End of Life Assistance (Scotland) Bill

Christian Institute (Scotland)

Introduction
The Christian Institute is a non-denominational charity established for the promotion of the Christian faith. We have over two thousand supporters throughout Scotland, including 500 churches and church leaders from almost all the Christian denominations.

We hold traditional, mainstream Christian beliefs about the sanctity of human life. We have previously contributed to the public debate throughout the UK on euthanasia and assisted dying.

Radical change in the law
In 2004 the Deputy Minister for Health and Community Care said: “Under Scots law, an act of euthanasia by a third party, including physician-assisted suicide, is regarded as the deliberate killing of another and would be dealt with under the criminal law relating to homicide.”

This is a very strong statement and reflects the serious nature of the offence.

The proposed End of Life Assistance (Scotland) Bill actually covers two distinct and separate actions. In a 2005 report, the House of Lords distinguished between ‘assisted suicide’ (providing someone with the means to end his or her own life) and ‘voluntary euthanasia’ (a third party ending another person’s life at his or her own request). The Bill would permit the “designated practitioner” to approve both. We believe this must be resisted.

Euthanasia and any form of assisted suicide should remain illegal in Scotland. Euthanasia is wide open to abuse, because those who feel uncertain about whether their lives are worth living are vulnerable to manipulation. Any weakening of the law in this area would also have a profound effect on the relationship between doctors and their patients. Instead of only having a healing or caring role, doctors become killers once euthanasia or physician-assisted suicide is legalised. Furthermore, suffering can be relieved without euthanasia. With modern advances in the care of the terminally ill there is no need for such patients to suffer uncontrolled physical pain or discomfort. It is essential that expertise in palliative care is disseminated throughout the NHS.

Palliative care
The idea that palliative care is consistent with physician-assisted suicide (PAS) (or even complements it) is fiercely denied by many medical practitioners. The strongest opposition to such views comes from palliative care specialists. Over 90 per cent of doctors working within palliative care

---

2 End of Life Assistance (Scotland) Bill, clauses 1 and 2
oppose euthanasia and PAS. These are the people most directly involved in the medical and nursing care of the dying. When they say, for example, that “[t]o travel down the path to PAS is to jeopardise the high standards of palliative care that exist in this country”\(^4\), this testimony carries considerable weight.

**Safeguards**

The Bill stipulates that a designated practitioner must be a registered medical practitioner. Involving the medical profession in an assisted suicide may seem like a safeguard, but this raises fundamental ethical problems. The seriousness of any act of deliberate killing must not be underestimated. The Bill requires the designated practitioner to be there at the time of the death. It seems especially inappropriate for doctors to be involved in deliberate killing since they are part of a profession that has sworn (literally\(^5\)) to do all it can to preserve life rather than end it.

The Scotsman published an opinion article from Hugh McLachlan, the outspoken Professor of Applied Philosophy at Glasgow Caledonian University’s School of Law and Social Sciences. By no means opposed to assisted suicide or euthanasia in principle, Prof McLachlan nevertheless pointed out the complications involved in licensing any members of society to kill others, even under restricted circumstances. Most significantly, he argues that: “Euthanasia and assisted suicide are contrary to the role and duty or, at the very least, the central role and duty of doctors. It is in the interests of both doctors and patients that the legal position is clear that doctors are not entitled to kill patients or help them directly to kill themselves”.\(^6\) If the medical profession is to retain its status and reputation in society, argues Prof McLachlan, doctors cannot give to their patients “all that they want or need”.\(^7\)

The eligibility requirements under the Bill for requesting end of life assistance include that the person “finds life intolerable”\(^8\). Whilst the Bill states that the designated practitioner must confirm this before the request is approved\(^9\), it is unclear on what basis that consulting professional is supposed to make this assessment. Is an assertion from the person requesting suicide that they find life intolerable sufficient as confirmation? To what standard of proof must the doctor appeal in order to affirm that the person finds life intolerable?

Furthermore, the term 'intolerable' is extremely subjective and would introduce a new legal concept which is currently not defined in law. Finding life intolerable can also be very much a transient state. Someone who has just

---


\(^5\) Nearly 50% of medical students swear some kind of oath on entry to medical school or at graduation, see Sritharan K, Russell G, Fritz Z et al, 'Medical Oaths and Declarations', *BMJ*, 323 (7327), December 2001, page 1440

\(^6\) *The Scotsman*, 26 February 2009

\(^7\) *Loc cit*

\(^8\) End of Life Assistance (Scotland) Bill, clause 4(2)

\(^9\) End of Life Assistance (Scotland) Bill, clause 7(2)
been diagnosed with a terminal illness, or recently become disabled, may at first feel as though life is intolerable. But with adequate counselling and care such an individual may completely change their mind.

Take the example of Martin. Facing terrible pain and fearing “being a nuisance” to his hospice nurses, cancer stricken ex-soldier Martin asked a doctor to help him die. Instead she arranged for him to attend a parade of cadets he had trained, who threw a party in his honour. His remaining days were transformed by a new sense of purpose and a realisation of his own value to others. Martin died peacefully two days later.  

