End of Life Assistance (Scotland) Bill Committee Report

SP Paper 523

1st Report, 2010 (Session 3)
Stage 1 Report on the End of Life Assistance (Scotland) Bill

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Remit and membership

Remit:
To consider and report to the Parliament on the End of Life Assistance (Scotland) Bill.

Membership:
Helen Eadie
Ross Finnie (Convener)
Michael Matheson
Ian McKee
Nanette Milne
Cathy Peattie

Committee Clerking Team:
Clerk to the Committee
Douglas Thornton

Assistant Clerk
Alison Wilson

Committee Assistant
Andrew Howlett
Stage 1 Report on the End of Life Assistance (Scotland) Bill

The Committee reports to the Parliament as follows—

INTRODUCTION

Procedure

1. The End of Life Assistance (Scotland) Bill ("the Bill") (SP Bill 38)\(^1\) was introduced by Margo MacDonald MSP, ("the member in charge"), on 20 January 2010. In accordance with the Standing Orders of the Parliament, the Bill was accompanied on introduction by Explanatory Notes (SP Bill 38–EN)\(^2\), which included a Financial Memorandum and a statement by the Presiding Officer on legislative competence, and a Policy Memorandum (SP Bill 38-PM)\(^3\).

2. The End of Life Assistance (Scotland) Bill Committee ("the Committee") was established by decision of the Parliament on 10 February 2010 with a remit to consider and report on the general principles of the Bill.

Purpose of the Bill

3. According to the Policy Memorandum, the purpose of the Bill is to enable persons whose lives have become intolerable and who meet certain conditions to “legally access assistance” to end their lives.

4. The Bill sets out a definition of end-of-life assistance for the purposes of the Bill and a range of eligibility criteria for persons requesting that assistance. It also provides a process applying to both those assisting the person and the person making the request, under which it is intended that a person would be able to receive an assisted death and those assisting would not have committed a criminal offence or a delict.

Definitions

5. There is no universally agreed usage of the terms “euthanasia”, “assisted suicide” and “physician-assisted suicide”. In the interests of avoiding confusion in respect of terminology used in this report, however, the Committee has adopted the following meanings—

- Voluntary euthanasia: the deliberate taking of another person’s life to relieve unbearable suffering, carried out at the request of the person in question;
- Assisted suicide: the situation where a competent person has expressed a desire to end his or her life but wants the assistance of another person to perform the act, for example by providing the means to do so. However, unlike euthanasia, the person seeking death carries out the final life-ending act;
- Physician-assisted suicide: an assisted suicide where the person providing assistance is a registered medical practitioner.

Pre-legislative consultation

6. The member in charge's consultation, The Proposed End of Life Choices (Scotland) Bill\(^4\), was issued on 8 December 2008 and closed on 9 March 2009.
7. There were 405 formal responses to the consultation. These are discussed in paragraphs 75 to 82 of the Policy Memorandum. A summary of responses was also published.

Committee consideration

8. The Committee records its thanks to those who gave evidence to, or otherwise participated in, its inquiry into the general principles of the Bill. The Committee also thanks its adviser, Alison Britton of the School of Law and Social Sciences at Glasgow Caledonian University.

Formal evidence

9. The Committee issued a call for written evidence on 3 March 2010. 601 responses were received before the closing date of 12 May 2010. These responses were published on the Parliament’s website and included in the summary of written evidence prepared by the Scottish Parliament Information Centre. Other correspondence received by the Committee was also published on its website.

10. The Committee subsequently agreed a programme of oral evidence sessions, which took place in September 2010 with—

- Dr Georg Bosshard, Lecturer in Medical Ethics at the University of Zurich and at the Fachhochschule Gesundheit WE‘G;
- Professor Martin Buijsen, Professor of Health Law, Institute of Health Policy and Management, Erasmus Universiteit Rotterdam;
- Dr Rob Jonquière, former Chief Executive of the NVVE (Dutch Right-to-Die Association) and Communications Director, World Federation of Right to Die Societies;
- Professor Penney Lewis, Professor of Law, School of Law and Centre of Medical Law and Ethics, Kings College London;
- The Rt Hon Lord Mackay of Clashfern KT;
- Adrian Ward, solicitor, expert in mental health and disability law;
- Professor Linda Ganzini, Professor of Psychiatry and Medicine Senior Scholar, Center for Ethics in Health Care at Oregon Health and Science University;
- Deborah Whiting Jaques, Executive Director/CEO, Oregon Hospice Association;
- Dr Iain Brassington, Lecturer in Bioethics, School of Law, University of Manchester;
- Professor Sheila McLean, Professor of Law and Ethics in Medicine, Centre for Applied Ethics and Legal Philosophy, University of Glasgow;
Professor Graeme Laurie, Professor of Medical Jurisprudence, School of Law, University of Edinburgh;

Professor Calum MacKellar, Professor of Research, Scottish Council on Human Bioethics;

Mark Hazelwood, Director, Scottish Partnership for Palliative Care;

Elaine Stevens, Chair, Independent Association of Nurses in Palliative Care;

Katrina McNamara-Googder, Head of Policy and Practice, Association for Children's Palliative Care;

Stephen Hutchison, Consultant Physician in Palliative Medicine, Highland Hospice;

Dr Chris Sugden, Medical Director, St Andrew's Hospice;

Dr Tony Calland, BMA Scotland;

Professor Colin Robertson, Royal College of Physicians of Edinburgh;

Dr Stephen Potts, Consultant in Liaison Psychiatry (Royal Infirmary of Edinburgh), Scottish Division, Royal College of Psychiatrists;

Dr Bill Mathewson, Deputy Chair (Policy), RCGP Scotland;

Malcolm Clubb, Policy Development Pharmacist, Community Pharmacy Scotland;

Theresa Fyffe, Director, Royal College of Nursing;

James Anderson, Clinical Psychologist, Scottish National Spinal Injuries Unit, and member of the Special Interest Group on Spinal Injuries, British Psychological Society in Scotland;

Detective Superintendent Brian Yule, Adult Support and Protection Working Group, Association of Chief Police Officers in Scotland;

Ruth Stark, Scottish Manager, British Association of Social Workers;

Kirsty Freeland, Senior Social Worker/Bereavement Service Coordinator, Scottish Regional Group, Association of Palliative Care Social Workers;

Paul Philip, Director of Standards and Fitness to Practise, General Medical Council;

Professor Tony Hazell, Chair, Nursing and Midwifery Council;

Reverend Dr Donald MacDonald, Retired Professor of Practical Theology, Free Church of Scotland;

Major Alan Dixon, Assistant to the Scotland Secretary, Salvation Army;

Reverend Ian Galloway, Convener of Church and Society Council, Church of Scotland;
Dr Bill Reid, Connexional Liaison Officer, Methodist Church in Scotland;
Dr Salah Beltagui, Convener, Muslim Council of Scotland;
Leah Granat, Public Affairs Officer, Scottish Council of Jewish Communities;
John Bishop, Secretary, Humanist Society of Scotland;
Frank Mulholland QC, Solicitor General;
John Logue, Head of Policy Division, Crown Office and Procurator Fiscal Service;
Pam Duncan, Board Member, Inclusion Scotland;
Johanna McCulloch, Policy Information and Parliamentary Officer, Scottish Disability Equality Forum;
Sarah Wootton, Chief Executive, Dignity in Dying;
Gordon MacDonald, Public Policy Officer, Care Not Killing Scotland;
David Manion, Chief Executive, Age Scotland;
Chris Docker, Director, EXIT;
Jan Killeen, Director of Policy, Alzheimer Scotland;
Tanith Muller, Parliamentary and Campaigns Officer, Scotland, Parkinson's UK;
Sheila Duffy, Member, Friends at the End;
John Deighan, Parliamentary Officer, Catholic Bishop's Conference of Scotland.

11. The minutes of all of the Committee's meetings are attached at Annexe A. Where written submissions were made in support of oral evidence, they are reproduced, together with the extracts from the Official Report of each of the relevant meetings, at Annexe B. All other written submissions and correspondence are included at Annexe C.

**DIRECTION AND PURPOSE OF BILL**

**The legal position**

*Background*

12. The Bill would decriminalise certain actions that currently fall within the ambit of the Scots law of homicide.

*Calls for ‘clarity’ in Scots law*

13. A recurrent theme in the evidence was a perception that the Bill would “clarify” the existing law in Scotland. For example, Paul
Philip from the General Medical Council stated that it would be “useful if the legal position on assisted suicide were clarified” and Dr Tony Calland from BMA Scotland stated that there had “always been a lack of clarity around issues at the end of life.” Similarly, the submission from West Dunbartonshire Council's Social Work and Health Services department expressed a hope that the process would “lead to greater clarity in the law and in public policy on end of life choices.”

Current Scots law on homicide

14. The Committee took evidence from the Solicitor General for Scotland (“the Solicitor General”), as deputy for the Lord Advocate, the head of the systems of prosecution and investigation of deaths. Asked about the prosecution process relating to homicide, the Solicitor General explained that a prosecutor’s role was to apply the law, not to change or innovate on it by means of prosecution policy. He went on to outline the general considerations taken into account when a case was reported to the procurator fiscal by the police. He explained that procurators fiscal follow a step approach to assessing whether to prosecute—

“We have to answer a number of sequential questions, the first of which is whether there is sufficient admissible, credible and reliable evidence that a crime has been committed. If the answer is yes, in the case of homicide the question is whether the criminal act caused death.

“Next, in the case of homicide, we have to answer the question whether the criminal act was carried out with intent to kill or with such wicked recklessness that it was regardless of the consequences. That is what is referred to as the mens rea—the intention for murder. For murder, we require an intention to kill or a wicked recklessness regardless of the consequences. In relation to the latter, if I stab someone 14 times to the body, an inference could be drawn by the jury that those actions and the multiplicity of blows were wickedly reckless because my actions show that I could not care less whether my victim lived or died. We consider the intent.

“Having answered that question, we will then assess whether there is provocation, which reduces the crime from murder to culpable homicide, or whether the perpetrator's responsibility was diminished. The appeal court looked at the concept of diminished responsibility fairly recently in the context of the Kim Galbraith case, which involved a woman in Argyll who shot her husband who was a policeman. The appeal court redefined diminished responsibility. The test used to be that diminished responsibility had almost to amount to insanity in law. The court redefined it as some condition that affects your responsibility and intention for the act. For example, if someone is suffering from significant bipolar syndrome, that might—depending on the expert advice that you get as a prosecutor—be sufficient to reduce the charge from murder to culpable homicide.

“Once we have assessed that there is sufficient, credible, reliable and admissible evidence, mens rea and causation and whether diminished responsibility or provocation apply, we will apply the public interest test, to which you are alluding. The factors that we take into account as a prosecutor in assessing the public interest are published in the "Crown Office and Procurator Fiscal Service Prosecution Code", which is available on the Crown Office website. In fact, last night I Googled "prosecution code Scotland" and the first hit was the prosecution code, so it is readily available to the public.

“In assessing the public interest, the prosecutor looks at the nature and gravity of the crime. It stands to reason that the more serious the crime, the more likely it is that the public interest will require a prosecution. Consideration is then given to the age, background and circumstances of the perpetrator—I am trying to make things as neutral as possible
by using the word “perpetrator”. We then look at the age and personal circumstances of the victim—the deceased—and their family; the attitude of the victim and the victim's family; the motive for the crime, if that can be ascertained; any mitigating circumstances that affect the prosecution of the accused; and the risk, if any, of reoffending. All those considerations are taken into account and weight is given to them in reaching an ultimate decision about whether it is in the public interest to prosecute.¹⁰

15. The Solicitor General added several points on assisted suicide. The first point was that the consent of the victim was no defence in law—

“That has been the consistent position. In 1947, there was the HMA v Rutherford case. There was also the Smart v HMA case. Two persons were brawling in the street and the defence was that the person who came off worse consented to it. In law, that is no defence.”¹¹

16. Secondly, he explained that the state of the victim’s health did not matter and that the chain of causation was not broken by voluntary ingestions—

“For example, if I supply someone with a lethal cocktail of drugs and that person ingests them, the chain of causation is not broken, so that would be a sufficient causal connection.”¹²

17. His next point was that motive was irrelevant in relation to criminal liability. He went on to explain that the law of concert would apply, i.e. if a first person assisted a second person – thereby acting in concert – to take that second person’s own life or attempted to do so, the first person would be dealt with under the law of homicide.¹³ The Solicitor General reminded the Committee that the Suicide Act 1961, which was relevant to the House of Lords’ interlocutor that the Director of Public Prosecutions publish guidance, applied only to England and Wales, not to Scotland.¹⁴ He also pointed out that, in a case in Scotland in 2006, a man was convicted of culpable homicide for assisting to end the life of his brother, who was suffering from Huntingdon's disease—

“He was convicted of culpable homicide and admonished. That case was the last reference that I could find. That indicates that in those circumstances our prosecution policy, applying the public interest test in that particular case, was to prosecute.”¹⁵

18. Asked whether he could conceive of circumstances in which a prosecution would not be brought if someone helped someone else to end their life, the Solicitor General answered—

“… it is difficult to look forward, as it would depend on all the circumstances, but I go back to a point that I made previously. The more serious the offence—the crime—the more likely it is that, on current law, the public interest is that we should prosecute … I would not like to say that almost everyone would be prosecuted. I go back to what I said about assessing the public interest and the sufficiency of the evidence. We would know whether the crime was murder or culpable homicide, and the more serious the offence, the more likely it is that the public interest demands a prosecution. I would not say that a prosecution would be mandatory or would occur in all cases, but there is more than a fairly strong possibility that, applying the law, the public interest would lie in a prosecution. Ultimately, it is for the court, in sentencing, to take account of the mitigating circumstances that may exist in a particular case.”¹⁶

“Double effect”
19. Where the person accused of a homicide is a member of the medical profession, the principle of double effect may provide a defence if the person can show that his or her primary intention in administering potentially lethal drugs was to alleviate suffering rather than hasten the death of the patient, even where the latter is known to be a likely result of the action. 

20. Describing the concept as something that was “accepted”, Professor Sheila McLean of the Centre for Applied Ethics and Legal Philosophy, University of Glasgow, said—

“The presumption there is that the person is increasing analgesia with the intention of easing pain, but the death is foreseeable … Legally speaking, when something is so foreseeable that it is inevitable, it is the same as there being intention. I can see that there might be a psychological distinction, but whether that translates into law, or even into ethics, is another matter.”

21. Referring to the tenets of Jewish faith, Leah Granat of the Scottish Council of Jewish Communities said that, although deliberately hastening death was not permitted, all measures to provide comfort and pain relief were “not only permitted but encouraged in the awareness that there might sometimes be a double effect – for example, in providing pain relief”. She went on to say—

“The intention is very important. If an opiate or any other form of pain relief is administered with the intention of providing pain relief and comfort to the patient, that is permitted, regardless of any double effect.”

22. The member in charge asked the Solicitor General how the use of double-effect medication related to the irrelevance of motive in the stepped assessment made by prosecutors when determining whether to proceed with a prosecution. The Solicitor General explained—

“I have been giving some thought to that matter, as I am aware of a couple of articles in legal journals that mention a double effect. The doctrine in question applies in England and Wales; the articles questioned whether it also applies in Scotland.

“If the intention is to alleviate pain, but that may hasten or cause death, the issue goes back to mens rea. The intention underlying the act would be assessed. One would assess the double effect, whether the medication relieved pain, whether that was the primary intention, and whether it was known that the medication might kill the person. The primary intention of the act and whether that is covered by criminal conduct would be assessed. An actus reas is needed for criminal conduct; an act and an intention are needed. Intention is well defined in the law of homicide and has been well known in Scotland for centuries. It is well understood by the public. As prosecutors, we would assess what a person’s intention was in providing drugs to the patient.”

23. The member in charge went on to ask whether this area of the law lacked clarity on the basis that two intentions had to be assessed in order to decide which was the greater. The Solicitor General conceded only that judgments of this nature were difficult to make. He explained that, under the current law, all the circumstances would be considered – medical records would be assessed and statements would be taken from the medical personnel involved in the patient’s treatment – and a prosecutor would have to determine what the intention was. He also stated—
“No such cases have been reported to me in 27 years … If such cases arose tomorrow or in the near future, say, they would be dealt with at the highest level by the local procurator fiscal and the highest level of crime counsel. Ultimately, I think that the law officers would deal with them.”

