ldw
living and dying well

Clear thinking on the end-of-life debate

ASSISTED SUICIDE (SCOTLAND) BILL [SP Bill 40]

Memorandum of Written Evidence submitted by Living and Dying Well

About Living and Dying Well

1. Living and Dying Well (LDW) is a public policy research body established in 2010 to examine the evidence surrounding the end-of-life debate, with a particular focus on whether physician-assisted suicide or physician-administered euthanasia should be legalised. LDW's role is to promote understanding of this complex and controversial subject through careful and rational analysis of the evidence. Its Patrons and Members include experts in the law, medicine, mental health, ethics and other disciplines relevant to the end-of-life debate who share a concern that public safety must be of paramount importance in this area.

2. Paragraphs 5 to 16 below address the specific questions posed in the Call for Evidence. Paragraphs 3 and 4 provide an introduction and also serve as an answer to the first of those questions concerning the general purposes of the Bill.

Introduction

3. The Bill seeks to legalise the provision of assistance with suicide to persons who have certain medical conditions. As such, it is proposing a major change both to the criminal law and to the principles underpinning clinical ethics. Before such a law could be responsibly enacted, clear evidence is needed that the law as it stands is not fit for purpose and, if that is the case, that what would be put in its place would provide adequate protection to vulnerable people. No serious evidence has been produced - for example in the consultation document which preceded the Bill or in the accompanying policy statement - to suggest that the present law is oppressive or otherwise in need of change; and, as explained in the paragraphs which follow, the Bill itself provides no effective safeguarding system to protect the public and especially its most vulnerable members.

4. The Bill's provisions conflict with social attitudes towards suicide. While people who attempt suicide are rightly treated with understanding and compassion, it is widely accepted that suicide itself is not something to be encouraged or assisted. Considerable efforts are made to prevent suicides and to put in place suicide prevention strategies, in which doctors have a key role to play. The Bill flies in the face of these attitudes and policies by seeking to create a class of people whose suicides it is appropriate to assist.

Answers to Specific Questions

Q2. The Bill compared with its predecessor

5. In one or two respects - for example, its limitation to assisted suicide and its inclusion of a preliminary declaration - the Bill may be said to have improved on its predecessor. However, these improvements are offset by a number of important weaknesses, including removal of the requirement for specialist psychiatric assessment and the creation of a class of 'licensed facilitators' whose role, insofar as it is defined, raises serious questions. Moreover, while the Bill's authors have removed the controversial provision in the previous Bill which would have made assisted suicide available to persons who are physically incapacitated and unable to live independently, they have also removed the requirement that a terminally ill applicant must have a prognosis of life remaining of six months or less. As a result large numbers of people with progressive and chronic illnesses have been brought within the Bill's ambit.

Q4. Declarations and Requests

6. The consultation document which preceded the Bill described a preliminary declaration as "*a clear delineator between those who might wish an assisted suicide and others who do not*". It also stated that, if a declaration had been on a patient's file "*for a period of time*", a doctor would be able "*to take this into consideration when looking at all the circumstances of a request for an assisted suicide*". These potential benefits are, however, nullified by the Bill's provision[1] that no more than a week need elapse between the making of a declaration and the filing of a first request for assisted suicide.

7. The two-stage assessment process contains no regime to govern the judgements which a doctor would have to make as to whether the criteria laid down in the Bill are met. The Bill requires simply that a doctor should state that "*to the best of my knowledge"* the request is voluntary and not being influenced by others, that the doctor is "*of the opinion*" that the applicant has the capacity to make the request and that his or her perception of an unacceptable quality of life "*is not inconsistent with the facts currently known to me*". For decisions of this gravity, such subjective opinion, unsupported by any evidence-based assessment regime, is wholly inadequate. The consultation document states that capacity assessment is "*something that they [doctors] routinely do*" and that there is therefore no need for psychiatric assessment to be mandatory. But, when doctors assess capacity, they do so with a view to protecting patients from harm, including self-harm, not to clearing the way for their suicide. Moreover, in these days when home visits are not as common as was once the case, doctors often know little of their patients' lives beyond the consulting room. Yet the Bill is asking them to make (literally) life-or-death decisions without any objective assessment regime to guide them.

Q5 Terminal or Life Shortening Illness

8. The Bill's clinical ambit (progessive and terminal or life-shortening illness) sets no limit of life expectancy. A wide range of illnesses - for example, multiple sclerosis, Parkinson's disease, cerebrovascular disease, diabetes, heart and lung disease - are incurable and progressive and over the course of years can be life-shortening. The

[1] Section 8(3)(c)

Bill encompasses, therefore, not only persons with conditions, such as cancer or other short-trajectory illnesses, that are normally regarded as terminal but also people with chronic, progressive and incurable conditions, whose numbers are considerably greater and life expectancy much longer. In this respect it has a much wider ambit than Oregon's physician-assisted suicide law, on which it purports to be modelled. Consequently the estimates of likely numbers of deaths which the Bill's authors have suggested[2] are considerably understated.

