

THE PROPOSED END OF LIFE CHOICES (SCOTLAND) BILL

Response to Consultation Document

1. This Memorandum is a response by the Care Not Killing Alliance to a Consultation Document (CD) published in December 2008 by Margo MacDonald MSP. The CD sets out various arguments for a law in Scotland to allow “*people who wish to decide when to end their lives*” to be “*able to do so, legally, with the assistance of a registered physician*”¹. It invites its readers to “*comment on any issues that you feel may be relevant*”.
2. The CD is somewhat unstructured document: some specific proposals for legislation are mingled with sections about such things as the existing law in Britain, euthanasia laws in the six other jurisdictions where they exist and what are referred to as ‘case studies’, meaning the stories of some individuals who support a change in the law. It seems to be more concerned with advocating the case for a change in the law than with telling the reader precisely what is being proposed in this respect.
3. Moreover, where specific changes are addressed, the document is often lacking in clarity. It is not stated, for example, whether assistance with suicide or voluntary euthanasia is envisaged: the reader is left to infer from some of statements made that it is the latter. In other respects, too, the document is less than clear. For instance, its title leads the reader to believe that what is envisaged is voluntary euthanasia for people nearing the end of life, but the subsequent text makes clear that others who are not nearing the end of life but who ‘find life intolerable’ would also be included.
4. In the interests of clarity we have not followed the unstructured shape of the document. Instead, we have sought to draw together and comment on its thinking, insofar as this can be determined, under various subheadings, such as the scope of any new law, its safeguards, the existing law, the experience of other countries which have gone down the euthanasia road and so on.
5. Our response consists of an executive summary and a more detailed analysis of the CD. These appear as Annexes 1 and 2 of this Note, respectively.

Care Not Killing Alliance (Scotland)

January 2009

¹ Foreword

Annex 1

THE PROPOSED END OF LIFE CHOICES (SCOTLAND) BILL

Care Not Killing Alliance Response to Consultation Document

Executive Summary

1. The Consultation Document (CD) asks for comments specifically on just seven issues, all of them concerned with the detail of any bill which may be put forward in the Scottish Parliament. It appears to assume that the principles underlying such a fundamental change in the law can be taken for granted, and it does not invite comment on key issues such as the proper ambit of any new law or the adequacy of any safeguards. The underlying principles of the proposed bill are, however, open to serious dispute, and the absence of any rationale concerning the scope of the proposed legislation or any clear view of the safeguards that would be needed to underpin it are significant deficiencies. Discussion of these issues in the CD is wholly insufficient, consisting as it does of a number of unsupported assertions of the case for a change in the law and of assumed objections from the opponents of such a change. It is putting the cart before the horse to examine points of detail, such as whether a 15-day ‘cooling off’ period is sufficient or what should be the responsibilities of a “consulting health professional”, before addressing in an objective manner the fundamental principles involved in a such an important change in the law and the scope and nature of any safeguards which might feature in a bill of this kind

Scope

2. The scope of the proposed bill is very wide indeed. Previous bills of this nature have focused on terminally ill people as potential applicants for what is sometimes referred to as ‘assisted dying’. And, in England and Wales at any rate, it has been thought politic, after unsuccessful attempts to legalise euthanasia, to restrict any proposals of this nature to physician-assisted suicide (PAS). By contrast, Ms MacDonald’s proposals are focused not only on those who are terminally ill but also on three other categories of people. These are, in the words of the CD²:

- “patients enjoying otherwise satisfactory health but with degenerative, irreversible conditions”;
- “patients who unexpectedly become incapacitated to a degree they find intolerable”;
- “patients who are not terminally ill, suffering from a degenerative condition or unexpectedly incapacitated but who find their life to be intolerable”.