Martin’s case highlights another concern about the Bill. Martin feared being thought of as a ‘nuisance’. Because the Bill covers people who are either terminally ill or physically incapacitated “to such an extent as not to be able to live independently” it is likely that many of them will experience this feeling, even if it is only for a brief time. Those tempted to think about themselves in this way need protection and counselling, not legal assistance to kill themselves. No one is ‘better off dead’. The pro-euthanasia lobby features a vocal minority of independently-minded and articulate patients who want to control the time and manner of their death. However, the vast majority of those seeking to access legal assisted suicide would not fit this category. Rather, they would be society’s most vulnerable members; the elderly, the terminally ill, the incapacitated and the depressed. These people often feel uncertain about whether their lives are worth living and fear becoming a burden to others. If assisted suicide were legal many would feel they had a duty to request an early death, especially if it was offered by their physician as a possible therapeutic option. Intended to enable and control assisted suicide for a few, such laws invariably encourage the vulnerable to end their lives prematurely, or lead to instances of malpractice, manipulation and involuntary euthanasia. The experiences of the few jurisdictions where assisted suicide is legal show that it is impossible to establish sufficient safeguards to prevent abuse and protect vulnerable patients (see Other Jurisdictions).

The Bill requires the person requesting euthanasia to have been registered in Scotland for a continuous period of at least 18 months immediately prior to making a request for end of life assistance, but it is not necessary that the requesting person should have been registered with the same medical practice throughout the period. This means the requesting person could seek assistance from a doctor who has no experience of dealing with the patient, has no relationship with the patient and no insight into the patient’s medical history or state of mind. This will lead to ‘doctor shopping’ for medical practitioners who are known to be sympathetic to such requests.

Although both the first and second requests have to be signed by two witnesses, the witnesses to the second formal request do not have to be the same as the witnesses to the first. Likewise, a psychiatrist has to meet with the patient after both requests. But the psychiatrist who meets the patient

---

10 Jeffreys, D., Against Physician Assisted Suicide: A Palliative Care Perspective, Radcliffe Publishing Limited, 2009, pages 95-97
11 End of Life Assistance (Scotland) Bill, clause 4(2)(b)
after the second request does not have to be the same psychiatrist the patient met after the first request. It is therefore difficult to see how the witnesses and psychiatrists can be sure that the patient is in a ‘settled’ state of mind. In terms of the witnesses, there appears to be no requirement for them to know the requesting person (unless the requesting person “is accommodated and cared for in accommodation provided by a care home service”\(^\text{12}\)). If the two witnesses are not required to know the person about whom they are signing a statement, the “best of the witness’s knowledge and belief”\(^\text{13}\) cannot be sufficient.

A person is not deemed to have the capacity to make a request for end of life assistance if they are “suffering from any mental disorder which might affect the making of such a request”\(^\text{14}\). However, it is not clear what conditions are covered by this. Does this include depression? It is likely that those seeking PAS because of a terminal illness or disability will suffer depression to some extent and this may influence their thinking. Will they still be allowed to proceed with PAS? It is probable that if their depression was properly managed they would have a very different outlook.

**Legal and political opinion**

In recent months, euthanasia and assisted suicide have been the subject of considerable public discussion.

During a House of Lords debate on end of life care Baroness Finlay of Llandaff pointed out that: “Midwives assist at birth and palliative care assists at death; assistance is supportive help, not accelerating death or cutting life short by months or years.”\(^\text{15}\)

Lord Carlile of Berriew QC has also spoken out, warning that “laws aren’t like precision-guided missiles. Once a statute, they can quickly be used to encourage acts they were designed to enable and control… This is not about religion or autonomy or medicine: it is about public safety, legal certainty and the protection by the law of the vulnerable”.\(^\text{16}\)

The Scottish Health Secretary Nicola Sturgeon has already given her verdict on the proposed End of Life Assistance (Scotland) Bill, telling the BBC that she was “not persuaded” that the law should be changed and that she is “not convinced we could put in place sufficient safeguards”.\(^\text{17}\)

Gordon Brown has declared that “we’ve got to make it absolutely clear that the importance of human life is recognised”\(^\text{18}\) and “[i]t is necessary to ensure

---

\(^{12}\) End of Life Assistance (Scotland) Bill, clause 6(3)  
\(^{13}\) End of Life Assistance (Scotland) Bill, clause 6(2)  
\(^{14}\) End of Life Assistance (Scotland) Bill, clause 9(4)  
\(^{15}\) House of Lords, Hansard, 18 November 2008, GC 86  
\(^{16}\) *The Times*, 5 November 2008  
\(^{17}\) *The Times*, 3 November 2008  
\(^{18}\) *The Daily Telegraph*, 30 December 2008
that there is never a case in which a sick or elderly person feels under pressure to agree to an assisted death or that it is the expected thing to do”.19