Q6. Eligibility

9. The Bill provides[3] for assisted suicide to be offered to persons who are not suffering from a mental disorder within the meaning of Section 328 of the Mental Health (Care and Treatment)(Scotland) Act 2003. Section 328 defines a mental disorder as a "*mental illness; personality disorder; or learning disability, however caused or manifested"* . However, it exempts from this definition a number of situations including "*dependence on, or use of, alcohol or drugs"*.

10. In clinical practice the expression of suicidal intent is normally regarded as grounds for psychological or psychiatric examination. Yet the Bill contains no provision that a request for assistance with suicide should be treated similarly. Establishing mental capacity is not simply a matter of deciding whether an applicant is suffering from a formal mental disorder. It is also necessary to establish whether any conditions are present which might impair judgement. Research has shown that major depressive disorder is a common concomitant of serious illness but often goes undetected by doctors. Moreover, some clinical conditions (for example, neurological illnesses) and/or the medication being taken to relieve them can have side-effects which affect capacity - not to mention the obvious potential of alcohol or drug dependence to impair judgement. The Explanatory Note to the Bill states that "*assessment of capacity is not generally something which requires psychiatric expertise"*. But capacity assessment is decision-specific, with a higher level of capacity required for some decisions than for others. A decision to commit suicide lies at the top end of such a spectrum of gravity: the Bill's reliance on Section 328 of the 2003 Act and its requirement that an assessing doctor be "*of the opinion*" that an applicant has capacity comes nowhere near providing an adequate safeguard.

Q7. Medical Practitioners

11. The Bill embeds the assessment of requests for assisted suicide within clinical practice. This raises a significant problem. The majority of doctors are opposed to legalisation and would be unwilling to participate in the practice if it were to be legalised[4]. As a result persons seeking assisted suicide would be obliged to shop around for, or to be vectored onto, a minority of willing doctors. These latter are, however, unlikely to know much about applicants as patients beyond their case notes. In these days of the multi-partner GP practice and infrequent home visits even a patient's regular practitioner often knows little of him or her beyond the consulting room. Doctors introduced to a patient specifically to consider an assisted suicide request are particularly badly-placed to conduct knowledge-based assessment of requests.

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[2] See Financial Memorandum Paragraphs 8-9

[3] Section 12(1)

[4] The Bill contains no 'conscience clause' enabling doctors to refuse to participate. It is assumed that this is an unintended oversight.

Q8. Means of Suicide

12. The Bill places on the shoulders of doctors responsibility for approving requests for assistance with suicide, but it is not clear whether this responsibility extends to supplying lethal drugs and/or whether other kinds of assistance with suicide would be permissible. The consultation document envisaged supply of lethal drugs but added that "*this will not be a requirement of the Bill*". The Bill itself refers[5] to "*any drug or other substance or means dispensed or otherwise supplied for the suicide of the person*", which implies that other means of suicide would be acceptable under its terms. This is a major uncertainty requiring resolution.

Q9. Licensed Facilitators

13. The Bill seeks to create 'licensed facilitators'. These would be authorised to provide "*such practical assistance as the person reasonably requests*"[6]. This concept raises a number of serious questions. Why should such facilitation be needed if, as the Bill states[7], death must be the result of action by the person committing suicide? Could the facilitator help the person concerned to ingest lethal drugs (for example, by holding a drinking vessel to his or her lips or by connecting a pump of lethal drugs to a feeding tube)? If so, this would take the Bill up to, and potentially across, the borderline between assisted suicide and administered euthanasia. How are such facilitators to be found? The task is one which many people would see as somewhat ghoulish and some would regard as morally questionable. The likelihood is that it would attract persons who see suicide as an appropriate response to serious illness and who might be less likely than others to counsel the intending suicide to reflect carefully before proceeding. Would political pressure groups advocating assisted suicide be eligible to involve themselves in facilitation - Section 22(1) appears to point in that direction? And is it seriously being suggested that someone as young as 16 years of age might act as a suicide facilitator for a person of advanced years?

Conclusion/Other Comments

14. The Bill makes no provision for acts of assisted suicide to be reported, monitored or controlled. This is a major omission: without an oversight system there would be no way of knowing whether the Bill's provisions were being abused.

15. Under the Bill's provisions, suicide must be carried out within 14 days of a second request being approved or the process must be re-started. This provision provides a perverse incentive to an intending suicide to proceed. The Bill also allows a person seeking assisted suicide but failing to meet the criteria to shop around until a favourable assessment is obtained, which calls into question the objectivity of any assessment.

16. More fundamentally, while the Bill provides considerable detail and precision relating to such bureaucratic issues as form-filling and the witnessing and filing of statements, the crucial assessment of requests for assisted suicide is governed by vaguely-worded eligibility criteria the interpretation of which is left to the personal opinions of individual doctors. The Bill mandates no procedures which those

[5] Section 19(c)
[6] Section 19(a)
[7] Section 18(3)

assessing such requests must follow in order to establish that the judgements they make meet the criteria laid down and are rooted in objectivity. There is nothing in the Bill to prevent similar requests for assisted suicide being handled in different ways by different doctors. Given these numerous and significant structural defects the Bill cannot be regarded as fit for purpose.

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