24. The member in charge asked further whether it would be better to have a “clearer legal demarcation line”. The Solicitor General responded—

“Sometimes trying to engineer a demarcation line can cause more problems than the line was intended to solve. Such cases are very fact-specific cases. I think that 16 factors in favour of a prosecution and six factors against a prosecution are listed in the bespoke guidance that the … [Director of Public Prosecutions] in England and Wales has issued. The difficulty lies in weighing up all the factors and deciding what weight to give each particular factor that applies to reach an overall judgment. Difficult legal concepts, such as mens rea, are involved. When someone speaks to a jury, they will explain the intention, but a man’s or woman’s mind cannot be looked into. Their actions will be considered, and one will try to infer from those actions what the intention was. In assessing mens rea, all the circumstances need to be considered to try to determine the true intention.”

25. Finally, the member in charge asked why there should be a difference in law between a double-effect action being taken by a medical practitioner and, for example, a carer. The Solicitor General responded—

“There is no difference in law. It seems to me that there is no class of person to which the law does not apply or applies to a lesser extent. Obviously, you recognise that the medical profession deals with terminally ill people and people who want to end their life, and you recognise its role in giving palliative care. However, there is no separate law for the medical profession as opposed to the rest of the public; the law is applied across the board. The circumstances in which the act took place would be taken into account. That is recognised in the DPP’s guidance.”

The law in the Netherlands

26. In the Netherlands, both voluntary euthanasia and physician-assisted suicide have, under certain circumstances, been decriminalised.

27. Under the Dutch penal code, it is a criminal offence either to terminate the life of a person on his or her request or to assist a person to commit suicide. However, from the 1970s onwards, courts found that doctors who performed active voluntary euthanasia or assisted suicide could use a statutory defence of necessity when faced with a conflict between their duties to preserve life and relieve suffering. The courts held that this defence was not open to lay-persons, including relatives and nurses, as only doctors could face such a conflict of duties. Over time, the courts began to place conditions on doctors using such a defence. In 1986, Government-approved ‘due care’ criteria were produced to take account of these conditions. As long as doctors followed the criteria, they would not be criminally liable for practising voluntary euthanasia or physician-assisted suicide. A later key development was the controversial Chabot case, which led to the courts accepting that assisted suicide could be justifiable in cases where, although no physical illness was present, the patient was experiencing intense emotional or mental suffering. There were two subsequent cases involving severely disabled infants, which led to an acceptance of euthanasia when requested by a parent of an infant experiencing unbearable and hopeless suffering.
28. In 1998, following concerns about the quality of reporting by doctors, the responsibility for reviewing cases was given to five regional review commissions. Doctors were required to report all cases of euthanasia and physician-assisted suicide to the relevant commission, which in turn decided whether the requirements of due care had been followed, before reporting the case to the public prosecutor regardless of the findings.

29. In 2001, a new law codifying existing practice was passed. Although it did not legalise voluntary euthanasia or physician-assisted suicide, it did provide statutory defences for each, subject to certain procedures being followed. This law applies to both adults and children. Between 16 and 18, young people can make their own decisions with parental involvement; between 12 and 16, parental consent is required. The law also sets out the membership and role of the five regional review commissions.

The law in Oregon

30. A law creating a system of physician-assisted suicide was passed following a state-wide ballot in 1994. A subsequent legislative measure to repeal the law was rejected by public ballot with 60% of votes against. In contrast with the Netherlands, where the momentum for a change in the law came through the medical profession, the Oregon Medical Association was a major opponent of the Oregon legislation and the impetus was civilian based. A later challenge at US federal level failed and the law remains in force.

31. The law in Oregon allows terminally ill adults to obtain a prescription for "lethal medication" for the purpose of committing suicide. It specifically prohibits euthanasia. To be eligible to request such a prescription, a patient must be 18 or older, a resident of Oregon, capable (defined as being able to make and communicate healthcare decisions) and diagnosed with a terminal illness, i.e. "an incurable and irreversible disease that has been medically confirmed" with a prognosis of death within six months. To comply with the law, physicians must report to the Department of Human Services all prescriptions for lethal medications. The law also requires a record of all of the oral and written requests of the patient, attending physician's diagnosis, prognosis, outcome and determination made during counselling, and the physician's determination that the patient is competent and acting voluntarily and has made an informed decision. Following an amendment to the statute in 1999, pharmacists must also be informed of the prescribed medication's intended use. The law in Oregon does not require the presence of a physician when a patient takes lethal medication, although it is permitted if the patient wishes it, provided that the medication is not administered by the physician.

32. Where the requirements of the law are adhered to, physicians and patients are protected from criminal prosecution and the status of a patient's health or life insurance policies is unaffected. In addition, there is a conscientious objection clause for physicians, pharmacists and healthcare systems.

Assisted suicide and voluntary euthanasia

Background

33. The Bill seeks to decriminalise both assisted suicide and voluntary euthanasia subject to certain conditions. The Bill uses the term 'end-of-life assistance', which is defined in the Bill as—

"... assistance, including the provision or administration of appropriate means, to enable a person to die with dignity and a minimum of distress."
The appropriateness of treating the two concepts together

34. That the Bill addresses both assisted suicide and voluntary euthanasia was widely commented on in the written submissions received. Professor Graeme Laurie and Professor JK Mason of the University of Edinburgh cautioned that treating the two acts together represented “largely uncharted territory for any jurisdiction”. They described it as a “leap into the unknown ... to be treated with exceptional care”.

35. The Rt Hon Lord Mackay of Clashfern KT (“Lord Mackay”) chaired the House of Lords Select Committee (“the Select Committee”) that considered Lord Joffe’s Bill on Assisted Dying for the Terminally Ill (“the Joffe Bill”) in 2005. Comparing the Bill with the Joffe Bill, Lord Mackay commented—

“... under Mrs MacDonald’s bill the choice between assisted suicide and voluntary euthanasia is to be left for agreement between the applicant and the registered practitioner, whereas Lord Joffe’s bill provided for voluntary euthanasia only where the applicant was unable to end his or her own life via assisted suicide. Given the much higher death rate from voluntary euthanasia than from assisted suicide where these practices have been legalised, the committee may wish to consider whether Margo MacDonald should be invited to introduce a similar limitation into her bill.”

36. A written submission from palliative care medical and senior hospice staff argued that the Bill was “couched in such terms” that the “inexperienced eye” was “unlikely to pick up” that it proposed euthanasia and called for the proposals to be “more transparent”. The submission went on to recall that the Select Committee considering the Joffe Bill had cautioned that, in any subsequent bill, a “clear distinction” should be drawn between assisted suicide and euthanasia “in order to examine the implications of both separately”.

37. Dignity in Dying, a campaign organisation, also commented on the appropriateness of treating the two acts together. The submission explained that the organisation viewed assisted dying, assisted suicide and voluntary euthanasia to be “distinct acts” and stated—

“Dignity in Dying’s understanding of ‘assistance’ is more focussed than the Bill proposes. For Dignity in Dying an assisted death is where a doctor prescribes a life-ending dose of medication to a mentally competent, terminally ill adult at their request and subject to legal safeguards. The patient then chooses to administer the medication themselves. The essence of the term ‘assistance’ lies in the fact that a third person only helps the person in question by enabling him or her to administer the life-ending medication themselves.”

38. Asked whether it was sustainable for the Bill to encompass both voluntary euthanasia and physician-assisted suicide, Professor Sheila McLean of the Centre for Applied Ethics and Legal Philosophy, University of Glasgow, suggested that “one of the logical points” in the Bill was the inclusion of both voluntary euthanasia and assisted suicide—

“It is interesting that the first challenge to the law in Oregon came from the disabled rights lobby, which argued that some of its members who might have wanted an assisted death were precluded from that because they would have to ingest the medication themselves and, in some cases, they were unable to do so.”

39. She went on to argue that, if the fundamental principle of choice at the end of life were accepted, it would be “illogical” to limit the
Bill to assisted suicide—

“I know that there are differences. The doctor's role is less active in one case than in the other case. I remind you, however, of what Lord Mustill said in the case of Anthony Bland, a young man who was injured in the Hillsborough disaster and ended up in a permanent vegetative state. On the so-called difference between acts and omissions—an omission is supposedly not nearly so bad as an act—Lord Mustill said that that distinction was simply not applicable in the circumstances and carried no moral weight. If the bill were to cover only assisted suicide, those who want to die but who need the simple assistance of a doctor would be deprived of that assistance on the basis of a legal rule that even the highest judges in the land do not think is applicable in such circumstances.”

40. Professor Laurie went on to recognise Professor McLean's comments questioning the validity of drawing a distinction. However, he suggested that, if the intention were to permit voluntary euthanasia only as a substitute for assisted suicide for people physically unable to help themselves, the Bill could be amended so as to restrict the meaning of assistance to including administration only "in the event of the requesting person being physically unable to utilise ... means" otherwise provided under the Bill.

41. Professor Calum MacKellar, Professor of Research, Scottish Council on Human Bioethics, commented—

"I agree with Professor Laurie that it is difficult to draw a distinction between assisted suicide and euthanasia. The three countries in Europe where both euthanasia and assisted suicide are legal are Luxembourg, Belgium and the Netherlands. On looking at the statistics, it is interesting to note that it is mainly euthanasia that is practised in those countries—the doctor killing the person. In a way, medics are more uncomfortable with assisted suicide because things can go wrong. That is why euthanasia is seen as preferable in the three countries that I cited."

42. Asked what the reasons were for excluding voluntary euthanasia from the law on physician-assisted suicide in Oregon, Professor Linda Ganzini of the Center for Ethics in Health Care at Oregon Health and Science University suggested firstly that it had been thought that the inclusion of euthanasia would result in the law not being passed and added—

"The second reason has to do with the nature of the north-western United States. There is a strong ethos of rugged individualism here. People have a strong desire to remain independent; they want to be in charge of what is going on with them and do not want doctors to be in charge.

"It is also true that end-of-life or palliative sedation is a reasonable alternative to euthanasia for people whose symptoms are uncontrollable—who have uncontrolled pain or who vomit uncontrollably, for example—in the final days of life. Since the law was passed, there really has not been a need to push for euthanasia because there are alternatives for such symptoms. There are not good alternatives for people who wish to be in control in the way that people who want assisted suicide wish to be."

Member in charge

Calls for clarity

43. The Policy Memorandum spoke of a need for people to be able to “expect “certainty, cogency and clarity” from the law on assisted dying”. The member in charge added in oral evidence that the practice of deciding whether to prosecute by reference to prosecutorial policy rather than to statute left “no guarantee of a consistent judgment on intent”. She stated—
“The bill would be much healthier, as it would introduce standards, procedures, rules and laws that must be adhered to, rather than leave it all to a public official, no matter how humane and well intentioned, to search through the fog to find out the intention.”

“Double effect”

44. The member in charge explained that the intention of the Bill was to ensure that no clinician could do as they were able to do at present and “make the decision” by giving a double-effect dose of medication near the end of life to shorten life—

“The bill says that the only person who can make that decision is the patient.”

Comparisons with other jurisdictions

45. The accompanying documents made much reference to the Oregon legislation, particularly in respect of predicting the impact of the Bill if enacted. The member in charge described Oregon as the “best parallel” for this purpose.

The appropriateness of treating assisted suicide and voluntary euthanasia together

46. The member in charge explained her own interpretation of the distinction between assisted suicide and euthanasia—

“That is why, when we were drawing up the bill, it was difficult to decide whether to use the word "euthanasia". This might be entirely personal, but I maintain that euthanasia is associated with someone else taking the decision, rather than the requesting patient. I accept that some people think that, in the final analysis, it is euthanasia if the requesting patient cannot self-administer the drug and a clinician gives assistance at the very end.

47. She repeated Professor McLean’s point that limiting the Bill to assisted suicide would be illogical and would leave those physically incapable of ending their lives without a means of doing so. She added that, under the Bill, the only person who could make the decision would be the patient—

“...no other person could instigate that process or make the decision.”

48. The member in charge further explained her view that assisted suicide and voluntary euthanasia as would be possible under the Bill were “two routes to the same outcome”. In response to the view that voluntary euthanasia put a very different responsibility on designated practitioners, she disagreed—

“If a practitioner who agrees to help someone to bring their life to an end has, in the final analysis, to give an injection or to help or allow someone to swallow something, that does not seem to me to be terribly different in principle from the same practitioner helping the person who has tried and failed to swallow a draught—say, by choking—to move forward to do so. The intention—or mens rea, as the Solicitor General called it—is all important in working out whether something is legal or illegal.”

49. Finally, she stated that she believed that there was “no difference” between intending to help someone to bring his or her life to an end and actually helping him or her to do so.
Conclusion

Calls for ‘clarity’ in Scots law

50. The Committee notes that there was some perception amongst those submitting evidence that the law in Scotland was somehow unclear and that this lack of clarity was the reason for some choosing to travel to other jurisdictions in order to commit an assisted suicide or access voluntary euthanasia. The Committee rejects this perception: the position in Scots law, as set out by the Solicitor General, is perfectly clear. The Committee’s view is that, if some people choose to travel to other jurisdictions to commit an assisted suicide or to access voluntary euthanasia, they do so because certain, inherent aspects of those actions are illegal in Scotland, not because there is a lack of clarity.

“Double effect”

51. The Committee notes the very full explanation given by the Solicitor General relating to the importance of establishing the intention of the person administering a double-effect medication. The Committee is not persuaded that there is any need for a change in the law to address this particular practice.

52. The Committee further notes the Solicitor General’s explanation of the issues that are taken into account when arriving at a decision of whether to prosecute, with reference to the Prosecution Code. The Committee finds this to be normal due process. That this process may, in some cases, not result in a prosecution should not be taken as condoning an illegal act nor be put forward as some type of “confusion” in the law.

Comparisons with other jurisdictions

53. The Committee recognises that there is some commonality of principle shared by this Bill and legislation in other jurisdictions insofar as they all address forms of assisted suicide and/or voluntary euthanasia. However, in each of those jurisdictions, there are also fundamental differences in the culture in which their laws evolved, as well as in the breadth and scope of the legislation. There is therefore no like-for-like parallel to be drawn with those jurisdictions. Comparison is, therefore, limited.

The appropriateness of dealing with assisted suicide and voluntary euthanasia together

54. The Committee draws the Parliament’s attention to the fact that the parameters of what the Bill seeks to decriminalise go beyond assisted suicide, encompassing voluntary euthanasia. A diverse range of contributors argued against doing so within a single legislative vehicle. Others argued that it would be logical to do so. The Committee believes that it would have been clearer for the two acts to have been dealt with as separate provisions in the Bill. The Committee further notes in this context that the Policy Memorandum and the evidence of the member in charge was based primarily on the experience of Oregon, despite the legislation in Oregon not including the provision of voluntary euthanasia.

CONCEPT OF AUTONOMY

Background

Policy Memorandum
55. According to the Policy Memorandum—

“The philosophical argument for autonomy is that "every competent person has the right to make momentous personal
decisions which invoke fundamental religious or philosophical convictions about life's value for himself". Death is seen
as among the most significant events of a person's life, "the final act of life's drama" which should 'reflect our own
convictions, those we have tried to live by, not the convictions of others forced on us in our most vulnerable
moment'.”

Case law

56. The principle of autonomy within the context of assisted suicide has been considered in two cases in the jurisdiction of England
and Wales by domestic and European courts. It should be noted that, in England and Wales, assisting a person to commit suicide is
contrary to the Suicide Act 1961 (“the 1961 Act”). In both cases, the applicants contended that the failure of the state to provide a
right to be assisted to take their lives was a breach of the European convention on human rights (“the Convention”) by the UK.

57. In the first case, the applicant, Mrs Pretty, suffered from motor neurone disease, for which no treatment was available and life
expectancy was short. Mrs Pretty sought an undertaking from the Director of Public Prosecutions for England and Wales (“the DPP”)
that her husband would not be prosecuted if he assisted her in accordance with her declared wishes to commit suicide. The House
of Lords held that a right to die could not be read into the right to life protected by Article 2 of the Convention. The European Court of
Human Rights confirmed the decision of the House of Lords on the point that Article 2 did not encompass a positive right to die.

Article 2 states—

“(1) Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the
execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

“(2) Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of
force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

(c) in action lawfully taken for the purpose of quelling a riot or insurrection.”

58. Furthermore, consideration was given to Article 8 of the Convention, on the right to respect for private and family life. This article
provides that—

“(1) Everyone has the right to respect for his private and family life, his home and his correspondence.