This huge catchment area covers just about anyone who believes his or her life is not worth living and wishes to end it. It includes, in addition to the terminally ill, all chronically-ill people, many of them disabled; people who have been unexpectedly

² See Section 2.3 of the Consultation Document

paralysed in accidents but have not had the time to come to terms with their new condition; and many others, such as parents who have recently lost a child in traumatic circumstances, prisoners serving life sentences and people who are suffering from severe depression. Such a law would fly in the face of the strenuous efforts (eg suicide watches and resuscitation attempts) which are taken, with public support, to prevent suicides among vulnerable people.

3. The proposals would also empower a physician “*to bring the patient’s life to an end should it become intolerable*”³. On the face of it, therefore, we have here a proposal for voluntary euthanasia (ie direct action by a doctor to end a patient’s life at the patient’s request) as distinct from PAS (ie the supply of lethal drugs by a doctor to a patient with which the end his or her own life). While this may be the result of careless wording in the CD, we have to assume that the document means what it says and that it envisages the legalisation of euthanasia as well as PAS.

Safeguards

4. It is surprising, given that there has been much public dispute about the strength of safeguards included in earlier ‘assisted dying’ bills within the UK, that Ms MacDonald’s proposals make no attempt to improve on what has gone before. Indeed, the so-called safeguards which appear in her proposals consist of little more than form-filling and box-ticking. They seem to assume that all applicants for euthanasia would be clear-headed, self-reliant and determined individuals – an idealised picture that is far removed from the real world of most seriously ill people.
5. The proposed criterion of ‘capability’ would not rule out euthanasia for people who were *compos mentis* but suffering from depression, and there is no reference to any requirement on an assessing doctor to establish that an application for euthanasia does not stem from coercion, whether by others or in the form of internalised pressures, such as a wish to remove a care or financial burden from the family.
6. As such, the proposals are out of touch with the real world. Those who work, day in and day out, with seriously ill people know only too well that depression and internalised coercion are very common states of mind which not infrequently prompt transient but recurring requests to die. The proposals in the CD, however, seem designed to fast-track applicants through the euthanasia application process rather than to try and address their underlying problems and ensure that vulnerable people, who far outnumber the small minority of people with a fixed wish to end their lives, are properly protected. The proposed ‘safeguards’ would safeguard nothing.
7. The proposals also reveal an imperfect understanding of the rationale and administration of the existing law and of the experience of ‘assisted dying’ in the few countries where it has been legalised.

³ Section 2.3

ANNEX 2

THE PROPOSED END OF LIFE CHOICES (SCOTLAND) BILL

Care Not Killing Alliance Response to Consultation Document

Detailed Analysis

1. In this Annex we examine the CD in more detail and comment on specific issues.

Scope

2. The first paragraph of the Foreword gives us a flavour of the scope of the proposals:

“The proposal that persons who wish to decide when to end their lives should be able to do so, legally, with the assistance of a registered physician has come about because of the experiences of people with degenerative conditions, terminal illness and those who become entirely dependent on others following a trauma”

This is a very wide catchment area for any euthanasia law, comprising as it does anyone who is suffering from an incurable condition, whether terminal or chronic, and anyone who is dependent on others through incapacity. Section 2.3, however, adds yet another category of applicant – “patients who are not terminally ill, suffering from a degenerative condition, or unexpectedly incapacitated but who find their life to be intolerable”.

3. There is no explanation of the rationale on which these specific groups of people have been chosen. The list appears rather to have been constructed around the wishes of specific and high-profile individuals, including Ms MacDonald herself (a sufferer from Parkinson’s Disease), Ms Debbie Purdy (Multiple Sclerosis) and the late Daniel James, a young man who became incapacitated after a rugby accident and went to Switzerland to commit suicide. Indeed, the CD states that *“the proposed bill would address the needs of people in situations like those of Val McKay, the Bowman family, Dan James, Dianne Pretty and Debby Purdy”*⁴. In other words, the proposals have been designed around the wishes of individuals who have been in the public eye rather than in accord with any rigorous examination of the case for euthanasia.
4. It is also significant that the proposals are focused on individuals who have become “unexpectedly” incapacitated. The inference here is that euthanasia is an appropriate course of action for people who have not come to terms with sudden incapacity but inappropriate for those who have learned to live with their condition. There are real dangers here, in that those who have recently become incapacitated, as the late Daniel James, and are still mourning their loss of function are particularly vulnerable and in need of the protection of the law.

