included in the Bill. Thirty days is an inordinately short time between the initial request being made and the provision of the ‘end of life assistance’. It is unlikely that two psychiatric assessments could occur within this time scale unless they were arranged privately. This raises the disturbing scenario of a few doctors and/or an organisation making financial gain by conducting such assessments. CARE is concerned also that some psychiatric conditions or depression may not be diagnosed with such a superficial process. It can take many months and many consultations before mental illness can be diagnosed accurately.

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

The ‘so called’ safeguards contained in the Bill are largely illusionary. There is the danger that many of those who opt for ‘end of life assistance’ will be suffering from untreated depression or psychiatric illness. It is estimated that 80% of patients with a terminal illness will suffer associated depression, psychological and/or psychiatric problems. It should not be assumed that medical staff will diagnose these illnesses during the process of facilitating euthanasia or assisted suicide.

We know from Ganzini’s research study in Oregon that 1 in 6 patients having physician assisted suicide had undiagnosed clinical depression. The authors of the study concluded that the Oregon law fails to protect the mentally ill. In one community hospice program in Oregon 27 of their patients had physician assisted suicide in 10 years. Twenty two of the scripts for the lethal drugs were signed by the same doctor. In Oregon, I found that not only does the law fail to protect the vulnerable but the application of so called safeguards have become less rigorous.3

In some cases these conditions may have been brought about by drug or alcohol dependency. However, the Bill makes no provision for such dependency to feature in the assessment process. Mental health legislation explicitly excludes depression brought about by such dependency from the definition of a mental disorder. Yet the Bill requires doctors to use this definition in their consideration of the psychiatric and psychological condition of the patient. In short, this Bill allows someone suffering from drug or alcohol induced depression, and with a terminal or a chronic condition which prevents him/her from living independently, access to euthanasia or assistance to commit suicide.

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3 Dr David Jeffrey in an address to the Scottish Parliament’s Cross Party Group on Palliative Care in February 2009.
It is unclear how the doctors involved would be able to satisfy themselves that the patient was not acting under some form of internalised or external pressure. All a patient would need to do would be to say that they did not feel under pressure in order to be able to access ‘end of life’ assistance. No social work report is required. The doctor is unlikely to have detailed knowledge of the patient’s circumstances to know if other family members may have been putting pressure on the patient. Even if this is not the case, the patient may feel himself/herself to be a burden but be unwilling to acknowledge this to the medical practitioners involved in the knowledge that doing so would disqualify their application for ‘end of life assistance’.

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

It is important to point out that the ELA Bill proposes to legalise euthanasia (as well as assisted suicide). As such, the Bill is more akin to the law in the Netherlands than it is to laws on assisted suicide in other jurisdictions. Margo Macdonald has claimed that the ELA Bill does not legalise euthanasia because it does not include non-voluntary euthanasia (ending the life of a person incapable of giving consent – e.g. a small child or someone in a coma). However, this view misunderstands the definition of euthanasia. It is by administering ‘end of life assistance’ with the intent of ending the life of the person concerned that an act of euthanasia would be committed.

It is worth the committee giving consideration to practice of euthanasia in the Netherlands. The first Remmelink report published in 1990 concluded that of 3,000 deaths from euthanasia in the Netherlands in over 1,000 cases there was no explicit request from the patient. It is estimated that there have been 6,700 deaths without an explicit request since 1990. In the Netherlands 8% of deaths are the result of ‘terminal sedation’ in which patients are first sedated and then starved and dehydrated. These deaths are not classified as euthanasia and there is no administrative mechanism to ensure effective scrutiny and regulation of medical practice in this area.

The Royal Dutch Medical Association and the Dutch Commission for the Acceptability of Life Terminating Action recommended that active termination of the lives of patients suffering from dementia is morally acceptable under certain circumstances. The Commission has also affirmed involuntary euthanasia of severely disabled babies. Perhaps 150 babies have been killed by Dutch doctors, including one case where a child was killed because it had abnormal genitalia. A campaign has now been launched in the Netherlands to allow anyone over 70 to have access euthanasia.

Bill Baird
Manager
CARE for Scotland
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4 In the UK Baroness Warnock hit the headlines in 2008 when she suggested that people suffering from dementia may have a ‘duty to die’.