“(2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance
with the law and is necessary in a democratic society in the interests of national security, public safety or the economic
well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the
protection of the rights and freedoms of others.”
59. The judgement held that the state’s reserving its right to prosecute in this case may, under section (2) of Article 8, be “justified as “necessary in a democratic society” for the protection of the rights of others” and, accordingly, that there had been “no violation of Article 8 of the Convention”. In particular, consideration was given to the question of whether the DPP’s refusal to give an undertaking not to prosecute was arbitrary or unreasonable. The judgement stated—

“It does not appear to be arbitrary to the Court for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allows due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence.”

60. The judgement went on to find that there was nothing disproportionate in the DPP’s refusal and that it could not “be said to be arbitrary or unreasonable”.

61. Article 8 was also considered in the second case, that of Mrs Purdy, also suffering from a degenerative condition. She wished to travel to a country where assisted suicide was permitted once her life became unbearable and was concerned as to whether her husband would be prosecuted if he assisted her to travel. One of the Lords of appeal for judgement in her case, Lord Hope, held that, contrary to what had been held in the Pretty case, Mrs Purdy’s rights were engaged under section (1) of Article 8. The question of whether any interference with the Article 8(1) rights could be justified under Article 8(2) related in this case to the DPP’s discretion in respect of the 1961 Act. The 1961 Act does not apply in Scotland; the relevance of this case is the principle that the exercise of that discretion should not be or appear to be arbitrary or unreasonable.

62. In evidence to the Committee, those supportive of assisted suicide and voluntary euthanasia argued that everyone should be able to make decisions over his or her own life and death. Some questioned why death was not treated like other momentous occasions in a person’s life. There was a concern amongst a small number of respondents that religious and other cultural traditions were unfairly discriminating against those who wished to make this choice. For others, the loss of control in end stages of terminal illness was a key driver in choosing to access assisted suicide and voluntary euthanasia.

63. From the opposite perspective, some asked whether an individual who was too vulnerable or, for whatever reason, unwilling or unable to exercise his or her autonomy could be subjected to undue influence or pressure or the feeling of being a ‘burden’. A further consideration was the effect on others: there was a broad concern amongst those opposed to the Bill that a choice of such magnitude would have an effect on those around the requesting person, including family, friends, health professionals and others who may care for them.

**Autonomy as an argument for assisted suicide and voluntary euthanasia**

64. Dr Iain Brassington, Lecturer in Bioethics at the School of Law, University of Manchester, stated that the value that a person ascribed to his or her own life was “irreducibly and overriding importance”—

“... though a person may be valuable to others, and they may prefer that he continue to live, a person’s own ascription of value to his own life is morally primary.”

65. He argued that it followed not only that no one else had a right to take that person’s life without consent but also that, if that person decided that his or her life was a burden to him or herself and preferred that it end, no one else had the right to prevent the
end of that life.  

66. He went on to point out, however, that “ending one’s own life may be difficult”. He stated—

“... a person may not succeed in a suicide attempt, and stands a reasonable chance of survival in a worse position than he found himself before the attempt. It is also entirely possible that a person would find suicide problematic because of the fact that the burden of finding his body would fall on others (the alternative being that another person would be asked to “stand guard” while the suicide happened, which would currently be both legally problematic and quite possibly unreasonably morally burdensome); he might well prefer his desired death to happen in circumstances affording the highest level of control. Moreover, of course, the ability to kill oneself is merely formal in respect of those whose medical condition is such as to incapacitate them in some way: the current state of the law is not exactly discriminatory towards the disabled (since they do have exactly the same rights as the able-bodied in respect of self-killing – they just find it harder to capitalise on them), but it does place them in a situation of “double jeopardy”, whereby the exercise of those rights is hampered by their condition when that condition is plausibly a contributing factor to their wanting to end their own lives to begin with.”

67. He also suggested—

“Nor is it clear why a person, motivated by humane considerations, ought not to be allowed to assist a person in the project of ending his own life, granted the supposition that ending his own life is genuinely what that person wants … For this reason, if a person wishes to end his life, and if he is unable or unwilling to set about this task on his own, he ought to be able to seek assistance.”

68. He went on to state, however, that it did not follow from this that the assistance ought always to be provided—

“... that a person has formulated a certain desire does not indicate that anyone is obliged to help him realise it. That I wish to be shot from a circus cannon does not imply that you have to lend me yours; that I want my broken arm treated with antibiotics does not imply that the NHS ought to provide them to me; and the same principle applies here. If no one is available or willing to assist a person in bringing about his own death, then he has no moral right to compel assistance; nor ought he to have the legal right. Hence the right to assistance takes the form of a permit rather than an entitlement.”

69. John Deighan, representing the Catholic Bishop’s Conference of Scotland, reasoned that, if autonomy was an argument supporting the Bill, it did not make sense to build in safeguards—

“Why should this course of action not be open to anyone and everyone who has the capacity? How in two short meetings would a psychiatrist be able to detect coercion or depression? How can safeguards prevent cultural change?”

70. Pam Duncan of Inclusion Scotland argued that autonomy was an issue quite separate from the intentions of the Bill. She contended that, “in quite an unequal society” in which, for example, disabled people did not enjoy the same autonomy as non-disabled people and in the current economic circumstances, the very services that supported independent living and made life tolerable were being cut—
“With those services being cut, we are at risk of again limiting people’s choice—and when one’s choice is limited it can sometimes be skewed.”

71. She went on to speak of a well-known case in which a person, rather than become “the type of person who would be pushed and fed”, had chosen to take her life—

“Well, I am that type of person and I do not think that it is fair to place such limited value on my life or the lives of disabled people who need the support to live independently—support that, I should add, is under threat in the current economic climate. In that respect, we need to question the intention with regard to choice and autonomy.”

72. Sarah Wootton of Dignity in Dying advocated what she termed “assisted dying” rather than assisted suicide. She explained that this was where terminally ill, mentally competent adults who felt that they were suffering unbearably had the “choice” of an assisted death—

“There is a clear distinction between assisted suicide, where someone wants prematurely to take their own life because of concerns about their quality of life, and assisted dying, where a mentally competent dying adult who feels that they are suffering unbearably shortens the dying process by a few weeks or days.”

73. She also argued that, in addition to “giving individuals choice” and preventing premature or “botched” suicide and “trips to Dignitas”, regulation would improve people’s quality of life because access to assisted dying would serve as what she called an “insurance policy” for the terminally ill—

“In Oregon, about 40 per cent of people who get the prescription for drugs to end their lives do not use it. That is interesting, and means that people feel that if they have the choice, they do not need to use it, and that extends their life. That insurance policy is important.”

74. Similar points were made by EXIT—

“EXIT’s most common letter of thanks is along the lines of, “Thank you for giving me the knowledge so I know what to do, should I ever need to.” For most of our members, the information on how to end their lives is never used; but it gives them immense reassurance, hope and courage to face an uncertain future. It gives back a sense of control.

“It is this very sense of owning one’s own life that an effective end of life assistance bill could and would provide ... the knowledge of ‘a way out’ is one of the major benefits of such legislation. The experience of EXIT is mirrored by granting of requests in Netherlands and in Oregon, where many patients who have had a request granted do not go on to actually use it. This does not mean the request was pointless: on the contrary. Immense comfort is derived from the knowledge that there is someone there who is willing to help in the last resort (in the way the patient wants).”

75. Professor Linda Ganzini of the Center for Ethics in Health Care at Oregon Health and Science University, however, commented that not going on to commit assisted suicide was not always a matter of choice—

“In some cases, people make a voluntary choice not to take the medication. More often, in my experience, they lose the ability to take the medication because the disease overtakes them unexpectedly, and they develop confusion,
Member in charge

76. Asked whether the importance of personal autonomy was such that it should be unlimited, the member in charge replied—

“To live in society together, we voluntarily agree to limit our autonomy in certain respects. The issue that we have addressed, the end of life, is not quite the same as driving on the same side of the road so that we do not have crashes. It is not even the same as getting yourself inoculated against a potentially fatal disease that can spread. There is a peculiarly singular quality to the decision that you take about your own life at its end. Therefore, I do not think that we can argue that personal autonomy is limited at the end of life because we agree to limit it in other aspects of life.”

77. She also said—

“If someone exercised their autonomy and decided that their life had come to an end for them and that they were left with just a shell of intolerability, the bill would give them the legal right to seek help.”

Conclusion

78. The Committee notes the discussion on autonomy. The Committee further notes that autonomy is a central argument advanced by the member in charge in favour of this Bill. The Committee is also aware that courts have acknowledged the right to respect for a private life; they have also acknowledged that this right may have to be tempered in the interests of wider society. As explored in the previous section on the direction and purpose of the Bill, the current law is clear and prosecutorial discretion cannot be said to be arbitrary as there is a due process to be followed. The Committee considered this proposal in the context of preserving a balance between an individual’s right to exercise autonomy and the interests of society as a whole. Most members of the Committee believe that the wider societal concerns should prevail in the context of the Bill and do not accept the principle of autonomy as argued by the member in charge. One member believes that the interests of the individual should prevail.

79. The Committee does not agree with the member in charge’s assertion that the Bill would give a person a legal right to seek help to commit suicide; rather, it would create a situation in which it would be lawful for that help to be provided.

80. The Committee also notes that further comparisons were drawn with Oregon and data from Oregon were cited during the discussions on autonomy. The Committee reiterates that Oregon is not a suitable comparison for this Bill: that a proportion of Oregonians receiving the lethal medication choose not to use it, in the context of the open-ended process available to them, tells us little about the implementation of this Bill, given the restrictions that would apply to the process that it proposes. The Committee further notes that data connected with the Oregon experience have been reported less comprehensively in recent years than it was previously and is necessarily limited by the fact that decision whether to proceed can remain entirely private to the individual concerned and cannot, therefore, be captured in the statistics. It is not, then, possible to consider trends or possible reasons for them based on the data that is available.

CONCEPT OF ‘DIGNITY’
Background

81. The definition of end-of-life assistance in the Bill is linked to the concept of assisting somebody to die “with dignity”. A key point made by several respondents was that “dignity” was a difficult concept to define, and its use in the Bill itself was questioned, leading to calls for greater clarification as to its meaning. The issue was of particular concern to groups representing those with a physical or mental disability or incapacity.

Defining dignity

82. The question of how dignity might be defined provoked a debate amongst the panel of experts on ethics. Professor Calum MacKellar of the Scottish Council on Human Bioethics described it as being “crucial”, with human dignity being a “really important concept” in this policy area. He said that there was “much misunderstanding” and “much confusion” and that people “used different definitions” to discuss it—

“I subdivide the concept into two. The first concept is that the way that somebody behaves displays a certain amount of human dignity. That kind of dignity comes and goes; sometimes people have it and sometimes they do not. There is an in-between state, in a way; there are different degrees of human dignity. That is how dignity is understood under the State of Oregon Death with Dignity Act 1997. It is also included in the understanding of dignity with which Dignity in Dying—that is the new name of the Voluntary Euthanasia Society—operates. That is the first way of defining human dignity.

“The second is the way that the United Nations Universal Declaration of Human Rights defines human dignity as being inherent. The preamble says:

"the inherent dignity ... of the human family is the foundation of freedom, justice and peace in the world".

“That is the foundation of the whole declaration. That kind of dignity cannot be lost. It is equal among everyone and is not variable, but the most important thing is that it can never be lost.”

83. Professor MacKellar argued that the Bill said that inherent human dignity—the inherent value, meaning and worth of a life—could be lost and that it amounted to saying that some lives may no longer be worth living because they had lost their inherent dignity—

“However, on the basis of inherent human dignity, Scotland should never say that there is such a thing as a life unworthy of life. That is why the Scottish Council on Human Bioethics, which bases all its positions on the United Nations declaration, is concerned about the bill.”

84. He added that dignity was “not scientific”, in his view—

“... human dignity is an important belief, which the UN declaration of human rights supports. It is a declaration of human rights, not a scientific proof of them.”

85. On the other hand, Dr Iain Brassington, Lecturer in Bioethics at the School of Law, University of Manchester, accepted the idea
that dignity was an important concept and played an important role in such debates but did not “entirely recognise” Professor MacKellar’s depiction of it—

“For one thing, I worry slightly about the claim that inherent dignity is not scientific. In reading the written evidence from the Scottish Council on Human Bioethics, I got the feeling that Professor MacKellar was playing a little bit fast and loose with the definition of human dignity on the basis that there is no scientific consensus about it.

“The general consensus in the bioethical debate is that dignity arises from self-determination. We have dignity qua moral agents or human beings because we have the capacity for self-determination and to give our own lives value. That is the foundation for dignity. It seems to follow that, if a person freely decides that they do not want to live this life any more and would rather that it ended, that does not undermine their dignity; it is a statement of their dignity. It follows that people appeal to UN definitions and understandings and the way in which dignity gets associated with things such as liberty if they think that dignity arises from self-determination and people’s ability to run their own lives as they see fit. There is then no conflict between dignity, as it used to defend assisted dying, and liberty and the valuable things that we might think that dignity protects. Those things are completely compatible. To that extent, limiting someone’s liberty would be an erosion of dignity.”

86. Professor Sheila McLean of the Centre for Applied Ethics and Legal Philosophy, University of Glasgow, agreed with Dr Brassington and disagreed “profoundly” with Professor MacKellar. She related the discussion to the concept of autonomy—

“I will use an important legal example. If it is the case that a person loses dignity because they choose to die or somebody else allows them to die, I would want to see the argument being developed that patients who are currently legally entitled to refuse life-sustaining treatment should be prohibited from doing that, as it is clear that they have also made a choice that will result in a chosen and knowing death. Doctors participate in such decisions; indeed, if they did not agree with the patient in those circumstances, they would be guilty of an assault. Those patients have made the same choices that the patients whom Margo MacDonald is attempting to reach have made. At the moment, not only is that legal but it would be an assault to interfere with those decisions. That is an important point.”

87. Professor Graeme Laurie of the School of Law, University of Edinburgh, stated that referring to dignity was a powerful rhetorical device but argued that the reality of using dignity as a legal concept was very different—

“Legal instruments notoriously and determinedly avoid defining what is meant by dignity because we cannot agree on what we mean by it. A good example is the UN’s attempt to ban cloning. Ultimately, the only agreement that it could reach was that whatever each country defines as being undignified is undignified. That is not useful in law.

“It is possible to make both objective constructs of dignity, as Professor MacKellar is doing, and subjective constructs of it, which are being made elsewhere and lead it to look like autonomy. If the bill is about autonomy and choice, I do not think that we need to refer to dignity at all.”

88. Dr Brassington, however, suggested that the inclusion of the concept of dignity in the Bill should not be problematic—

“... if it is true that we all have our own definition of dignity, I struggle to see what objection there is to the bill on the grounds of dignity. If we all have our own understanding of dignity, that is great—we should pass it to the patients and
let them decide. That seems to be pretty much what the bill says." 75

Dignity as a basis for hastening death

89. For Leah Granat of the Scottish Council of Jewish Communities, the concept of dignity was closely related to respect for a person's life. 76 John Bishop of the Humanist Society of Scotland agreed but questioned whether it would then be disrespectful to follow the wishes of a competent adult who, in his or her own subjective judgment, had decided that life had become undignified—

“Can I not define for myself when my dignity has gone? Who are we to dispute the interpretation of dignity by another human being who is facing death?” 77

90. The Reverend Ian Galloway, Convener of the Church of Scotland's Church and Society Council, acknowledged that people may suffer a loss of dignity at the end of their lives but argued that this could and should be addressed in ways other than assisted suicide or voluntary euthanasia—

“Over the years I have worried about the fact that our society too often leaves people with little dignity at the end of their life because the level of care that has been given in some settings has been far short of what we would want it to be. I have seen an enormous qualitative difference between death for some people and death for others in our society. Partly, it comes down to whether you are lucky, where resources are and who is on duty and that kind of thing—it is not an exact science—but it also shows up the social inequality in our society. If you are middle class—a professional—you are likely to get better care than if you are not. That is not a comment on individual GPs, but time and again I have seen how much longer it has taken other people to get diagnoses, treatment plans and so on. Also, quite a lot of the people I have accompanied have not been easy patients—they have been difficult to work with—and the response to that is often not good enough.