⁴ Section 4.6

5. The scope for applications under the proposed bill is therefore very wide indeed. It is wider than the 2002 Dutch Euthanasia Law, which has the largest ambit of any of those in the six existing jurisdictions around the world. The proposal to legalise euthanasia for people who simply “find their life intolerable” is especially open to objection. One might ask where this would leave such people as a mother who is finding it difficult to come to terms with the tragic loss of child, a prisoner serving a life sentence or anyone who happens to be suffering from suicidal depression. It is also fair to ask why, if such people are to be brought within the scope of a euthanasia law, their applications should be processed by doctors, who would be required under the proposals in the CD to “*inform the patient of his or her medical diagnosis, his or her prognosis*”⁵. The applicants in question are not ‘patients’: they are individuals who, for one reason or another, say they “*find life intolerable*” and want someone to end their lives for them. So why should doctors be involved?
6. Nowhere in the CD is it stated clearly whether the intention is to seek legalisation of physician-assisted suicide (PAS) or voluntary euthanasia. It would appear from various phrases used that the intention is the latter. In particular, in Section 2.3 we have a reference to a request to a doctor “*to bring the patient’s life to an end*”. This may possibly be just careless drafting. For the purposes of this response, however, we have had to assume that the CD means exactly what it says – that what is envisaged is the legalisation of euthanasia. . Whatever the meaning, the lack of clarity is worrying given the gravity of the subject.
7. Whatever view one takes of the acceptability or otherwise of ‘assisted dying’, it is clear from the evidence of other countries that have gone down this road that full euthanasia is much more likely to draw in vulnerable people than is PAS, where the applicant has to be determined enough to take the lethal drugs himself or herself. The difference in death rates from euthanasia and PAS in Holland and Oregon respectively illustrate this – with 1 in 38 deaths in Holland occurring from euthanasia and 1 in around 700 in Oregon from PAS. To say this is not to commend PAS, around the practice of which there are many serious hazards. But PAS is less likely to lead to a large cull of vulnerable sick people or to lead to a culture of death on demand.
8. In sum, the proposals as presented are very wide in scope and show no evidence of rigorous thinking about which groups of people should be brought within the ambit of any future bill and why.

Safeguards

9. The safeguards which are envisaged seem to consist of the qualifying conditions and the paper trail which the “attending physician” has to put in place. There does not seem to be an underlying concept that one of the purposes of any euthanasia bill should be to examine applicants carefully in order to ensure that they know what they are doing or that they are not acting under pressure. There is an assumption that

⁵ Section 2.3

everyone who applies for euthanasia will have thought the matter through very carefully and that the primary purpose of the assessment is to facilitate the application process. Given the gravity of what is being proposed, the reverse should be the case: applicants should have to comply with very strict conditions designed to make them reflect and reconsider.

