



Assisted Suicide (Scotland) Bill

Supplementary Evidence by Care Not Killing

Care Not Killing is a UK-based alliance of individuals and organisations which brings together disability and human rights groups, healthcare providers, and faith-based bodies, with the aims of:

- 1. promoting more and better palliative care;*
- 2. ensuring that existing laws against euthanasia and assisted suicide are not weakened or repealed;*
- 3. influencing the balance of public opinion against any further weakening of the law.*

We believe the Assisted Suicide (Scotland) Bill is flawed both in principle and in detail and should be rejected

Flawed in principle

1. The case for legalising voluntary, active euthanasia (VAE) and/or assisted suicide (AS) has been repeatedly and exhaustively considered, and overwhelmingly rejected, by legislatures, courts and expert committees worldwide.
2. The case has also long been rejected by the medical profession as uncontrollable, unethical and unnecessary. The World Medical Association reaffirmed its opposition in 2013. A change in the law is formally opposed by the British Medical Association, the Association for Palliative Medicine, the British Geriatric Society and the Royal Colleges of Physicians and General Practitioners. Medical opposition has been frequently reaffirmed as with the BMA in 2012 and the RCGP in 2011 and 2014, when 77% of respondents favoured maintaining college opposition.
3. A first major reason for maintaining the historic legal and medical prohibition on intentionally killing patients, and intentionally helping them to kill themselves, is the fundamental equality-in-dignity of all patients. As the House of Lords Select Committee on Medical Ethics put it in 1994: ‘That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal.’
4. VAE and AS are, by contrast, grounded in the belief that some patients have lives which are no longer ‘worth living’ and that they would be ‘better off dead’. Once the law abandons its historic, bright-line prohibition on intentionally ending the lives of patients, or on intentionally helping them to end their own lives, it invites arbitrary and discriminatory judgments about which patients would be ‘better off dead’. This has dangerous historical precedent. It is noteworthy that all major disability rights groups in Britain (including Disability Rights UK, SCOPE, UKDPC and Not Dead Yet UK) oppose any change in the law believing it will lead to increased prejudice towards them and increased pressure on them to end their lives.
5. The two main arguments typically used to justify AS equally justify VAE. The first is respect for patient autonomy. The second is that death would benefit the patient by ending suffering (though the Bill does not even require suffering, merely that the patient finds their quality of life ‘unacceptable’). If those arguments justify lethal prescriptions, they equally justify lethal injections (especially if the patient is physically unable to commit suicide). They also apply equally to people who do not fall within the bill’s already wide qualifying criteria of having a ‘terminal or life-shortening illness’ or a ‘progressive and terminal or life-shortening condition’. The bill thereby is discriminatory and has within it the seeds of its own extension being ripe for legal challenge on equality grounds.

6. Any change in the law to allow assisted suicide would place pressure on vulnerable people to end their lives for fear of being a financial, emotional or care burden upon others. This would especially affect people who are disabled, elderly, sick or depressed. The right to die can so easily become the duty to die. Current legislation also protects vulnerable relatives from being subtly coerced into assisting a suicide against their better judgement. The pressure people will feel to end their lives if assisted suicide is legalised will be greatly accentuated at this time of economic recession with families and health budgets under pressure. Elder abuse and neglect by families, carers and institutions are real and dangerous and this is why strong laws are necessary. This fear is borne out by the American data. In Washington in 2013, 61% of people opting for assisted suicide gave the fear of being a burden to family, relatives and caregivers as a key reason. 13% cited 'financial implications of treatment'. In the same year in Oregon the equivalent figures were 49% and 6%.

7. Experience in other jurisdictions, such as Belgium, the Netherlands and the American states of Oregon and Washington, shows that any change in the law will lead to 'incremental extension' and 'mission creep' as some doctors will actively extend the categories of those to be included (from mentally competent to incompetent, from terminal to chronic illness, from adults to children, from assisted suicide to euthanasia). This process will be almost impossible to police. We also see in all these jurisdictions a steady annual increase in the overall numbers undergoing assisted suicide or euthanasia.

8. The Oregon data show that those people citing 'inadequate pain control or (even) concern about it' constitute just 23.7% of cases overall. So what are the main reasons given for taking one's life? In 2013 93% cited 'loss of autonomy', 89% said they were 'less able to engage in activities making life enjoyable' and 73% listed 'loss of dignity'. These are not physical but existential symptoms. But should people who feel their lives no longer have meaning and purpose be assisted by the state to kill themselves? This will lead to suicide contagion by presenting suicide as a solution for existential problems (the well-recognised 'Werther' effect) and will also undermine Scotland's suicide prevention strategy.