“This is a complex thing; whether there is dignity in these processes shows up in the fabric of our society. We have an awful lot more to do. Outreach services from hospices to hospitals and so on are endeavouring to get some of the values in there. That is important, but it is a mark of society, in some ways, where dignity does or does not show up. If someone has the resources, the wherewithal and the ways of thinking, they are much more likely to be able to achieve the things that we would associate with dignity. One of my worries is that, in passing the bill, we might think we have dealt with that when in fact we have not.” 78

91. The Reverend Dr Donald MacDonald, a retired Professor of Practical Theology representing the Free Church of Scotland, argued that there was an “inherent dignity”. For the Reverend Dr MacDonald, if dignity depended on a person's capacity, there would be “unfortunate individuals who would perhaps be accounted worthy of less dignity”. He stated—

“As someone who is disabled and getting more disabled because I have a progressive disease, I can envisage the day when I will lose many bodily functions and have to rely on other people more and more, but, perhaps because of my medical background, I do not find bodily functions undignified; they are just part of what it means to be human, in the same way that animals are dignified in the way they conduct themselves.” 79

92. He went on to put forward the view that linking a loss of autonomy with a loss of dignity and using this as a reason for ending a life “diminished” human dignity for everybody—
“It is only as we learn to receive care from others when we begin to lose our strengths and we are suffering that that improves our human condition and the condition of society. Again, I appeal to those who support the bill to think again. The quick way out is not the dignified end. That is why I very much resent Oregon’s Death with Dignity Act and the idea that the purpose of the bill is to enable people to die with dignity. To me, using language in this way is twisting language. Many people who are entirely helpless have dignified deaths: because of their spirit and the way in which they cope with suffering, they show tremendous human dignity, which enriches—rather than diminishes—us all.”

93. He acknowledged the difficulties surrounding the concept of dignity but stated his belief that the Bill placed “too much emphasis on the subjective aspect of dignity – the dignity that one thinks one has, or that society thinks one has”. He urged that this be rethought.

Conclusion

94. The Committee notes that the word ‘dignity’ is capable of two interpretations. The Committee also notes the views of those opposing what they saw as an apparent acceptance in the Bill that the only dignified way of dealing with suffering was through ending life. The Committee further notes the theme underpinning these views, namely that no-one could ever lose their dignity, it being an inherent part of what it means to be human and, therefore, impossible to erode regardless of health or circumstance.

95. The Committee believes that including the concept of dignity in the Bill presents a particular problem: whilst those in favour of assisted suicide see it as a means of preserving dignity in the terminal stages of life and in the moment of death, those against present an equally compelling argument that a hastened death is undignified by its very hastening and that the key to preserving dignity in the terminal stages of life lies in the quality of care available to and the respect afforded to the dying. The debates that took place in the evidence taken by the Committee served to demonstrate that it is impossible to reconcile these arguments.

MENTAL CAPACITY AND VOLITION

Background

96. The Bill proposes that psychiatric assessments would be required as part of the process for consideration of the first and second formal requests. Under the Bill, it would be required that a psychiatrist meet the requesting individual in person and subsequently report on whether the person (a) has capacity to make the request, (b) is doing so voluntarily and (c) is acting under any undue influence. The Bill also sets out a standard against which the person’s capacity would be judged.

97. The Bill would also require that the requesting person had been registered with a medical practice in Scotland for a continuous period of 18 months immediately prior to making the request; it would not be required that this be the practice of the designated practitioner.

Mental capacity

Appropriateness of assessing capacity in all cases

98. The Royal College of Psychiatrists described a concern common to many of its members—
"... the Bill ... assigns to psychiatrists the assessment of capacity in requesting persons without mental disorder. As the Adults with Incapacity Act 2000 and its associated Code of Practice make very clear, assessing capacity is intended to be a generic responsibility of clinicians in all areas. Where it is a matter of assessing capacity to consent to (or decline) specific medical or surgical treatments, then the responsibility for assessing capacity falls on the doctor primarily responsible for the treatment in question – in this case the doctor offering end-of-life assistance. The Act and its Code also make it clear that there is a general presumption of capacity: in other words all adults are presumed to have capacity for all decisions, until proven otherwise; and the burden of proof falls on those who would deny it.

"The Bill reverses these presumptions, so that there is no presumption of capacity in persons seeking end of life assistance: instead they are to undergo psychiatric assessment, where the burden of proof falls on the psychiatrist to declare that they have capacity: and the psychiatrist is expected to do so even when there is no question of mental disorder. There was a general reluctance amongst respondents to accept these responsibilities, at least in these terms."81

99. Adrian Ward, a solicitor and expert in mental health and disability law, developed this point—

"... there is a curious reversal of the ... [Adults with Incapacity (Scotland) Act 2000]. On issues of capacity and incapacity, validity and invalidity and related issues of discrimination, we want to be sure that we screen out people who cannot make a decision but do not exclude those who can. If, simply because of the presence of some disorder we exclude someone who could in fact deal with something, we are discriminating. Reading section 9(4) carefully, we find that it tells us that the gateway is that a person has a

"mental disorder which might affect the making of ... a request".

"So if one has such a mental disorder, even if one is in fact capable of making a request, one is excluded. Obviously, this discussion is not about the principle of whether there should be such a procedure; it is about how such a procedure, if there were to be one, should be applied and what should be the gateways.

"A depression could affect someone’s ability to make a capable decision but, upon assessment, it might be found that it does not and that they can make such a decision. Those people should not be excluded. The Adults with Incapacity (Scotland) Act 2000 requires incapability—defined rather similarly to the way in which it is defined in the bill—that is caused by a mental disorder. That is the other way round, and it is quite different. It does not say, “If you’ve got a mental disorder at all, you are out.” Even if someone does not have a mental disorder, are they capable? I suggest that the bill puts matters the wrong way round."82

100. He went on to add—

"The issue really comes back to the task. Capacity is task specific. Many people have capacity for some things but not for others and capacity at some times and not at other times. Therefore, the capacity has to be task specific to a decision of the nature that we are discussing."83

101. Dr Stephen Potts, a consultant in liaison psychiatry representing the Royal College of Psychiatrists, commented on this same issue—
“If I have understood it correctly, the bill would reverse that presumption ... Psychiatrists would be asked to say that someone has capacity, and to do so when there was no evidence or question of mental disorder. There is therefore a separation between the role of psychiatrists in deciding capacity questions in medical and surgical wards, and that in deciding capacity questions that would arise under the bill. I do not understand why the bill takes a significantly different view of the psychiatrist’s role in assessing capacity from the existing incapacity legislation.”

102. Professor Penney Lewis of the School of Law and Centre of Medical Law and Ethics, Kings College London, made that point that, whilst capacity would be important in respect of a decision of this nature, it would be no more so than in relation to other end-of-life decisions made by patients—

“I sometimes worry about the overscrutiny of decisions in the context of euthanasia and assisted suicide. They deserve scrutiny, but so do those other sorts of decisions that have similar ramifications.”

103. Jan Killeen of Alzheimer Scotland expressed a different perspective—

“On competence and mental capacity, Alzheimer Scotland is relieved that the bill excludes people who have a mental disorder and who lack the capacity to make informed decisions. As you know, under the Adults with Incapacity (Scotland) Act 2000, capacity must be assessed in relation to the specific decision that a person wishes to make.”

Conclusion

104. The Committee draws to the Parliament’s attention the presumption in Scots law on capacity: if a person aged over 16’s capacity is to be challenged, the challenger has to lead evidence to demonstrate the impairment or the loss of capacity. The Committee notes that the majority of evidence questioned why the Bill would create an unprecedented requirement across the board, to the effect that all individuals requesting assisted suicide and voluntary euthanasia would be subject to a test. However, the Committee believes that, in a situation such as this, the approach would be justified.

Volition

Assessing undue influence

105. The Royal College of Psychiatrists stated—

“... psychiatrists have nothing to offer in assessing coercion. It is not a psychiatric skill, and forms little or no part of psychiatric practice.”

106. Dr Potts of the Royal College of Psychiatrists was asked whether his role as an independent assessor under the human tissue legislation had informed his views on how easy or difficult assessing undue influence was. He replied that it had, by “confirming that assessing coercion or its absence was “definitely not a matter for psychiatrists”. He went on—

“That is not to say that psychiatrists cannot do it, but their position is no stronger than that of general practitioners, nurses, psychologists, hospital specialists and others. The matter is not specifically psychiatric—psychiatrists do not bring specifically psychiatric skills to the assessment. One concern with, or possible flaw in, the bill is that it assigns the responsibility for assessing and excluding coercion to a psychiatric assessment.”
107. Mark Hazelwood of the Scottish Partnership for Palliative Care stated that “more specific guidance” would have to be provided on what would be judged, in retrospect, to have been reasonable measures for practitioners to have taken in reaching their conclusion—

“There might be a great range of measures that one could take to establish whether someone was acting under undue influence, from simply asking them whether anyone was putting pressure on them, right through to undertaking a series of interviews with different family members. I am talking about a more forensic examination of the dynamics of the family, which might involve looking at the state of the finances of people in the family and the wider circumstance.”

108. He went on to explain that the Bill indicates a role for only the designated medical practitioner and the psychiatrist, whereas some of the matters of judgment in question seemed to be ones that did “not necessarily fall within the expertise of those practitioners”, such as, potentially, financial pressures or circumstances surrounding the request for assistance—

“... the bill does not contain the detail that would give guidance or reassurance to a practitioner who had to make such decisions.”

109. Dr Georg Bosshard, of the University of Zurich and the Fachhochschule Gesundheit WE‘G, gave an example of another type of person that could be well placed to make or contribute to the making of an assessment. Speaking of the situation in Switzerland, he said—

“Real cases in Switzerland involve huge responsibility not only on the part of the doctor but on the part of the volunteer from the right to die society, who usually has much more experience of assisted suicide. The doctor is probably involved in it for the first time, but the volunteer from the right to die society will have experience of five, 10 or 15 other cases. Furthermore, not only a doctor can stop a case; a volunteer from the right to die society can stop a case and say, "I have a bad feeling that there is pressure." The process therefore relies not just on the doctor, but on the right to die society handling the case sensitively.”

110. Professor Penney Lewis of the School of Law and Centre of Medical Law and Ethics, Kings College London, spoke of the importance of the length of the relationship between patient and physician in assess voluntariness—

“The better that the physician knows their patient, the more likely they are to be able to assess whether the decision is out of character and whether the patient appear to be acting in a way that just does not sit right.”

111. She added that, in some cases in Oregon, there appeared to have been a “very short relationship ... of zero weeks or one week” between the doctor and the patient—

“One worries slightly about how easy it is for the doctor to assess capacity and voluntariness when they have just met somebody.”

112. This same point was touched on by legal experts. Adrian Ward, a solicitor and expert in mental health and disability law, commented—
“...as a practising solicitor, when somebody wants to make a power of attorney I have to assess whether they have capacity to do that and whether somebody is pushing them into doing it. It is much easier to make those judgments with clients and families whom I have known for a long time professionally than with somebody who has come into my office only that day. The difference really is huge.”

113. Lord Mackay drew attention to the development of medical practice towards there being much more of a team approach than there used to be—

“It is now common for a patient to see a different doctor on a succession of occasions. Therefore, there is not quite the same relationship between a patient and a doctor that might have obtained at an earlier time here and which may obtain in other countries such as the Netherlands. There, the doctor gets to know the patient—their family, their circumstances and so on—over a period of years. Here, particularly when a patient is in hospital, a full team is often involved and it is quite difficult for any one member of the team to get to know the patient so well. Indeed, some of the evidence suggests that the nurses are subject to conversations about what should happen more than the consultants and other members of the medical team.”

Feasibility of successfully assessing undue influence

114. Asked about the Dutch experience and how confident he could be that no undue influence had been exerted on people who requested assisted suicide, Dr Rob Jonquière, former Chief Executive of the NVVE (Dutch right-to-die association) and Communications Director, World Federation of Right to Die Societies, conceded that this could not be known for certain—

“I will be honest. I think that I am confident, but one never knows, because the patient is dead after the event.”

115. Dr Bosshard agreed. He added, however, that whilst one could “never really know” what happened “in the depths of somebody’s mind”, one could “feel” what happened in that person’s family—

“Normally ... the family is not happy at all with the patient’s wish and they need several months to accept that their father or mother wants to die. Anyone who has experienced that course of events will know that it is pretty unlikely that, behind what one can see, it is completely the opposite and there is pressure from the family. Of course, in some exceptional cases there is a danger that that could be the case; therefore, we should be very careful.”

116. Pam Duncan of Inclusion Scotland questioned whether it was realistic to consider that undue influence could be ruled out by assessment as proposed by the Bill, stating that there were “direct and indirect forms of undue influence”. She argued that it could be “naive and short-sighted to rely solely on safeguards” in relation to very vulnerable people for whom health inequalities were already “extremely high”, affecting their lives in very basic ways—

“A 21-year-old woman whom I worked with did not choose the socks she wore in the morning not because she was incapable but because she had been disempowered. How will we ensure that there is no undue influence on certain people if they are not even able to choose for themselves the colour of socks they pick out of their drawer in the morning because that job is done by someone who rushes in for 15 minutes and has no time to listen to them...?”
117. Professor Sheila McLean of the Centre for Applied Ethics and Legal Philosophy, University of Glasgow, went further, questioning whether it was possible or even desirable to seek to establish whether there had been any undue pressure—

“There might well be pressures. Indeed ... you would imagine that there would be pressures, because people are part of a group, family or community. The chances are that there will be pressures on people, but such pressures could be to live. If the pressures are subtle, I do not see a way of being able to assess whether they exist.”

118. She drew a comparison with the situation of a patient that refused life-sustaining treatment, pointing out that it was possible that they too were subject to pressures but that they were not required “to jump through hoops”.

Member in charge

119. The member in charge was asked about the link between the length of relationship between the patient and the practitioner and the latter’s ability to distinguish whether there was any undue internal or external influence on the patient’s choice, given that the designated practitioner could be a practitioner other than the one with whom the patient had been registered for 18 months as required by the Bill. She explained that the proposed requirement to be registered with a medical practitioner in Scotland for 18 months had been included with the intention of preventing “suicide tourism”. She explained further that the Bill would not require the designated practitioner to be the registered practitioner in the interests of flexibility—

“It might well be that a person’s general practitioner would not want to take part in the procedure, so we did not want to be too prescriptive. However, we said that, if the person was unable to contact someone who was willing to help, the GP would have a duty to help them. There is an entirely reasonable supposition that the person would be known to one or other of the medical specialists, whether that was the person to whom they first mentioned the issue or the person to whom they were subsequently referred.”

120. Pressed on the point about whether the practitioner who ultimately became the designated practitioner would know the patient well enough, the member in charge pointed out that that the requesting person would have to have two witnesses, who would have to be able to say that the person was not being coerced. She added that there would also have to be recourse to specialist psychiatric or psychological advice. She said that there would be a “network of support” and conceded that the requesting person would be “unlikely to be unknown to everyone that they met”.

121. The member in charge was also asked about fears that less than scrupulous families or care homes might apply pressure on people in vulnerable situations to pursue assisted suicide or voluntary euthanasia if they were legitimised, on the basis that the vulnerable people were a burden. She responded that the Bill went “out of its way” to ensure that trying to coerce someone into requesting assistance to die would be illegal and rejected what she described as an implication that people would become less moral if the Bill were passed.

122. She went on to remind the Committee of the evidence of Professor Linda Ganzini of the Center for Ethics in Health Care at Oregon Health and Science University who had said on this issue—

“When I interview patients about not wanting to be a burden, what frequently comes across is their lack of value of the dying period, because that is a period in which someone is dependent on other people to take care of them and they
find that an anathema and an appalling idea. When I ask them whether they feel a burden, I frequently see the family in the background saying that they would be honoured to take care of them and would like the opportunity, but the individual does not want it ... I have not seen cases of coercion or in which there is a sense from the family that the individual is a burden.”

123. The member in charge herself added—

“Remember that the bill rests on the autonomy of the person concerned and their feelings about their death and the period leading up to their death. I understand ... those fears ... but I think that they are groundless.”

**Conclusion**

124. In relation to the assessing of undue influence, the Committee notes, with particular concern, the issues raised around the length of the relationship between the requesting person and the designated practitioner. The Committee recognises that the member in charge had in mind that the medical practitioner with whom a requesting person was registered may refuse to take part in assisted suicide or voluntary euthanasia and sought to include some flexibility; however, the outcome is that it would be possible in practice for the relationship to be limited to two formal requests and presence when end-of-life assistance was provided. The Committee accepts that it would not necessarily be possible, in any circumstances, to determine with absolute certainty that there was no undue influence; however, the chances of any such influence going undetected would surely be greater with such minimal contact than would be the case with a longer, more involved relationship.