10. The qualifying conditions are that an applicant should be an adult (defined as someone over the age of 16), live in Scotland and be “capable”. The first two are straightforward enough – though it is far from clear why it is considered appropriate, when the age of majority for most things is 18, to reduce it to 16 for decisions to have one’s life ended! But the third – the requirement that an applicant should be “capable” – brings some real problems.
11. The CD describes an “incapable” person (ie someone who would not qualify under the proposed bill) as someone who is “*incapable of acting, or making decisions, or communicating decisions, or understanding decisions, or retaining the memory of decisions by reason of mental disorder or of inability to communicate because of physical disability*”. Where, one is entitled to ask, would this leave applicants with depression? Most depressed people can take actions, make and communicate decisions, and understand and remember what they have decided. What they cannot be relied on to make is *sound* decisions – ie decisions which have been properly thought-through and which do not reflect transient mood swings. It is very doubtful whether such people would be protected under Ms MacDonald’s proposals.
12. Even if people suffering from depression were deemed by Ms MacDonald to be “incapable” for the purposes of having their lives ended, they may nonetheless pass muster for euthanasia. The CD contains the familiar caveat – “*if the attending physician doubts the mental capacity of a patient to make and communicate health care decisions to health care providers, the patient would be evaluated by a consulting health professional*”. This is easy enough to say, but experience has shown that caveats like this cannot be relied on to be effective. Look, for example, at Oregon, where recent independent research has revealed that as many as one in six of those who have ended their lives with suicide drugs from their doctors have been suffering from treatable but undiagnosed depression. These findings are hardly surprising when one considers that the referral rate for psychiatric evaluation among applicants for PAS in Oregon is as low as one in ten, indicating that most physicians simply do not have the skills to spot the possible presence of such psychiatric disorders.
13. However, there is another category of person whose existence the CD does not recognise – namely, those who are not mentally incapable but who are suffering from internalised but undisclosed pressures to die early. Yet these are, perhaps, the most vulnerable people of all – those who are not themselves in a hurry to die but who are concerned about the burdens, real or imagined, that they are imposing through their illness on their children. The authors of the CD seem to be heedless that such people might apply for euthanasia. Their focus is so fixed on giving a resolute and

determined minority what they say they want that they have forgotten that many more could suffer collateral harm as a result. And yet in these days of economic recession it takes little imagination to understand the concerns that many older people might have about being a burden to children who are struggling to maintain precarious jobs and pay rising bills.

14. Nor is there any attempt made to define what might constitute an “intolerable” life. As the proposals are drafted, an applicant need do no more than state that he or she considers his or her life intolerable. Many people perceive their lives to be intolerable at different stages and for various reasons, and some of them attempt suicide as a result. But, mercifully, under the law as it stands they cannot invoke assistance to that end. Ms MacDonald’s proposals, on the other hand, would smooth the path for them. There is no safeguard whatever here.
15. In sum, the proposals as drafted contain almost no safeguards to protect vulnerable people and do not appear to recognise that a law designed to meet the wishes of a determined and self-reliant minority could bring collateral harm to much larger numbers of less resolute persons.

Euthanasia and the Refusal of Life-Saving Treatment

16. The CD attempts to argue in a number of places that there is an inconsistency under the present law between a patient’s right to refuse life-saving treatment and the absence of a right to seek “*medication that would have the same result*” – ie euthanasia. This is a familiar refrain of the pro-euthanasia movement. It was comprehensively and impartially examined and rejected by a House of Lords select committee four years ago⁶. Suffice it to say here that:
 - A right to refuse medical treatment exists in order to protect patients from having unwanted treatments administered to them. It is not the same thing as a right to demand specific treatments, where judgements must be made by health care professionals on the basis of the patient’s condition, the risks versus benefits involved and – not least – clinical ethics.
 - While some patients who refuse life-saving treatment may do so as the result of a positive wish to die, the great majority do so simply because they are finding the treatment too burdensome: they accept that death may follow, but it is not something they are seeking. It should not be assumed, as the pro-euthanasia movement is wont to do, that the wishes of a minority of seriously ill people are representative of the wishes of all.
 - It is important to remember that ‘assisted dying’, if it is set within the health care system, involves a doctor as well as a patient. In the case of withdrawal of treatment, the doctor is doing no more than letting nature take its course, whether at the patient’s request or because the treatment has proved futile. The doctor’s

⁶ See House of Lords Paper 86-I (Session 2004-05), Paragraphs 48-51 and 64-65

intention is not to end the patient's life. If the patient dies, he or she dies of the underlying illness. There is a world of difference from the doctor's point of view between that and taking action deliberately to end a patient's life. The General Medical Council has commented that a law which allowed such action "*would have profound implications for the role and responsibilities of doctors and their relationships with patients*" and would be "*difficult to reconcile with the medical ethical principals of beneficence and non-maleficence*"⁷.

