End of Life Assistant (Scotland) Bill Committee
T3.60
Scottish Parliament,
Edinburgh.
EH99 1SP.

Submission on the End of Life Assistance (Scotland) Bill.

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

I do not agree that a person should be able to request end of life assistance from a registered medical practitioner.

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

No, I am not satisfied. The Bill would allow a person as young as 16 to request end of life assistance. This age is below the age of majority. There is no way of ascertaining the maturity of such a young person taking such a serious decision.

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

No, I am not satisfied. Assistance can be requested by anyone who is 'terminally ill' or 'permanently physically incapacitated' [to an extent of dependency on others] and 'finds life intolerable'.

The range of people covered by the Bill is extremely wide. It would offer assisted suicide to people who are to some degree dependent on others and would include those with life threatening and non life-threatening disabilities, and those with relatively common conditions such as, for example, insulin-dependent diabetes, heart or lung disease. Tens of thousands of seriously ill and disabled people throughout Scotland would fall within its remit.

The term 'finds life intolerable' is highly subjective and a legal definition is not given.

- 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?

No, I am not satisfied.

The requesting person must be registered with a medical practice in Scotland for a continuous period of at least 18 months before making the request. However, the doctor need not be the person's own doctor. There is then the possibility of the doctor [who is applied to] having insufficient information as to the patient's psychological state.
Moreover, the applicant does not need to be registered with the same medical practice for the whole 18 months, thus allowing the possibility of 'death tourism'.

Death tourism could also occur by people moving to Scotland in order to register with a sympathetic practice.

Furthermore, as the Bill does not stipulate a NHS practice, it is possible that a practice may be set up in order to facilitate and encourage assisted suicide.

The Bill requires that the requesting person makes two written formal requests for assistance to a registered medical practitioner, signed by two witnesses each. He/she must also meet with a psychiatrist after each formal request is made. However, it is reported that two thirds of applicants suffer from depression, which is not always clear without a thorough and rigorous assessment.

An independent second opinion is not possible as the physician must and the psychiatrist can be the same person for both requests.

The physician and psychiatrist are not required to agree on the application, the physician having the final say.

Regarding palliative care, this is required to have been discussed but need not have been undertaken. In fact, many persons who experience palliative care change their minds regarding assisted suicide. While relatives of the applicant are not allowed to be witnesses in order to prevent vested interests being involved, in fact an outsider may have less knowledge than relatives regarding the applicant's motive for requesting assistance.

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

No, I do not consider the safeguards to be satisfactory.

It is possible that a hurried decision may be made since there is a time frame of having 30 days within which to make the second request. After this the procedure would have to be restarted.

It is impossible to ensure that the applicant has not been externally influenced.

It is impossible to ensure that all doctors will make accurate and lawful judgments.

The Bill contains no specified procedures by which doctors would report their involvement with an assisted suicide. This makes meaningful audit of how the law was working highly problematic.
It is reported that one out of five cases of assisted suicide fail with patients regurgitating drugs, awakening from unconsciousness and experiencing devastating trauma. [cf. 'Considering Physician Assisted Suicide' by Professor John Keown.]

Voluntary euthanasia has progressed to involuntary euthanasia as newborn babies with disabilities are killed. Over 1000 people die each year without an explicit request in the Netherlands. [cf. 'Considering Physician Assisted Suicide' by Professor John Keown.]

- Do you have any other considerations on the Bill not included in answers to the above questions?
The Bill purports to allow assisted suicide (where a patient is provided with lethal drugs by a physician for self-administration). In fact it goes much further. It would also legalise euthanasia (where a physician administers lethal drugs to a patient directly).

The Bill is not clear on what means can be used to end a person's life. One might assume that it is envisages lethal drugs but this is not specified.

The Bill places responsibility for providing "end of life assistance" on the shoulders of Scottish doctors, for whom it contains no 'conscience clause' and the majority of whom would not be prepared to participate in implementing the proposals of the Bill.

The vast majority of medical practitioners and all the Royal Colleges of Medicine do not support assisted suicide.

The presence of Assisted Suicide legislation can send a message to elderly or disabled people that their lives no longer have any meaning, value or worth and that, therefore, they should request assisted suicide so as not to be burden on people.

The Bill is intended to 'enable a person to die with dignity and a minimum of distress'. This is already provided through good health care and particularly palliative medicine.

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8 MAY 2010.