**INTERPRETATION**

**Background**

125. Much of the oral evidence heard focussed on the interpretation of the terminology used within the Bill. The following terms and phrases were thought to be ambiguous and confusing—

“end of life assistance”;

“intolerable”;

“permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable”;

“terminal illness”;

“independent living”.

**Use of the phrase “end of life assistance”**

**Background**

126. The Bill uses the words “end of life assistance” to indicate “assistance, including the provision or administration of appropriate
means, to enable a person to die with dignity and a minimum of distress”. The Policy Memorandum states that the purpose of the Bill is to “enable persons whose life has become intolerable and who meet the conditions prescribed in the Bill to legally access assistance to end their life”. 106

**Scope for confusion with palliative care**

127. Several respondents, particularly those from a palliative care background, felt that the Bill’s definition of “end of life assistance” was potentially misleading in connotation. There was a concern that this could cause confusion amongst patients and the public that the Bill concerned the provision of palliative care whilst it intended to propose various forms of assistance to end life.

128. Mark Hazelwood, Director, Scottish Partnership for Palliative Care, explained that the partnership felt that the Bill’s definition was a “broad” piece of wording—

“In fact, when you read it, that definition would be consistent with the ordinary practice of palliative care ... a lot of the practice of palliative care physicians is about exactly that: it is about enabling a person who is dying to maintain their dignity and to have a minimum of distress.” 107

129. He went on to speak of the “sensitive and nuanced” nature of communication between clinicians and patients in certain situations. He illustrated the type of difficulties that could arise because of the wording used in the Bill—

“For example, in order to try to understand the feelings and needs of a patient in such circumstances, a clinician may ask the patient whether they have feelings that their life is worthless. The partnership's submission makes it clear that we are concerned that, given the vagueness of the bill's wording, it will be possible in such situations for the patient to infer that the clinician's communication is signposting them towards consideration of euthanasia or physician-assisted suicide.” 108

130. He suggested that, given the ambiguity in that wording, the use of “clearer and better understood” terms, such as voluntary euthanasia and assisted suicide, should be considered. He drew attention to what the partnership regarded as a “real lack of clarity” in a concept at the heart of the bill and called on the Parliament to consider what consequences that might have for the practice and provision of palliative care. 109

131. The Scottish Partnership for Palliative Care’s position was supported by Stephen Hutchison, Consultant Physician in Palliative Medicine, Highland Hospice and Dr Chris Sugden, Medical Director, St Andrew's Hospice. For Stephen Hutchison, what the Bill was called was more than “just a matter of semantics”. He felt that it was very important that it be “absolutely crystal clear” what law was being proposed—

“People get confused about what exactly we mean. For instance, we know from a study that was done two or three years ago that less than 20 per cent of the British public have a full, complete or well-developed understanding of what palliative care is. We know that many people are anxious—for understandable reasons—about being referred to a palliative care service. People do not understand exactly what we do and there are many misconceptions about how we treat our patients and what can be achieved. We have touched on some of them, such as double effect. Therefore, it is important that we be crystal clear in what we call the bill and that we do nothing that obscures the issue for the general public.” 110
132. Dr Chris Sugden agreed, adding—

“The vast majority of the patients who come into a hospice's in-patient unit—or even an out-patient clinic, for that matter—are extremely vulnerable and very anxious, especially at first contact. The bill uses the term “End of Life Assistance”; in our specialty, we use the word "assistance" quite often. A vulnerable person may latch on to that, become confused and mix up our assistance with the wording of the bill.”

Potential constraint on delivery of palliative care

133. In addition to the potential for confusion of assisted suicide and voluntary euthanasia with palliative care, witnesses feared that decriminalising assisted suicide and voluntary euthanasia could have a negative impact on how palliative care services are delivered. For example, Elaine Stevens of the Independent Association of Nurses in Palliative Care elaborated this point—

“Some people who come into palliative care are distressed, demoralised and lacking in dignity and will say, "I wish it was all over". However, if you sit down and talk to them using skills of communication, you find that distress, pain and other issues are leading them to think that. After a period of quite specialised intervention, you can move people forward and reduce the amount of requests for it to be all over. Such people often go on to have a very good quality of life with their families. People have expressed thanks for what we have done for them, saying that the time that they have had has been precious and has allowed them to do many things.”

134. Stephen Hutchison was asked whether the conversations that he currently had with terminally ill patients might be different if the Bill were enacted. He explained that the legislation might inhibit his ability to engage patients in dialogue that allowed them to express their distress in that, if their distress were such that they expressed a wish for their life to be over, assisted dying would “have to be on the agenda” as opposed to a hypothetical that served to put across the level of distress being suffered—

“A number of safeguards have been proposed. Essentially, people would be allowed to withdraw from the process if they wished. In doing that, I believe that they should be able to discuss openly with their doctor the concerns that are in their mind, but I think that the legislation would inhibit that dialogue.”

135. Leah Granat of the Scottish Council of Jewish Communities expressed the following view about the terminology used in the Bill to describe the acts that it seeks to decriminalise—

“We have a very good English word for what the bill refers to as

“the provision or administration of appropriate means, to enable a person to die”.

“That is not end of life assistance nor is it... about administering death-invoking treatment; it is killing. Previous witnesses to the committee have spoken about the possibility that the bill could lead to termination of life without request. There is also a very good English word for that; it is "murder". If the bill is to progress, its supporters ought to be willing for the bill to go forward in plain English—in terms such as "killing" and, potentially, “murder”—instead of euphemisms and circumlocutions such as “end of life assistance”.”

Conclusion
136. The Committee believes that the Bill’s definition of “end of life assistance” is confusing and arguably misleading and inconsistent with the member in charge’s stated reasons for proposing the Bill. The Committee recommends that the simplest way of achieving clarity over the Bill’s intentions would be to use the terms “assisted suicide” and “voluntary euthanasia” if these are the actions that it seeks to decriminalise.

Use of the term “intolerable”

Background

137. Section 4(2) of the Bill would make end-of-life assistance available only to—

- a person that has been diagnosed as terminally ill and finds life intolerable; or
- a person that is permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable.

138. Specific and discrete concerns were raised in relation to the different eligibility requirements of (a) terminal illness and (b) permanent physical incapacity inhibiting independent living; those concerns are discussed under separate headings below. Both requirements, however, repose on the concept of finding life “intolerable”.

139. The Explanatory Notes explain that ‘intolerability’ has not been further defined in order that the test be a subjective one determined by the person requesting end-of-life assistance, subject to a psychiatric assessment. It is also explained that the second condition, relating to permanent physical incapacity inhibiting independent living, would “encompass persons who have been the subject of a trauma as well as persons with progressive and irreversible conditions, in each case provided the dependency and intolerability criteria are met”. The Policy Memorandum clarifies that permanent physical incapacity would in itself not be “enough to qualify for an assisted death”, it would be necessary that, as a result of the incapacity the person be unable to live independently and find life intolerable.

Subjectivity of the term

140. A general criticism in the oral evidence heard was that the term was too subjective: how could it be ascertained or measured, given its dependence on many unspecified factors including the psychological, emotional, physical, spiritual and social? Partly related to these factors, it was stated that an individual’s state of mind can change or fluctuate in relation to what they can tolerate at any given time.

141. Lord Mackay highlighted discussions within the House of Lords Select Committee (“the Select Committee”) that had considered Lord Joffe’s Bill on Assisted Dying for the Terminally Ill in 2005. Originally, the Bill used the term “unbearable suffering”. Lord Mackay explained that, after hearing evidence calling for more objectivity, the Select Committee suggested “unrelievable” or “intractable” suffering as a more satisfactory criterion, as long as it was associated with a suitable test—

“We canvassed a number of different possibilities, and the ones that we ultimately came up with as looking to be the most objective were the ones that are included in the report. There is quite a range of possibility in that respect, and I commend the issue to the committee as something that has to be thought about with a degree of care, given the possibility that a doctor might rely on the criterion in defence or in support of what he or she has done.”
This point of view was supported by Adrian Ward, a solicitor and expert in mental health and disability law. He stated that only the person suffering the pain could judge whether the pain he or she was feeling was intolerable, whereas someone else could judge whether it could be relieved or treated or whether it was unrelievable and intractable. In relation to the argument that only the patient who experienced the pain could judge whether it had been relieved and that, therefore, the alternative terms proposed were equally as based on subjectivity, Lord Mackay responded—

“In that case, though, we are talking about a report on the effect of what you have done to relieve the patient's pain. If the pain is unrelievable, the patient will say, "I'm no better". But the question is whether anything can be done to make him or her better. If you have tried something and the patient says that it has not worked, that is a completely objective matter. You have to accept his or her verdict in that respect.

“I agree that pain is very much a matter of subjective experience but, on the other hand, there are criteria by which relieving pain can be judged. Those of us who have been involved in personal injury cases will have been used to dealing with back pain, for example. Sometimes, the back pain is very severe, but it allows the person to do marvellous things off the record. Pain is certainly subjective to a substantial degree, but the means available to relieve it are objective.”

Pam Duncan of Inclusion Scotland expressed in practical terms the difficulty of including ‘intolerability’ in the eligibility requirements—

“... the bill ... says that, if someone has to depend on someone else and they do not live independently, they could, technically, find life intolerable. That touches on the question of what "intolerable" means, and that is entirely subjective. People tell me that I have a high pain threshold. I had a tattoo on my foot last week, and people asked me how I could bear it. Tolerability is very subjective ... It is the fact of being left in their own faeces or to soil a wet nappy that makes someone's life intolerable.”

Other witnesses made the point that a patient’s intolerable situation could be addressed without recourse to assisted suicide or voluntary euthanasia. For example, Dr Stephen Potts, a consultant in liaison psychiatry representing the Royal College of Psychiatrists, reasoned that finding life intolerable was sometimes the symptom of a depressive illness that needed treatment, rather than being an understandable response to a serious medical problem—

“It is important to point out that it can be extraordinarily difficult to judge whether a patient's finding life intolerable arises from a mental illness, a medical disorder or both. For that reason, the psychiatrists whom I represent have concerns about the use of that language.”

Stephen Hutchison of Highland Hospice, however, spoke of one patient for whom a number of interventions and different means of support had been tried but the palliative carers’ perception was that they had been “achieving nothing”. He said that he did not think, however, that that had been the patient’s or the family’s perception and added that the issue of accelerated dying had not been raised. Asked whether it was a concern that there were people whom palliative care could not help further, he said—

“Of course I have a concern about that. The patient whom I mentioned gave me a lot of heartache, because I did not feel that I was able to do anything for him. My heart would sink when I visited him, because I felt powerless to help him.
122. Asked by the member in charge what palliative carers did when their specialist intervention did not either comfort the person, work as they wanted it to or have the effect that they desired, Elaine Stevens of Independent Association of Nurses in Palliative Care said—

“We journey along with the person as best we can and will be with them as partners in their distress and end of life care. We do not abandon them.”\(^{123}\)

123. It was also suggested that the judgement of a person in an intolerable situation might be impaired by that very situation. Dr Iain Brassington, Lecturer in Bioethics at the School of Law, University of Manchester, stated—

“It seems to me that if a person is suffering intolerably, that at least gives a prima facie reason to suppose that their request or consent might not be valid. It seems to make perfect sense to say that people in pain might not think straight, whereas we would have reason to think that someone who is not yet suffering has thought about matters and is coming at them in as clear headed a way as possible.”\(^{124}\)

124. Gordon MacDonald of Care Not Killing Scotland commented that intolerability is not necessarily a fixed perception—

“It is important to be reminded that what people perceive to be intolerable can change over time. Just because somebody might think that something is intolerable at one point, that does not mean that they will continue to think that as the illness progresses. It is very subjective, and other factors can influence the situation. We must be aware of the looseness of the definition and of how the situation can change over time.”\(^{125}\)

Member in charge

149. In relation to meeting the conditions in respect of which acts of homicide would be decriminalised, the member in charge was asked whether it would be more appropriate to determine this on an objective measure by the state rather than on a previous expression of a subjective point of view by the deceased. She answered—

“I do not think so. The state determines what is and is not legal. If the requirements in the bill are not met, it has not been legally enforced. The law would be broken if there were not two witnesses who testified A, B and C—that the person had not been coerced, and so on. The law would be broken if no psychiatric assessment was made of the person’s competence and state of mind. The law would be broken if the doctor whom they approached for help did not ensure, one way or another, that they were informed of the whole picture—including palliative care or a different form of such care, another assessment from another doctor, or whatever. The law would be broken if the terms as outlined were not kept to.”\(^{126}\)

150. Pressed on the point about the desirability, if decriminalising acts of homicide, to have a more objective test in order to give protection to the state, the member in charge argued—

“The word that we have used in relation to the exercise of autonomy, as opposed to the state’s requirements and
definitions, is "intolerable". We have said that the requesting patient has to feel life to be intolerable. No state has the right to determine for any one of its citizens whether what they feel is intolerable or tolerable as regards their ability to have their wishes respected and their priorities recognised. That is a question for the individual, and the state guarantees those rights.  

151. She added—

"In Lord Joffe's House of Lords evidence, he talked about suffering meaning pain. Suffering is not necessarily all about pain. In fact, most of the people who suffer from multiple sclerosis or Parkinsons or other progressive conditions who have spoken to us say that it is not pain that they fear but the loss of personality, will and—as they judge—dignity and autonomy right at the very end of life. That is what they fear. That is what they wish to avoid. I fail to see where the state has a role in forbidding someone from addressing that."  

Conclusion

152. The Committee finds that the Bill, in setting out eligibility requirements in Section4, ostensibly provides for an objective standard. The Committee believes, however, that the standard set out is inherently subjective. Indeed, the member in charge placed great emphasis throughout the inquiry on her intention that the wishes and self determination of the requesting person be paramount. Such a test cannot, therefore, stand up as an objective test.

Use of the phrase “permanently physically incapacitated to such an extent as not to be able to live independently and finds life intolerable”

Background

153. As outlined in relation to intolerability above, one criterion of eligibility relates to being permanently physically incapacitated to the point of not being able to live independently. In much of the evidence taken by the Committee, this provoked a major concern given the breadth of this provision and the large number of people that could feasibly be covered.

Chronic physical disability

154. The British Psychological Society in Scotland argued that the inclusion of the physically disabled seemed “haphazard” and suggested that there had been “little thought” about how those with a disability and terminal illness differed from those with a life-time of chronic physical disability. According to the British Psychological Society in Scotland, arguments about intolerable pain, hastened death and insurance against future loss were “largely irrelevant” to the lives of those with physical disability—

"...for example a spinal cord injury is generally not life limiting and the inability to tolerate their lives can emerge from factors very different to those of terminal disease."  

155. The society also stated that research evidence suggested that many able bodied people over-estimated the intolerability of physical disability—

“To include the physically disabled in such a Bill without clear justification as to what is unique about their suffering seems to run the risk of reinforcing the worst prejudices about those with disability. In fact, intolerability in those with
physical disabilities is often due to the vagaries and limitations of the services available rather than the condition itself.  

156. The society reasoned further that the process of adaptation to a physical disability could take many years—

“To offer an assisted death to people early in this process (as the Bill suggests it would) may undermine the ability and resolve for all those involved to engage with the long process of adjustment. We see this as potentially a serious loss and ultimately detrimental to individuals, their families and Scottish society.”

157. Finally, the society made the point that the Bill and its accompanying document offered no explanation as to why it proposed to offer end-of-life assistance only to people with physical disabilities and not to other categories of person that felt their lives to be intolerable, such as those with mental illness, chronic pain, bereavement or poverty.

158. Johanna McCulloch of the Scottish Disability Equality Forum made a related point about the presumed link between permanent physical disability and intolerability—

“Our members raised the issue of choice, who the bill gives the choice to, and why. One point that was made a lot was, if a person is physically incapable of taking their own life, they are not equal with a non-disabled person. To assist them to do so puts them on an equal footing with non-disabled people. However, as the bill is drafted, the criteria are so wide that the disability does not need to prevent someone from taking their own life; it just needs to impede their ability to live independently. Some people feel that that indicates that disability is the only thing that can make life so intolerable as to justify assisted death. From an equality perspective, they would prefer the bill to be aimed at people who are physically incapable of taking their own life—for that to be the only situation in which assistance might be justified.”