- Not only is the intention of treatment withdrawal different from that of euthanasia: the results are also sometimes different. It is not unknown for patients in this position to survive, and sometimes even to recover.

Responsibilities of the Attending Physician

17. Five conditions are laid down in the CD, all of which are of the 'tick-in-the-box' variety. The concern seems to be more to get the paperwork in order than to protect the applicant from doing something foolish but irrevocable. All of them assume that the applicant is fully resolved and in control. None of them would provide any serious protection for an applicant with any degree of vulnerability.
18. As an example, we are told that the attending physician must "*inform the patient of all feasible alternatives, including but not limited to hospice care and palliative care*". It is hardly likely that an applicant would have reached the stage of requesting euthanasia without having been informed of the existence of palliative care services: what he or she would not know is how effective such services could be, and that can only be discovered by experience. This is what Help the Hospices said in 2004 in evidence to the House of Lords select committee examining Lord Joffe's second 'assisted dying' bill:

*"Experience of pain control is radically different from the promise of pain control, and cessation is almost unimaginable if symptom control has been poor. On this view patients seeking assistance to die without having experienced good symptom control could not be deemed fully informed"*⁸.
19. Indeed, the experience of palliative care physicians in Belgium has been that, where palliative care 'filters' have been introduced (ie a requirement that patients seeking euthanasia must undergo a course of palliative care before confirming their request), most applicants withdraw their applications after experiencing what palliative care can do for them. By contrast, the 'tick box' approach in Ms MacDonald's proposals seems more designed to fast-track applicants for euthanasia than to attempt to resolve their underlying problems by alternative means.

⁷ See House of Lords Paper 86-II, Page 112

⁸ House of Lords Paper 86-II (Session 2004-05), Page 702

Opposition to Euthanasia

20. The CD assumes that opposition to legalised euthanasia stems from a belief that “*God determines where life ends*”. It goes on to observe, correctly, that “*our society embraces many people who do not share this belief, who believe in the autonomy of the individual in taking responsibility for, and exercising choice over, how life is lived, including the end of life*”.
21. There is however a palpable fallacy here. The authors of the CD have noted that there is faith-based opposition to what they are proposing. But, just as they have assumed that all seriously ill people share the views of a determined minority who want to have their lives ended prematurely, so they assume that, because people with a religious faith oppose them, all opposition must therefore be faith-based. We have here an instance of the familiar ‘all cats have tails’ syndrome – religious people are opposed to us, these people are opposed to us, therefore they must be religious.
22. Yes, people with religious beliefs are usually opposed to the legalisation of euthanasia: it would involve some interesting moral gymnastics for them to take any other view. But what about the medical profession? All the Medical Royal Colleges and the British Medical Association have, after consulting with their members, declared their opposition to a change in the law. Are we to assume that these bodies are motivated by religious beliefs? Of course they are not. They have made clear that their opposition rests on the conflict between ‘assisted dying’ and medical ethics and on its potential for collateral harm to vulnerable patients.
23. While some of the opposition to euthanasia comes from the churches and other religious bodies, most of it stems from concern, whether from people with a religious faith or with no faith at all, that a facility created to meet the wishes of a self-reliant and determined minority would pose dangers for the less resolute and more vulnerable majority of seriously ill people. The authors of the CD seem naively unaware that laws such as this are not like precision-guided missiles. They have a habit of causing collateral damage beyond the intended target area. Very real concerns on this score cannot be removed simply by intoning assurances that there would be ‘safeguards’. The safeguards that have been seen in recent ‘assisted dying’ bills in the UK may look reasonable on paper, but it is doubtful whether they are real-world-proofed enough not to bend under the stresses of terminal or other serious illness and the pressures of every day clinical practice. The authors of the CD have failed to identify, much less to address, the principal objection to what they are proposing. It is not religion that is the main driving force of the opposition; it is concern over public safety. Religious opposition is being used as a convenient scapegoat in order to avoid tackling the real problem.