9. The present law making assisted suicide illegal is clear and right and does not need changing. The penalties it holds in reserve act as a strong deterrent to exploitation and abuse whilst giving discretion to prosecutors and judges in hard cases. It has both a stern face and a kind heart. The current law is working well. The number of British people travelling abroad to commit assisted suicide or euthanasia is very small (243 at the Dignitas facility in 11 years) compared to numbers in countries that have legalised assisted suicide or euthanasia. With an 'Oregon' law Scotland would have 115 deaths a year and with a 'Dutch' law over 1,525. The scope of this bill lies between Oregon and the Netherlands.

10. Persistent requests for assisted suicide and euthanasia are extremely rare if people are properly cared for so our priority must be to ensure that good care addressing people's physical, psychological, social and spiritual needs is accessible to all. Patients almost always change their minds about euthanasia when they experience good care. A good doctor can kill the pain without killing the patient. This bill is therefore unnecessary.

11. Public opinion polls can be easily manipulated when high media profile (and often celebrity-driven) 'hard cases' are used to elicit emotional reflex responses without consideration of the strong arguments against legalisation. But this public opinion is uninformed, uncommitted and unconvincing. Public support for Falconer's Bill dropped from 73% to just 43% when the five key arguments against it were heard.

Flawed in detail

12. The bill gives huge power to doctors without proper accountability. This invites abuse. It will be doctors who see the patients, fill out the forms, prescribe the lethal drugs. Some of them will push the boundaries. Some will falsify certification. There may be some who, like Harold Shipman, will develop a taste for killing and they will be very difficult to detect. But many will simply be too busy, too pressured and facing too many demands to make the kind of cool comprehensive objective assessments that this kind of law requires. And very few of them will really know the patients or their families. Society is reluctant to touch and question

doctors. The police are reluctant to investigate. The Prosecution service hesitates to prosecute and the courts are unwilling to convict. Parliament turns a blind eye. It is simply not safe to give doctors this sort of power because some will abuse it as they have in other countries and it will be very difficult to stop them.

13. The Bill's loose and relativistic wording, the emphasis on precluding individuals from criminal or civil responsibility, and the absence of any penalties for abuse result in the Bill's containing no meaningful legal protections for Scotland's citizens. Its compatibility with Article 2 of the European Convention on Human Rights (ECHR) must be in question. Notably, section 24 ('savings') removes culpability for 'incorrect' and 'inconsistent' actions 'in good faith' and contains no penalties for abuses or 'careless' errors, nor any suggestion of how such might be investigated. This will inevitably encourage some doctors and facilitators to act outside the bill's provisions.

14. We have seen already how doctors operate when licensed to end life in the case of abortion. We began with a very strict law which allowed it only in limited circumstances. Now there are 200,000 cases a year. Most of them fall outside the boundaries of the law. There is illegal pre-signing of forms, abortions for sex selection, abortions on demand for 'mental health' grounds (over 98% of all abortions) in the absence of peer-reviewed evidence that abortion protects mental health and only one conviction for illegal abortion in 45 years.

15. The Bill's vague wording gives wide scope for eligibility. Most progressive conditions will have a life-shortening effect – cancer, coronary heart disease, chronic obstructive airways disease, multiple sclerosis, diabetes, hypertension, obesity and many mental forms of mental illness and acquired and congenital disability. This life-shortening effect need not be pronounced, as the framers chose not to include any prognosis-based time limit.

16. Even at first and second requests, there is no mandated or recommended psychological (or indeed physical) assessment. It is deemed sufficient that the individual has not already been diagnosed with a mental disorder and has some powers of communicating decision. No assessment by a psychiatrist is required even though mental capacity can be very difficult for a non-specialist to assess and mental illness which may have contributed to suicidal ideation difficult to diagnose. This is compounded by that fact that the doctor need not know nor examine the patient nor confirm objectively that the patient does in fact have a qualifying illness or condition as opposed to simply believing or claiming this.

17. There is no conscience clause for doctors, despite widespread medical opposition to assisted suicide. If AS is legalised his will inevitably lead to it being included as a therapeutic option for all life shortening illness which doctors will be obliged to mention or offer and coercive pressure being placed on doctors to provide 'the full range of services'. Licensing doctors to end life would thereby fundamentally alter the doctor-patient relationship. While the framers muse (PM 39) on anticipated professional guideline changes to allow for opt-outs, this is preceded (PM 38) by a very clear expectation that pharmacists will dispense any medicine prescribed for the purpose of suicide.

18. In summary, the Assisted Suicide (Scotland) Bill:

(i) undermines a fundamental and historic legal and ethical principle: respect for the equal worth of all patients.

(ii) is a 'foot in the door'. The main ethical arguments which will be used to support it, misguided understandings of 'autonomy' and 'beneficence', are equally arguments for euthanasia for the competent, and for the incompetent, and, in either case, whether 'terminally ill' or not.

(iii) evades a vital question: 'Precisely how will it ensure what relaxed laws in other jurisdictions have conspicuously failed to ensure: effective control of PAS, not least to protect those who do not want to die and those for whom there are alternatives?'