159. The member in charge stated that she had not intended the Bill to apply to permanently disabled people, including those who had been disabled from birth—

“That was never my intention. The intention was for the bill to apply to progressive degenerative conditions. It is inequitable to say that because a person is handicapped in their movement in some way, they have less autonomy than I have. I refer to will, beliefs and morals. I prefer to treat all people the same. If the committee can come up with a better wording, I will be grateful.”

Conclusion

160. The Committee finds that there are a number of equalities issues under this heading. The Committee notes that the terminology used was aimed at capturing a small number of people who find life intolerable; members recognise the concerns that it would also apply to a wider group of people with a range of physical conditions or physical incapacity. The Committee finds this to be symptomatic of the breadth of the member in charge’s intentions. Whilst the Committee recognises the immense difficulty of drafting a provision that would capture all those that the member in charge means to include without extending to whole other groups, members find this terminology to be extraordinarily wide. This is
possibly not what the member in charge intended; the Committee welcomes her willingness to revisit this wording.

Use of the phrase “terminal illness”

Background

161. Under section 4(4) of the Bill, a person would qualify as being terminally ill if the person suffered from a progressive condition and if death within six months in consequence of that condition could reasonably be expected. The Policy Memorandum states that this definition “follows the general understanding of members of the medical profession”. However, the definition was a point of concern raised in particular by the medical profession and palliative care groups in evidence to the Committee. The key point made was that it was extremely difficult to predict, particularly in non-cancer, non-malignant conditions.

Issues raised

162. Breast Cancer Care favoured the six-month criterion in the Bill—

“‘Terminal’ as defined by having less than six months to live is a specific and helpful definition that prohibits people with a general ‘advanced’ cancer diagnosis, many of whom can live much longer than six months, particularly in the typical case of a secondary breast cancer diagnosis, where the average life expectancy is 18-36 months.”

163. Highland Hospice, however, stated—

“The six month prognosis is a common figure in proposals for assisted dying, but is an arbitrary figure. Determination of prognosis is notoriously inaccurate in malignant disease and even more so in terminal non-malignant disease. It would also be difficult for a doctor to determine whether or not the degree of dependence was sufficient for the purposes of this Bill, all the more difficult because each of us is inevitably dependent on others in most aspects of life, even in health.”

164. CARE for Scotland also made the point about it being difficult to predict “with any accuracy” the life expectancy of a person suffering from a terminal illness—

“In individual cases people may live for many months or even years after having been given a prognosis of having 6 months or less to live. Indeed the accuracy or inaccuracy of such predictions has been a prominent feature of Scottish political debate during the past year. We suggest that to allow those given such a prognosis access to euthanasia or assisted suicide is mistaken and may prevent many people from enjoying some of the most cherished and precious times with loved ones who have a terminal illness.”

165. Pam Duncan of Inclusion Scotland also favoured this argument, citing the example of the late American scientist, Stephen Jay Gould, who, she said, had been told in 1982 that he had an incurable disease with a median mortality after discovery of eight months. She recounted that he then found out that this meant that “half of those with the disease will have died within eight months” but also that “the other half will live longer.” She went on—

“Stephen Jay Gould quickly worked out that his chances of being in the other half of the curve were quite high. On what basis? He was young, his disease had been recognised early, he was affluent, he was a middle-class male and..."
he would be able to command the best medical treatment available. He had everything to live for, and he had the support of a loving family and friends. He did not die in 1983, 1984 or 1985—he lived until 2002, 20 years after his initial diagnosis. I am not saying that the same thing can happen to everyone who is told that they have only three days or 10 months to live, but the point is that there are mitigating circumstances—not always, but sometimes—outwith the individual's medical condition that can have an impact.  

166. Professor Linda Ganzini of the Center for Ethics in Health Care at Oregon Health and Science University recognised that it could be “fairly difficult” to predict life expectancy but made the point that physicians tended to “overestimate life expectancy five times more often” than they underestimated it. Sarah Wootton of Dignity in Dying also raised this point—

“In fact, doctors tend to underplan for the length of time that people will live, and they tend to state that they will live longer than they do. There are clear definitions, and the decisions that are made by doctors are probabilistic.  

“However, there are guidelines. There is the end of life care strategy, which was published in 2008. There are the General Medical Council guidelines, which were published this year, which have clear definitions of what constitutes ‘terminally ill’. To access palliative care, people need to be terminally ill.”

167. The Oregon Hospice Association’s Deborah Whiting Jaques explained further—

“There are tools that hospice medical directors use to prognosticate, and training is available for that purpose to physicians who are board certified in hospice and palliative medicine, but it is an art, not a science. We see in hospice that physicians overestimate the length of time that people will take to die. In many instances, we have patients in our hospice service not for six months but for two weeks—very short stays. Those patients could have benefited from the comfort and care of hospice for six months, rather than two weeks.”

168. Professor Ganzini also commented that there were cases in which terminally ill people lived longer than expected after commencing hospice care, which was often because, from that point, they got “good, basic, everyday nurse-focused care”.

Member in charge

169. The Policy Memorandum states that the definition of the phrase “terminally ill” in the Bill “follows the general understanding of members of the medical profession to relate to a life expectancy of approximately 6 months”. The Explanatory Notes state further that it would be “for the designated practitioner to be satisfied of the likely life expectancy”.

Conclusion

170. The Committee draws to the Parliament’s attention the points made in evidence about the inclusion of “terminal illness” as an eligibility requirement. The Committee believes that there are real problems in the Bill’s definition of “terminal illness” as it is based on a notion of timescale that may be difficult to ascertain.

Use of the phrase “independent living”

171. There was much discussion amongst those with disabilities about how these provisions could affect the perception of disabled people amongst wider society.
172. The Scottish Disability Equality Forum (SDEF) based its written submission on the results of a survey of its members and found that just over half of those that responded were, in principle, favourable of a relaxation of laws criminalising assisted suicide. However, even amongst this group, few were entirely satisfied with the Bill as introduced, and the proposal for the eligible medical conditions was a significant area of debate, particularly the second eligible condition. Some felt that this provision would “bring the rights of those who are physically incapacitated in line with those of able bodied people, in that they would be able to choose when to end their lives”. However, a key concern amongst SDEF members was the terminology within “incapacitated to such an extent as not to be able to live independently”. SDEF stated that this issue was raised as a result of the complex nature of the barriers to independent living.

173. Inclusion Scotland stated that the Bill could lead to a situation where most of those qualifying for assistance would be people with disabilities, whilst the vast majority of those excluded from assistance would be people without disabilities—

“That suggests that the lives and existence of one group are being treated as of less value than the other.”

174. Pam Duncan of Inclusion Scotland linked independent living to the capacity to make one’s own decisions, arguing that this could entail depending on others in order to do so—

“Surely independent living is about me being able to decide what I need to support myself … However, the bill does not do that. It says that, if someone has to depend on someone else and they do not live independently, they could, technically, find life intolerable.”

Conclusion

175. The Committee draws to the Parliament’s attention the issues raised in relation to using the inability to live independently as an eligibility requirement. The Committee found evidence from organisations representing people with disabilities to be particularly compelling because of the way in which society may let an individual’s life be intolerable by neglecting to provide sufficient and appropriate support. Using the inability to live independently as an eligibility requirement for end-of-life assistance raises issues of definition, clarity and subjectivity similar to those relating to other terminology in the Bill, with the additional possibility of unintended consequences.

QUALIFICATIONS FOR DESIGNATED PRACTITIONERS AND PSYCHIATRISTS

Background

176. Under the Bill, the “designated practitioner” would be a registered medical practitioner to whom a first formal request for end-of-life assistance had been made by a requesting person. The process set out in the Bill would also require a report to be made by a psychiatrist following a meeting with the requesting person. Neither of these roles could be fulfilled by a relative of the requesting person; a person who would benefit from the requesting person’s estate on the requesting person’s death, or a person who would have another interest in that death.

Issues raised

Medical practitioners
177. Professor Colin Robertson of the Royal College of Physicians of Edinburgh pointed out that the Bill referred only to “a registered medical practitioner”, which could mean that a relatively junior and inexperienced doctor could be involved in decision making and in the process—

“We felt that some guidance would be required not only on the grade and seniority of the individual involved but on specific training in psychiatric aspects for non-psychiatrists and the process to assist the end of life activity. That process might involve, for example, the administration of certain drugs; if so, the nature of those drugs, the way in which they would be administered and the dosages concerned would be outwith the normal experience of a registered practitioner, and additional training would be required on the drugs that could or should be used, the ways in which they should be used and possible complications.”

178. Dr Bill Mathewson of the Royal College of General Practitioners Scotland added—

“... a general practitioner can prescribe any drug that is in the “British National Formulary” and in relation to which he has appropriate experience and knowledge. One would not expect a general practitioner—or any practitioner, for that matter—to prescribe drugs with which they are not familiar and of which they do not have sufficient experience to prescribe. The point is explicit in some of the GMC guidance—practitioners of whatever specialty should not reach into areas in which they do not have competence, experience and knowledge. The proposal in the bill would reach into the area of practitioners prescribing drugs that they might not be used to prescribing on a general, daily basis ...”

179. The Royal College of Physicians and Surgeons of Glasgow made the point as follows—

“The specific assumption that doctors have the expertise to deliberately end life is groundless. Medical care is delivered within the paradigm of competence, which in turn is dependent on training and case exposure. There is no basis in the UK for training in the deliberate ending of life, and it would take time for training programmes to be established at undergraduate and postgraduate levels. This has direct implications for UK medical schools and Royal Colleges. Given the probable low numbers of people who would wish to avail themselves of the provisions of this Bill, it is highly unlikely that any one doctor would acquire sufficient expertise to be considered competent.”

Psychiatrists

180. The Royal College of Psychiatrists’ submission pointed out that the Bill referred to assessments to be made by “a psychiatrist” and set out what such assessments would be expected to cover but did not specify the term further. The submission stated that “additional minimum criteria” would be required, to ensure that psychiatrists undertaking this work were “suitably trained and experienced”. Various criteria were suggested, including, as a minimum, the term membership of the Royal College of Psychiatrists and approved medical practitioner status under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

181. The Royal College of Psychiatrists’ representative, Dr Potts, added—

“A purpose of revalidation is to ensure that all aspects of a doctor’s practice are subject to oversight and clinical governance. In other words, we should not be allowed to have practitioners working in isolation and at risk of becoming rogue practitioners. As far as I can see, the bill makes no provision to ensure that that is the case for the psychiatrists who might be involved in giving opinions about end of life assistance in this specific area of their work. If
such work is part of and subsumed into their national health service work, those appraisal and clinical governance arrangements will apply, but if it is additional to and separate from it, additional arrangements will need to be put in place to ensure adequate oversight.”

Member in charge

182. These issues were raised with the member in charge of the Bill, who responded—

“I doubt whether a huge amount of extra training would be needed. I think that for a doctor, whether a GP or hospital consultant, who agrees to take part in procedures that bring about an end to life a bit prematurely it would be a question less of formal training and more of aptitude. I may be wrong in that, and I will be honest that I have not asked too many people ... I do not think that much extra training would be needed because it will depend much more on the personality and aptitude of the doctor.”

Conclusion

183. The Committee shares the concerns raised in evidence about qualifications and experience of the designated practitioner and psychiatrist roles but notes that this may raise competence, regulatory and legal issues. The Committee did not hear evidence that these issues had been explored.

AGE

Background

184. In order to make a formal request for end of life assistance under the Bill, a person would have to be 16 years of age or over at the time of making the first formal request.

16-18 age group

185. Dr Iain Brassington, Lecturer in Bioethics at the School of Law, University of Manchester, recognised that setting a lower age boundary would be “pragmatic” and that setting it at 16 would be consistent with medical law in other fields. He did argue, however, that from a “purely moral” point of view, the age limit was “a little bit arbitrary”, drawing a comparison with gender and ethnicity.

186. Professor Laurie and Professor Mason of the University of Edinburgh argued that Scots law had a tradition of protecting children up to and beyond the age of 16 from decisions that were manifestly against their interests—

“... for example, while a child has capacity to enter a contract between 16 and 18, this is can be struck down up to the age of 21 if it is shown to be against his or her interests. Similarly, while the law provides that a child under 16 who understands a medical treatment can give valid consent to that treatment, it does not provide for an automatic right to refuse treatment.”

187. They recognised that the arguments were “balanced finely” around the need to respect and protect the evolving capacity of the child, but stated that it was “clearly the case” that Scots law could and did “intervene to protect children from harmful decisions”. On
this basis, they suggested that there were “strong reasons to argue that the Bill should only apply to those of 18 and over”. 156

188. The Royal College of Psychiatrists’ submission expressed a “general reluctance” to “contemplate end of life assistance in young people”. Whilst acknowledging that setting the age of eligibility at 16 would be consistent with the definition of “adult” used in the Adults with Incapacity (Scotland) Act 2000, the submission pointed out that other legislation covering psychiatric practice, namely the Mental Health (Care and Treatment) (Scotland) Act 2003, required health boards to provide “age-appropriate” mental health services for those under 18. The Royal College of Psychiatrists reasoned, therefore, that psychiatrists expected to undertake assessments in 16- and 17-year-olds seeking end of life assistance would need to be specifically trained in adolescent mental health—

“Most of Scotland has no psychiatric service at all for adolescents in general hospital settings, and if those few specialists providing it opt out, there will be no age-appropriate and clinically aligned psychiatric assessment available anywhere in the country.” 157

189. The Royal College of Psychiatrists recommended that, “for this reason alone”, the age limit should be revised to 18. 158

190. This point was echoed by Ruth Stark of the British Association of Social Workers—

“We are also deeply concerned about the age limit, which we firmly believe firmly should be over 18, in line with the United Nations Convention on the Rights of the Child.” 159

Conclusion

191. The Committee draws to the Parliament’s attention the points made about the age threshold. Some members found the threshold at 16 to be consistent with other legislation. Other members were sympathetic to the arguments in favour of setting the threshold at 18.

REQUIREMENTS RELATING TO THE ACTUAL PROVISION OF ASSISTANCE

Background

192. The Bill would require, where a second formal request were approved and before end of life assistance could be provided, the requesting person and the designated practitioner to agree who would provide the end of life assistance. It would not be possible for end-of-life assistance under the Bill to be provided by a relative of the requesting person; a person who would benefit from the requesting person’s estate on the requesting person’s death, or a person who would have another interest in that death.

193. The Bill would also require the end-of-life assistance to be provided within 28 days of the date when the requesting person was informed of the approval of the second formal request.

194. It would also be required that the place where the end of life assistance were to be provided should not be one to which the public had access at the time at which the assistance was being provided.

195. Where end-of-life assistance were provided under the Bill, the designated practitioner would have to be present at the end of the requesting person’s life.
196. Under the Bill, the means by which assistance would be provided would have to be agreed in advance. Nothing further is specified. The Policy Memorandum states that the means of death “must be humane and minimise the distress to the person receiving end of life assistance”, adding that the decision not to specify the means and method of delivery “reflects an individual’s choice, acknowledges medical development and accepts expertise is best left to registered medical practitioners”.

The assisting person

197. Professor Colin Robertson said that the Royal College of Physicians of Edinburgh had a “grave concern” that, if assistance were undertaken by non-medical practitioners, those people should not be empowered to undertake medical procedures for which they had no training.  

198. A similar point was made by Theresa Fyffe of the Royal College of Nursing. She argued for the provision of end-of-life assistance under the Bill to be restricted to the designated medical practitioner.

199. In the written evidence, there were, in general, calls for greater clarity in the Bill on who should undertake the final assistance.

The 28-day provision

200. Of those that responded in detail concerning this provision there was a general feeling that 28 days was too short.

201. For some, the issue was in connection with provisions in the Bill that should timescales not be met then the requesting person, should they still wish to, would have to start the process again. Professor Laurie and Professor Mason of the University of Edinburgh felt there should be a provision to allow a further 28 days if needed. Professor Sheila McLean of the Centre for Applied Ethics and Legal Philosophy, University of Glasgow, felt there was no obvious rationale for the request’s validity to expire after 28 days. She noted that, in Oregon, there was evidence to suggest that some people were comforted by knowledge they could end their lives at a time of their choosing and may, in fact, live longer than if forced to take medicine within a specified time limit.