The Existing Law

24. The CD states, on the basis of recent decisions by the Crown Prosecution Service (CPS) not to prosecute relatives of people who have ended their lives at the Swiss

suicide facility *Dignitas*, that “*penalties will not be invoked against anyone assisting them to end their lives because, for example, a degenerative condition has made life intolerable*”. This statement is untrue and betrays a serious misunderstanding of the existing law and how it is administered. The law prohibits assistance with suicide and threatens those who are convicted of it with a severe penalty – a maximum of 14 years in prison. But, like any other law, it is administered in such a way as to allow for compassion (ie a decision by the CPS not to prosecute or a lenient sentence by the courts in the event of a conviction) in appropriate cases. This combination in the law of a stern face (to deter coercion or other abuse) and a compassionate heart (to deal appropriately with cases where such abuse is considered to be absent) is not unique to assisted suicide: it exists in other criminal laws too. And it is the reason why the cases we see are few in number and the outcomes often lenient. The law is working exactly as it should, and it is misguided to draw invalid conclusions from a number of high-profile Swiss suicide cases.

Ambiguities – What Ambiguities?

25. The CD states that “*there are ambiguities and a lack of clarity around the issue*”⁹ and that “*the purpose of the proposed bill is to clarify the laws...relating to the assistance given to end the life of a person requesting such help*”¹⁰. As explained above, the law is clear and contains sufficient flexibility to enable it to be applied sensibly in a range of circumstances. Where there is a lack of clarity it is with the authors of the CD, and the pro-euthanasia movement as a whole, about the purpose of the law – which is, first and foremost, to deter abuse and, as a secondary aim, to deal appropriately with cases where breaches of the law occur. What the authors of the CD are trying to do is not to clarify the law but to enact an exception to the law which would create a legal facility available as of right. While such a facility might meet the wishes of a minority of determined and self-reliant people, it would remove the impartial and effective protection which the existing law provides to all and especially to the vulnerable majority. All law-making has to balance potential benefits against harms and, where there is any doubt, to come down firmly on the side of protecting the weak against giving ‘rights’ to the strong. In the case of euthanasia, while it is impossible not to sympathise with people who feel miserable and want to die, there can be little doubt where the balance of harm lies.

Autonomy

26. The authors of the CD refer to “*the principle of autonomy, that a person has the right to determine the quality of his or her own life and its value, unrestricted by the moral, cultural, religious or personal beliefs of others*”. It is on this ‘principle’ that the authors argue for “*a patient’s right to end of life choices*”¹¹.

⁹ Foreword

¹⁰ Section 1

¹¹ Section 1

27. This ‘principle’, like the proposals that appear in the CD, is so widely drawn that it is difficult to believe it has been given much serious thought. It is one thing to argue that every human being has a right to form his or her own perceptions of life and personal values. This is so self-evident that it hardly needs to be asserted as a ‘right’. Problems arise, however, when individuals wish to exercise these ‘rights’ in such a way as to endanger others or to require others to do things which they would not otherwise do. In the real world there is no such thing as an absolute right: all rights have to be circumscribed by the impact which their exercise might have on others. The ‘rights’ described in the CD are essentially designed around the wishes of self-reliant and self-contained individuals. Sound legislation, on the other hand, has to be based on the interests of the population as a whole, the majority of whom want good care and support rather than a ‘right’ to have someone end their lives but who could be put at serious risk if the barriers which the present law erects for their protection were to be breached in order to provide a facility to a vociferous few.