**Medical opinion**

A poll by *GP* newspaper found that more than 60 per cent of GPs do not want to see assisted suicide legalised.20 As has already been mentioned, opposition is even stronger among those involved in palliative care, with a 2006 survey of the members of the Association for Palliative Medicine of Great Britain and Ireland finding 94 per cent against any change in the law.21 The British Medical Association and Royal College of General Practitioners have also issued statements opposing any moves to legalise assisted suicide.22

Senior experts have been concerned enough to speak out publicly. Dr David Jeffrey, former chairman of the Association for Palliative Medicine’s ethics committee, and Peter Beresford, Professor of Social Policy at Brunel University, have warned of the dangers of legalising assisted suicide. Dr Jeffrey is deeply concerned for people who are “frightened, possibly depressed and a bit confused” and who need the law’s protection.23 Prof Beresford questions the “ramifications for policy”, chiefly the lack of motivation for further improvement in the care of people near the end of their lives who do not wish their deaths to be hastened.24

Last month 16 senior palliative care specialists sent a letter to The Times clearly stating their objection to the End of Life Assistance (Scotland) Bill. They said the Bill “sends a message to all disabled people and terminally ill patients that somehow because they are dependent on others they are of less value to our society and so may feel that they ought to choose to bring forward the time of their death”.25

**Other Jurisdictions**

The Netherlands formally legalised voluntary euthanasia and PAS in 2002. The practice of involuntary euthanasia is now established, with 546 deaths in 2005 as a result of lethal drugs not explicitly requested by the patient. A House of Lords Committee concluded that if the Dutch euthanasia rate was replicated in the UK it would mean approximately 13,000 medically-assisted deaths per year.

The US state of Oregon legalised PAS in 1997 in the Death with Dignity Act 1997. Because patients seeking assisted suicide tend to approach doctors known to be willing to prescribe lethal medication (so-called ‘doctor shopping’), most end up consulting a physician with no detailed knowledge of

---

19 House of Commons, Hansard, 10 December 2008, col. 533
20 *GP*, 5 February 2009
21 *The Press Association*, 10 May 2006
22 *GP*, 5 February 2009
23 *The Times*, 11 October 2008
24 Guardian Online, 6 November 2008, see http://www.guardian.co.uk/society/joepublic/2008/nov/06/assisted-suicide-nhs-care as at 9 March 2009
25 *The Times (Scottish Edition)*, 23 April 2010
their medical history or emotional state. In 2009, 50 per cent of patients requesting suicide were assisted to die by a doctor who had been their physician for nine weeks or less.\textsuperscript{26} The Oregon Health Department does not record whether certain doctors write a series of lethal prescriptions for multiple patients, but the practice of ‘doctor shopping’ makes this highly likely.\textsuperscript{27} It should be borne in mind that these concerns surround a law which requires patients requesting assisted suicide to have been diagnosed as terminally ill, just like the proposed Bill in Scotland.

The Oregon Death with Dignity Act 1997 is also a prime example of the detrimental effect legalised assisted suicide has on palliative care services. Oregon does not have an integrated system of end of life care equivalent to UK palliative care services. Legalising PAS has deprived Oregon of the motivation to improve such services. In the last two years Oregon has been rocked by the stories of cancer patients Barbara Wagner and Randy Stroup. Both were denied life-prolonging treatments by Oregon’s state-run health plan, but were informed that the state was prepared to cover the cost of drugs for a physician-assisted death.\textsuperscript{28}

**Conclusion**

The End of Life Assistance (Scotland) Bill is flawed in its principle and its particulars. Physician-assisted suicide and voluntary euthanasia are not rights and are certainly not component elements of effective palliative care. Careful consideration of the consequences of legalising PAS, together with the experiences of jurisdictions where it is currently permissible, show that watertight safeguards from abuse are impossible. PAS undermines fundamental principles of medical administration and the doctor-patient relationship.

First penned 2,400 years ago, the Hippocratic Oath has proved an enduring summary of the ethical code practising physicians should abide by. We see no reason for Scottish law to reverse one of its central tenets:

“I will give no deadly medicine to any one if asked, nor suggest any such counsel”.\textsuperscript{29}

Christian Institute (Scotland)

May 2010

\textsuperscript{26} Oregon Death with Dignity Act Annual Reports, 2009, Table 1, see http://www.oregon.gov/DHS/ph/pas/docs/yr12-tbl-1.pdf as at 28 April 2010

\textsuperscript{27} Jeffrey, D, *Against Physician Assisted Suicide: A Palliative Care Perspective*, Radcliffe Publishing Limited, 2009, page 66

\textsuperscript{28} Fox News, 28 July 2008, see http://www.foxnews.com/story/0,2933,392962,00.html as at 3 March 2009; *ABC News*, 6 August 2008, see http://abcnews.go.com/Health/story?id=5517492 as at 3 March 2009

\textsuperscript{29} The Hippocratic Oath, translated by Francis Adams, see http://classics.mit.edu/Hippocrates/hippooath.html as at 9 March 2009