202. However, for others the issue was connected with the possibility that putting such a short timescale on the process may in fact lead to the person feeling pressured to carry it through.

The place of end of life assistance

203. A number of respondents felt this needed to be further clarified. One discussion point related to whether or not the final act should be allowed to take place in a NHS hospital, with arguments on both sides. Others were concerned that palliative care premises could be used. A number of respondents were concerned that hospices and hospitals could be the place of end of life assistance, with one point being made that it might make many vulnerable people reluctant to enter them. Another point raised was whether or not the places chosen would be regulated in any way.

204. The Cabinet Secretary for Health and Wellbeing wrote to the Committee in response to a question about whether the terms of the National Health Service (Scotland) Act 1978 (“the 1978 Act”) would permit any health professional employed by the NHS to undertake end-of-life assistance as proposed by the Bill. The Cabinet Secretary’s letter stated the Scottish Government’s view that
the provisions of end of life assistance as set out in the Bill would not be within the powers as set out in the 1978 Act and therefore is not within the powers of Health Boards in terms of that Act. It follows from this that the Scottish Government believes that NHS General Practitioners or any other health professionals who provide services through the NHS in Scotland could not provide such assistance while acting in that capacity.\textsuperscript{167}

**The requirement for the designated practitioner to be present**

205. Some respondents considered that it may not always be possible or easy for a doctor to be present at the very end\textsuperscript{168}. Moreover, Dignity in Dying pointed out that it may not always be desirable—

> "We are concerned by the provision that the medical practitioner must be present at the end of the person’s life. This potentially forces practitioners to be involved in a stage they might not want to and doesn’t allow the patient and family privacy at this sensitive time."\textsuperscript{169}

206. The Royal College of Physicians and Surgeons of Glasgow argued that there were further problems associated with the requirement—

> “Significant technical problems, complications, and failure of completion are associated with euthanasia and assisted suicide, particularly in the latter. The Bill gives no account of the expectations on doctors in such circumstances. Would resuscitation of the patient, or acceleration of the assisted dying be required? Additional clarity is required regarding the action of a doctor who is overseeing but not conducting the procedure. Highest standards are expected in every other area of medical practice, but this Bill demonstrates no concept of this in regard to its requirements.”\textsuperscript{170}

207. This view was shared by the Royal College of Physicians of Edinburgh, which pointed out that there were “no provisions within the legislation to control who” administered the assistance and that it was unclear whether the designated practitioner would be expected to “supervise and intervene in the event of complications”, such as unexpected side effects or failure to die.\textsuperscript{171}

**The means by which assistance would be provided**

208. The majority of those who discussed this issue looked for greater clarity on what the means would be. Community Pharmacy Scotland, for example, speculated that the “most likely chosen route of ending life” would be by injection of high dose opiates and barbiturates or insulin—

> “It is not clear from the Bill how it is intended to source any medicines that may be required to end life. The supply of medicines is currently governed by the Medicines Act 1968 and the Misuse of Drugs Act 1971 (as amended). These acts are reserved legislation and there is a need to examine where precedence lies and if supplies for this purpose are permitted.”\textsuperscript{172}

209. The Royal College of Nursing Scotland recognised why a definite method had not been stipulated but raised the concern that, coupled with the option of nominating a layperson to deliver the final act, it could not be adequately ensured that the clinical intervention chosen would be delivered by a “suitably competent person”.\textsuperscript{173} Similarly, the Scottish Partnership for Palliative Care drew attention to the importance of considering “how the risk of complications and untoward events could be minimised during the actual provision” of voluntary euthanasia or assisted suicide.\textsuperscript{174}
210. Finally, there were concerns that the absence of specified means or methods could prove problematic in relation to due diligence. The Association of Chief Police Officers in Scotland (“ACPOS”), for example, commented that the Bill not specifying what methods would be available for ending the life of the requesting person could be “problematic” in the event of an inquiry. ACPOS also cautioned that any investigation into a suspicious death was “likely to be protracted and resource intensive” and that the potential for such an investigation to be required for any death where there was “any accusation or uncertainty over the meeting of the Bill’s eligibility conditions” needed to be considered. ACPOS suggested that consideration be given to “providing further detail around method, means and recording”.

211. Dignity in Dying also commented on this issue—

“… we believe that this end-stage must be defined to ensure all participants in the process know what to deliver and expect, is applied with uniformity and can be audited.”

Conclusion

212. The Committee acknowledges concerns expressed on the lack of detail with regard to the requirement for the presence of the designated medical practitioner but believes that any medication administered during the end-of-life process should nonetheless be in the presence of a medical practitioner.

213. The Committee is concerned that the setting of a limit of 28 days for the provision of end-of-life assistance could encourage a person to proceed prematurely.

SAFEGUARDS FOR DOCTORS AND OTHER PROFESSIONALS

Background

214. The Bill would decriminalise certain acts subject to certain procedures; the Policy Memorandum explains that the Bill would not specifically require any particular person’s participation in any of these acts or procedures—

“The Bill imposes no element of compulsion on a registered medical practitioner to participate in the end of life assistance processes set out in the Bill … Ethical guidance produced by the General Medical Council (GMC) explains how a registered medical practitioner should act when they have a conscientious objection to performing a certain procedure. This Bill does not affect this guidance in any respect.”

215. The Policy Memorandum continues—

“The GMC guidance states that registered medical practitioners should not share their personal view with the patient and should make them aware of all options. In this instance, while a registered medical practitioner may be opposed to assisting in a person’s death, they must not conceal information. The registered medical practitioner also has a duty to advise the person that they can see another registered medical practitioner and, if they are unable to make such arrangements to see another registered medical practitioner, it is for the registered medical practitioner to make arrangements for the person. In terms of the Bill, it is expected that some registered medical practitioners will have an objection to being involved in assisted dying and as such it may not always be immediately identifiable who to
approach. The GMC guidance is clear, however, and there would be a duty on registered medical practitioners who object to participating to make arrangements to see a registered medical practitioner who would be prepared to consider a request for end of life assistance."

Conscience clause

216. Mark Hazelwood of the Scottish Partnership for Palliative Care raised the “practical issue of arrangements for staff who have a conscientious objection to being part of the process” and asked members to consider the fact that the Bill was silent on the matter.

217. Elaine Stevens of the Independent Association of Nurses in Palliative Care commented that “many practising nurses, although not all, would not want to be involved in implementing” the Bill and that the association would prefer this area to be “strengthened”. 177

218. This view was echoed by Theresa Fyffe of the Royal College of Nursing, who stated that the college’s members that were “strongly against” the Bill wanted a “conscientious objection provision” to allow them to state that they did not have to “participate in the process”. 178

219. The calls for some form of conscience clause were supported by Gordon MacDonald of Care Not Killing Scotland—

“It has been fairly well articulated in previous evidence sessions that there should be, at the very least, some sort of conscience clause in the bill. That should apply not just to doctors but to health care staff, social workers and others who are involved in end of life care.” 179

220. Asked about the view that practitioners would be able to opt out on the basis that the Bill would place no requirements on them, Professor Hazell from the Nursing and Midwifery Council cautioned that there was potentially a difference between how that would work “theoretically” and “realistically”. He explained that the position under the Bill would be “theoretically … clearly an acceptable practice”. He went on to state, however—

“I am sorry to say that the practicalities can be somewhat different. We hear about a lot of rather disturbing cases of nurses being put under enormous pressure to do things that they believe are unethical or even illegal. We have received some alarming evidence that the phenomenon is developing significantly in the primary care setting. In general practices, nurses are being told that, unless they do something, they will be sacked. That sounds dramatic, but I assure you that it is factual.

“We need to be aware of the difference between theory and practice. Theoretically, a nurse can opt out; practically, in certain situations, they can be put under a lot of pressure. To support them in that regard, we are about to issue guidance on what we call escalating concerns, to give nurses the courage to bring forward cases in which they are being asked to provide care that is inappropriate. However, in small, isolated areas, it is difficult for them to do that.” 180

221. Adrian Ward, a solicitor expert in mental health and disability law, comparing the situation to the practice of law, felt that this would be a matter for professional regulation—

“There is always a question, in dealing with any profession, about the extent to which you constrain that profession by law and the extent to which you leave matters to professional regulation. There has to be professional regulation.
“... we are probably getting into the area of professional regulation and what a professional should do when his conscience is against doing something that he knows that other doctors might be willing to support, which is very different from being asked to do something that no doctor would do.”\(^{181}\)

**Member in charge**

222. The member in charge stated that “no doctor, no medical professional and no social worker – in fact, no person at all” who came into professional contact with the requesting patient would be obliged to take part in the process.\(^ {182}\) She stated—

“The bill says that they would be able to refuse to take part in any procedure.”\(^ {183}\)

223. Asked why she thought that a conscience clause such as is contained in the abortion legislation was not relevant, she replied—

“We did not want to make it obligatory for anyone—requesting patient, assisting psychiatrist or the doctor whose help has been requested—to take part in the procedure. As I have explained many times, I fully accept that the bill deals with the interface of private morality and public policy, which means that there is greater acknowledgement of the autonomy not just of the patient but of the person who might be qualified to take part in the procedure but objects on moral grounds.

According to the GMC’s advice, doctors should, where practical, tell the patient in advance if they are not going to provide a particular procedure because of a conscientious objection. However, doctors must be careful to be respectful of the patient’s dignity and views, whatever the doctor’s personal beliefs about the procedure in question. The registered medical practitioner has a duty to advise the person that they can see another registered medical practitioner. If the person is unable to make such arrangements, the medical practitioner would be under a duty to do so. I suggest ... that such advice already applies to medical care that is being given in some of our more remote areas. People will make arrangements that are suited to where they live, the facilities on hand and their own abilities and beliefs.”\(^ {184}\)

224. She added that she did not think that it would be easier for the people involved if the Bill included such a clause—

“They do not need such a security blanket. After all, it has already been assumed that everyone, no matter whether they are the patient or the doctor, has a conscience and that they have an equal right to exercise it.”\(^ {185}\)

**Conclusion**

225. The Committee recognises the member in charge’s argument that the Bill would not explicitly require the participation of any particular person or class of person in assisted suicide or voluntary euthanasia. The Committee questions, however, her assertion that the Bill “says that they would be able to refuse to take part” in any procedure allowed by the Bill: an absence of a requirement is not necessarily equivalent to a right to refuse.

226. The Committee recognises the calls for a form of ‘conscience clause’ to be specified in the Bill. The view that the Bill’s approach, depending on not specifying any requirement to participate, may not hold in practice struck a particular chord with the Committee. The Committee also notes that this may fall within the ambit of regulation of the health professions
and, therefore, outwith the legislative competence of the Parliament. The Committee draws to the Parliament’s attention the potential difficulties for this Bill of attempting to find a satisfactory solution within legislative competence. The Committee believes, however, that, in legislation of this nature, a conscience clause should be included.

CONSIDERATION OF EQUALITIES ISSUES IN THE POLICY MEMORANDUM

Background

227. The Committee’s inquiry has uncovered a range of equalities concerns inherent to the main objectives of the Bill. Those issues have been dealt with in the main body of the report under the headings to which they relate, as an integral part of the discussion of those issues. In addition, the Policy Memorandum addressed equalities issues under the heading ‘Effects on Equal Opportunities, Human Rights, Island Communities, Local Government, Sustainable Development etc.’ This section of the report examines those issues and their treatment in the Policy Memorandum.

228. The Policy Memorandum stated that the Bill would have a “positive impact on issues of equality” and commented on the impact for equal opportunities in respect of physical disability, vulnerable people and island communities.

Physical disability

229. The Policy Memorandum stated that, for those seeking an assisted death, the “only viable option” had been to travel to Switzerland but that, for many, however, it had not been possible to make this journey—

“For some their physical disabilities are such that it would be impossible to undertake such a trip or even if they are able to undertake the trip they may be unable to release the medication as is required under Swiss law. For others the cost of travelling to Switzerland and the payment to Dignitas has proved prohibitive. The Bill will remove this inequality and ensure that assisted dying is not solely accessible to those who are physically capable and sufficiently affluent.”

Vulnerable people

230. The Policy Memorandum also stated that the Bill had in place a “series of stringent protections” to ensure that those seeking an assisted death were “resolute in their request … not being coerced and … mentally capable of making the request”, adding—

“The Bill will ensure that vulnerable people are protected. Given the experience of Oregon, the protections contained in the Bill and the quality and capability of the medical profession in Scotland, the Member is confident that this Bill will not place vulnerable people at any risk and will in fact provide greater protection.”

Island communities

231. The Policy Memorandum stated—

“It is not anticipated that this Bill will have any differential impact on island communities. The fact that an assisted death can take place at the home of the requesting person or wherever that person chooses will mean a person is not forced to leave their island community to receive an assisted death.”

View of disabled people’s organisations
232. Pam Duncan of Inclusion Scotland pointed out the resistance to the Bill by several organisations—

   "... a number of disabled people’s organisations, which represent a huge groundswell of disabled people, are opposed to the bill. Those include the Royal Association for Disability Rights, the National Centre for Independent Living, the UK Disabled People’s Council, Disability Awareness in Action and the not dead yet UK campaign. It is unfair to believe that disabled people are not fundamentally against the bill."\[189\]

233. Johanna McCulloch of the Scottish Disability Equality Forum stated—

   "Our members raised the issue of choice, who the bill gives the choice to, and why. One point that was made a lot was, if a person is physically incapable of taking their own life, they are not equal with a non-disabled person. To assist them to do so puts them on an equal footing with non-disabled people. However, as the bill is drafted, the criteria are so wide that the disability does not need to prevent someone from taking their own life; it just needs to impede their ability to live independently. Some people feel that that indicates that disability is the only thing that can make life so intolerable as to justify assisted death. From an equality perspective, they would prefer the bill to be aimed at people who are physically incapable of taking their own life—for that to be the only situation in which assistance might be justified."\[190\]

234. Dr Chris Sugden of St Andrew’s Hospice made the point that the “vast majority” of patients coming into a hospice as in-patients or outpatients were “extremely vulnerable and very anxious, especially at first contact”. He went on to say—

   "The bill uses the term “End of Life Assistance”; in our specialty, we use the word “assistance” quite often. A vulnerable person may latch on to that, become confused and mix up our assistance with the wording of the bill."\[191\]

235. NHS Western Isles stated that it was likely that it would be necessary for psychiatry services from the mainland to be used in relation to the process set out in the Bill.

Member in charge

236. In addition to the points made in the Policy Memorandum, the member in charge, speaking in the context of willingness amongst practitioners to participate in remote areas, stated that people will make arrangements that are suited to where they live, the facilities on hand and their own abilities and beliefs.\[192\]

Conclusion

237. The Committee reminds the Parliament that many of the issues dealt with elsewhere in this report are inextricably linked to issues of equality.

238. The Committee further draws to the Parliament’s attention the evidence noted in this section that the Bill could, contrary to the assertions of the Policy Memorandum, have a negative effect for disabled people.

239. With particular regard to island communities and other remote areas, the Committee has reservations about the member in charge’s belief, as stated in the Policy Memorandum, that the Bill would not have any differential impact on
island communities and that those living in such areas would be able to make arrangements under the Bill without leaving their home area. The member in charge has consistently defended the view that the Bill would not require any person to discharge any particular function. That being the case, if no practitioner in or near to a remote location were willing to fulfil the role of designated practitioner or psychiatrist, how would the patient commit assisted suicide or voluntarily be euthanized without being forced to leave his or her island or other remote community or otherwise access services on the mainland without incurring significant inconvenience?

240. There is also an inequalities issue relating to affordability; this is discussed further in the section below on the Financial Memorandum.

241. The Committee is not confident that equalities issues have been robustly considered in the preparation of this Bill. The Policy Memorandum asserts that the Bill will have a “positive impact on issues of equality” but does not appear to be able to support this claim. It is an established practice that Scottish Government bills and policies are impact assessed to ensure that a negative impact is not inadvertently created for equality groups. The member in charge has not followed this example and the Committee finds that, as a result, the consideration of the equalities impact of the Bill lacks rigour.

FINANCIAL MEMORANDUM

Background

Financial memorandum

242. The Financial Memorandum acknowledges the difficulties associated with estimating what demand there would be for end of life assistance as proposed in the Bill, mentioning in particular that there is no indication of how many people would choose such assistance if it were available.