Opinion Polls

28. The CD raises the familiar theme that there is a groundswell of public opinion demanding euthanasia. We do not call into question the accuracy of the poll data quoted by the authors but rather its significance. An impartial House of Lords select committee addressed this subject four years ago by commissioning specialist research into opinion polls conducted in recent years. The report of the professional firm carrying out the study noted that, though among the general public there appeared to be “*widespread and growing concern to legalise the situation of the terminally ill who wish to die and those prepared to help them...doctors appear to be notably less in favour of legalising euthanasia*”. It concluded that:

“The findings [of opinion polls] should be treated with great caution. Very little research exists which is built on techniques for so complex and sensitive a subject as euthanasia and whether/how it should be legalised. Research sponsors frequently appear to have been more concerned to achieve statistics for media consumption than to work towards achieving a comprehensive understanding of public and health sector attitudes”¹².

29. Though it may well be the case that 80% of the public tell opinion pollsters they would favour a change in the law, it does not follow from this that there is strong public demand for legalised euthanasia. What the opinion polls do not tell us is how many of those who say they favour legalisation understand the complexities of the subject and reached rational conclusions about it – as distinct from others who have given the subject little thought but have sympathy with the position of very sick people. When asked whether people who are “suffering unbearably” or who “find their lives intolerable” should be given a ‘right’ to have ‘medical help to die’, many respondents will picture people wracked with pain that is not being relieved and will be inclined to assent. But this is simply not the reality. Modern palliative care can deal expertly with pain and other symptoms of serious illness in a way it could not do

¹² House of Lords Paper 86-I (Session 2004-05), Page 121

20 or even 10 years ago. The campaign to legalise ‘assisted dying’ today is more about the promotion of personal autonomy and control than about the relief of symptomatic suffering – as the title of Ms MacDonald’s recent Panorama programme (“I’ll Die When I Choose”) indicated.

30. The fact is that, like capital punishment, the European Union and immigration, the legalisation of euthanasia is a highly complex and emotive issue on which large numbers of people have simplistic, one-dimensional views but which poses such potential dangers to vulnerable people that decisions by law-makers have to be based on in-depth understanding rather than knee-jerk reactions. Opinion polls can be a useful indication of public opinion, but they cannot be taken at their face value as a basis for legislation.

End of Life Choices in Other Countries

31. The title of this section (Section 6) is very misleading. The only ‘end of life choice’ discussed is euthanasia. There is nothing about palliative care, and as a result the reader is left in ignorance that the quality and scope of palliative care is of a lower standard in all six jurisdictions named than in the UK. None of them has Britain’s extensive network of hospices and specialist palliative care departments, and in all of them palliative care is a form of additional training for generalist doctors rather than, as in the UK, a recognised medical specialty with an intensive four-year training programme required for admission. In Britain, moreover, palliative care is available for and tailored to the needs of chronically as well as terminally ill patients.

Conclusion

32. The Consultation Document contains proposals which are ill-thought-out and poorly presented. There is no rationale underlying the ambit of the proposed bill other than that it should cater for people similar to Ms MacDonald herself or other cases which have been recently in the public eye. The proposed safeguards against error or abuse are near to non-existent.
33. The argumentation in favour of a law permitting euthanasia betrays a failure to understand the reasons for the existing law or the way in which it is administered: such an understanding is a prerequisite of any discussion of a change in the law. Similarly, the important ethical, practical and legal differences between a patient’s right to refuse life-sustaining treatment and the absence of such a right to demand euthanasia have not been understood. Nor is there any recognition of the role of palliative care other than that an applicant for euthanasia should be informed of its existence – a surprising omission given that Britain is a world-leader in this branch of health care.
34. The fundamental problem with the proposals, however, is that they assume that all applicants for euthanasia are fully convinced in their minds and are not suffering from depression or coercion of any kind. This idealised picture is far removed from the

real world of most seriously ill people, who often alternate between hope and despair and are vulnerable to pressures, whether from others or (more often) from internalised feelings of guilt at the burdens (real or imagined) that they are imposing on others by remaining alive. In a word, the proposals are simply not real-world-proofed.