243. The Financial Memorandum goes on to make an estimate based on the situation in Oregon, insofar as there is data, on the number of assisted suicides committed under Oregon law, calculating the total number between 1998 and 2008 as a proportion of all deaths. It then applies the resulting figure to the General Register Office for Scotland’s population statistics for 2007 and arrives at an estimate of 55 deaths in Scotland per year.

244. The Financial Memorandum goes on to envisage that main bulk of the costs would fall to the NHS, most probably within general practice. No estimate of what those costs would be is offered and it is assumed that much of the work that would be required under the Bill would fall within what a GP would normally do.

245. It is also stated in the Financial Memorandum that there would be some costs incurred by individuals requesting an assisted death—

“The Bill does not prevent persons from requesting an assisted death from a registered medical practitioner working in private practice or to see a psychiatrist working in private practice. Time and availability may be significant constraints on who can be consulted. It is possible that while it may be possible to access an NHS general practitioner, time and availability constraints may mean it is less possible to see an NHS psychiatrist. It is difficult to predict what the cost of consultations with a psychiatrist may be particularly as it is difficult to estimate how many consultations a psychiatrist might require to be satisfied the person is capable of making the decision to receive an assisted death. In order to estimate a figure we have drawn on the advertised costs of a number of psychiatrists operating in the UK. Based on
these figures and on the assumption that there might be four consultations, two for each request, the cost will be in the region of £675. This is considered to be up at the upper end of the potential costs and is unlikely to be higher."  

Finance Committee

246. The Finance Committee considers all financial memorandums accompanying a bill on introduction. In relation to the Bill, the Finance Committee agreed to seek written evidence from organisations financially affected using a standard questionnaire and to pass responses received directly to the Committee. The Finance Committee’s letter enclosing the responses is attached at Annexe D.

247. The Finance Committee’s letter noted that most responses were “broadly content” with the Financial Memorandum, although some health boards raised issues.

Use of Oregon data as a basis for estimating the financial impact of the Bill

248. Very few submissions commented on the Financial Memorandum. Of those that did, the main criticism was the use of Oregon as the model for estimating a number of potential deaths arising from the Bill if it were passed. This argument was founded on the assertion that the Bill’s scope was much wider than the Oregon legislation, which is limited to physician-assisted suicide. For example, Care Not Killing Scotland stated—

“It is clear from the Bill’s definition of ‘end of life assistance’ that it is intended to cover both assisted suicide (where a patient is provided with lethal drugs by a physician for self-administration) and euthanasia (where a physician administers lethal drugs to a patient directly). This is therefore a Dutch-style euthanasia bill rather than an Oregon-style bill providing only for assisted suicide. For this reason the Oregon-based estimate given in the Explanatory Notes that the Bill would result in some 55 deaths a year in Scotland is considerably wide of the mark. Based on the experience of The Netherlands, where a similar euthanasia regime operates, the number of Scottish deaths caused annually would be many times this figure – perhaps as many as 1500.”  

Assumption that costs would fall to the NHS

249. As mentioned earlier in the report, the Committee wrote to the Cabinet Secretary for Health and Wellbeing to seek her views on whether assisted suicide and voluntary euthanasia could be provided under the National Health Service (Scotland) Act 1978 (“the 1978 Act”) by any health professionals employed by the NHS, including registered medical practitioners, in the course of their duties for the NHS, using NHS resources and/or on NHS premises. The Cabinet Secretary’s response stated—

“The Scottish Government takes the view that the provisions of end of life assistance as set out in the Bill would not be within the powers as set out in the 1978 Act and therefore is not within the powers of Health Boards in terms of that Act. It follows from this that the Scottish Government believes that NHS General Practitioners or any other health professionals who provide services through the NHS in Scotland could not provide such assistance while acting in that capacity.”

Member in charge

250. The member in charge stated that Oregon had been used as the basis for estimating how many people would commit assisted
suicide or access voluntary euthanasia under the Bill as she had thought that it was the “best parallel for such a judgment”. In response to the point that the Bill’s scope was much wider than that of the Oregon legislation and that the Netherlands may have been a more appropriate starting point, she stated—

“We do not claim that it is an exact science—it is not. We can only look at parallels and make estimates of what we think is likely to be correct. There are a number of significant differences between what would be permitted under the bill and what is permitted in the Netherlands. We have drawn the bill much more tightly. The involvement of a psychiatrist to assess a person’s competence is probably the most significant difference, because that would reduce the numbers, I think. We have included an extremely robust process that only the most determined would have the willpower to complete. In fact, that is one of the things that I sometimes wonder about. We are not making it easy for people.”

251. It was put to the member in charge that the Dutch legislation, whilst not parallel to the Bill either, would have served as a better benchmark than the Oregon legislation and, using the same modelling that was used to compare with Oregon, would have given a figure closer to 1,000 people per year that would make use of the legislation here. The member in charge replied—

“... the reporting system is so different ... [in the Netherlands] that it is difficult to tabulate the figures. I thought that, roughly speaking, the rigour of the procedures in the bill is almost balanced out by the fact that in Oregon, a large percentage of people do not take advantage of the prescription that they receive—they use it as an insurance policy. It seemed to me that there is a similar social attitude towards the issue here.”

252. In respect of the issue about use of NHS facilities and resources, the member in charge indicated an intention to lodge an amendment at Stage 2 that would amend the 1978 Act to allow assistance as envisaged by the Bill to be provided under the NHS.

Conclusion

253. The Committee considers that the expected number of assisted suicides and deaths by voluntary euthanasia under the Bill is inextricably linked to consideration of expected costs. The Committee believes that it is not sufficient merely to assume that the proportion of deaths by these methods in a jurisdiction that already has legislation in this area – be it Oregon, the Netherlands or anywhere else – can straightforwardly be transferred to Scotland: not only does the form and scope of legislation in those jurisdictions differ greatly from what is proposed in this Bill, but Scotland’s culture and existing structures differ from those in other jurisdictions. These are all factors that would potentially affect a person in Scotland’s decision. Whilst the Committee accepts that the number cannot actually be foreseen, it believes that it could be forecast – the member in charge could, for example, have commissioned an academic modelling exercise to take the relevant factors into account. The Committee draws it to the Parliament’s attention that no such exercise has been undertaken.

254. In relation to the assumption that most costs would fall to the NHS, the Committee finds the Financial Memorandum to be flawed. The Committee believes that the Parliament’s decision at Stage 1 cannot be predicated on a potential amendment at Stage 2, the outcome of which cannot be guaranteed at the time of the Stage 1 decision. The Financial Memorandum should have explored thoroughly the costs that would result from the Bill as introduced being passed, as well as possible costs arising from subsequently hoped-for amendments. Furthermore, the Committee is disappointed
that, even in respect of the costs assumed to fall to the NHS, the Financial Memorandum appears to be vague.

255. There may flow from this an equalities issue: if NHS facilities and personnel would be unavailable to persons seeking to commit assisted suicide or access voluntary euthanasia, those persons would then have to turn to private practice in terms of the designated practitioner and psychiatrist roles specified in the Bill. There would naturally be costs associated with private practice and the Committee is consequently concerned that the affordability to individuals from varying backgrounds has not been thought through.

CONCLUSION AND RECOMMENDATIONS

256. The Committee recommends that the Parliament take the following findings of the Stage 1 inquiry into account when arriving at a decision on the general principles of the Bill—

- There is no ambiguity in current Scots law in this area – if some people choose to travel to other jurisdictions to commit an assisted suicide or to access voluntary euthanasia, they do so because certain, inherent aspects of those actions are unlawful in Scotland. That the decision of whether to prosecute is separate and subject to the Prosecution Code is part of due process. Any call for clarity is, therefore, spurious.
- Examples from other jurisdictions have been offered as though comparable with the proposal in this Bill. However, there is firstly an important difference in the cultural and legislative contexts of those countries compared with Scotland. Secondly, there is a fundamental difference in the breadth and scope of this Bill.
- The Bill seeks to decriminalise both assisted suicide and voluntary euthanasia under a single definition – it would have been clearer for the two acts to have been dealt with as separate provisions in the Bill.
- An individual’s ‘autonomy’ has been advanced by the member in charge as a central argument in favour of the Bill. The Bill would not, however, accord or establish any rights. Further, although courts have acknowledged the right to respect for a private life, they have also acknowledge that this right may have to be tempered in the interests of wider society. The Bill should be considered, then, in the context of preserving a balance between an individual’s right to exercise autonomy and the interests of society as a whole. Most members of the Committee believe that the wider societal concerns should prevail in the context of the Bill and do not accept the principle of autonomy as argued by the member in charge. One member believes that the interests of the individual should prevail.
- The preservation of an individual’s ‘dignity’ has also been presented as a central argument in favour of the Bill. However, ‘dignity’ is capable of two interpretations. Whilst those in favour of assisted suicide see it as a means of preserving dignity in the terminal stages of life and in the moment of death, those against present an equally compelling argument that a hastened death is undignified by its very hastening and that the key to preserving dignity in the terminal stages of life lies in the quality of care available to and the respect afforded to the dying. It is impossible to reconcile these arguments.
- In Scots law, if a person aged over 16’s capacity is to be challenged, the challenger has to lead evidence to demonstrate the loss of capacity. The majority of evidence questioned why the Bill would create an unprecedented requirement across the board, to the effect that all individuals requesting assisted suicide and voluntary euthanasia would be subject to a test. However, the Committee believes that, in a situation such as this, the approach would be justified.
- The Bill would establish a procedure, one of the purposes of which would be to detect undue influence. However, the approvals necessary to proceed would be obtainable following two meetings with a medical practitioner and one other meeting with a psychiatrist, neither of whom would need to have previously had any contact with the
requesting person. The question is whether this level of contact with these particular categories of person would give sufficient assurance that there had been no undue influence on the requesting person’s decision.

- The Bill attributes a meaning to the phrase “end of life assistance” that does not explicitly include any notion of hastening death. This use of terminology is confusing and arguably misleading and inconsistent with the member in charge’s stated reasons for proposing the Bill. It would have been unambiguous to use the terms “assisted suicide” and “voluntary euthanasia”.

- The Bill, in setting out eligibility requirements in Section 4, ostensibly provides for an objective standard based on finding life “intolerable”. The Committee believes, however, the standard set out is inherently subjective. Indeed, the member in charge placed great emphasis throughout the inquiry on her intention that the wishes and self-determination of the requesting person be paramount. Such a test cannot, therefore, stand up as an objective test.

- A further eligibility requirement set out in the Bill would be based on being “permanently physically incapacitated to such an extent as not to be able to live independently”. This raised a number of equalities issues. The terminology used was aimed at capturing a small number of people who find life intolerable but could also apply to a wider group of people with a range of physical conditions or physical incapacity. This is symptomatic of the breadth of the member in charge’s intentions. The immense difficulty of drafting a provision that would capture all those that the member in charge means to include without extending to whole other groups should be recognised; this terminology is, however, extraordinarily wide.

- There are real problems in the Bill’s definition of “terminal illness” as it is based on a notion of timescale that may be difficult to ascertain.

- In relation to the eligibility requirement based on an inability to live independently, the Committee found evidence from organisations representing people with disabilities to be particularly compelling because of the way in which society may let an individual’s life be intolerable by neglecting to provide sufficient and appropriate support. Using the inability to live independently as an eligibility requirement for end-of-life assistance raises issues of definition, clarity and subjectivity similar to those relating to other terminology in the Bill, with the additional possibility of unintended consequences.

- The Bill does not specify any particular qualifications or experience for the designated practitioner and psychiatrist roles. The Committee shares the concerns raised in evidence about this issue but notes that this may raise competence, regulatory and legal issues. The Committee did not hear evidence that these issues had been explored.

- Points were also made about the age threshold. Some members found the threshold at 16 to be consistent with other legislation. Other members were sympathetic to the arguments in favour of setting the threshold at 18.

- Concerns were expressed on the lack of detail with regard to the requirement for the presence of the designated medical practitioner but believes that any medication administered during the end-of-life process should nonetheless be in the presence of a medical practitioner.

- The Committee is concerned that the setting of a limit of 28 days for the provision of end-of-life assistance could encourage a person to proceed prematurely.

- The Bill would not explicitly require the participation of any particular person or class of person in assisted suicide or voluntary euthanasia. Nor does it state explicitly that they would be able to refuse to take part. An absence of a requirement is not necessarily equivalent to a right to refuse. There were calls in the evidence for a form of ‘conscience clause’ to be specified. This may, however, fall within the ambit of regulation of the health professions and, therefore, outwith the legislative competence of the Parliament. It may be difficult for this Bill to find a satisfactory solution within legislative competence. The Committee believes, however, that, in legislation of this nature, a conscience clause should be included.

- Contrary to the assertions of the Policy Memorandum, the Bill could have a negative effect for disabled people.
There are also potential issues of inequality in relation to remote areas where it could prove difficult to find locally practitioners and psychiatrists willing to participate.

- The Committee is not confident that equalities issues have been robustly considered in the preparation of this Bill. The Policy Memorandum asserts that the Bill will have a “positive impact on issues of equality” but does not appear to be able to support this claim. It is an established practice that Scottish Government bills and policies are impact assessed to ensure that a negative impact is not inadvertently created for equality groups. The member in charge has not followed this example and the Committee finds that, as a result, the consideration of the equalities impact of the Bill lacks rigour.

- Consideration of the Financial Memorandum uncovered weaknesses in its approach to estimating the number of assisted suicides and deaths by voluntary euthanasia that would occur if the Bill were enacted. In particular, no sufficiently sophisticated modelling has been undertaken. The Financial Memorandum also makes flawed assumptions about where costs would fall and is vague in respect of their scale. A further potential equalities issue – the possible differential impact on people from varying economic backgrounds – also appears to have been overlooked in terms of costs that may have to be met by individuals.

257. Overall, the majority of the Committee was not persuaded that the case had been made to decriminalise the law of homicide as it applies to assisted suicide and voluntary euthanasia, termed 'end-of-life assistance' in the Bill, and, accordingly, does not recommend the general principles of the Bill to the Parliament.

ANNEXE A: EXTRACTS FROM THE MINUTES

4th Meeting, 2010 (Session 3)

Tuesday 7 September 2010

End of Life Assistance (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Dr Georg Bosshard, Lecturer in Medical Ethics at the University of Zurich and at the Fachhochschule Gesundheit WE’G;

Professor Martin Buijsen, Professor of Health Law, Institute of Health Policy and Management, Erasmus Universiteit Rotterdam;

Dr Rob Jonquière, former Chief Executive of the NVVE (Dutch Right-to-Die Association) and Communications Director, World Federation of Right to Die Societies;

Prof Penney Lewis, Professor of Law, School of Law and Centre of Medical Law and Ethics, Kings College London;

Lord Mackay of Clashfern;

Adrian Ward, solicitor, expert in mental health and disability law;

Prof Linda Ganzini, Professor of Psychiatry and Medicine Senior Scholar, Center for Ethics in Health Care at Oregon Health and Science University;

Deborah Whiting Jaques, Executive Director/CEO, Oregon Hospice Association.
5th Meeting, 2010 (Session 3)

Tuesday 14 September 2010

End of Life Assistance (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Dr Iain Brassington, Lecturer in Bioethics, School of Law, University of Manchester;

Professor Sheila McLean, Professor of Law and Ethics in Medicine, Centre for Applied Ethics and Legal Philosophy, University of Glasgow;

Professor Graeme Laurie, Professor of Medical Jurisprudence, School of Law, University of Edinburgh;

Professor Calum MacKellar, Professor of Research, Scottish Council on Human Bioethics;

Mark Hazelwood, Director, Scottish Partnership for Palliative Care;

Elaine Stevens, Chair, Independent Association of Nurses in Palliative Care;

Katrina McNamara-Goodger, Head of Policy and Practice, Association for Children's Palliative Care;

Stephen Hutchison, Consultant Physician in Palliative Medicine, Highland Hospice;

Dr Chris Sugden, Medical Director, St Andrew's Hospice.

6th Meeting, 2010 (Session 3)

Monday 20 September 2010

End of Life Assistance (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Dr Tony Calland, BMA Scotland;

Professor Colin Robertson, Royal College of Physicians of Edinburgh;

Dr Stephen Potts, Consultant in Liaison Psychiatry (Royal Infirmary of Edinburgh), Scottish Division, Royal College of Psychiatrists;

Dr Bill Mathewson, Deputy Chair (Policy), RCGP Scotland;

Malcolm Clubb, Policy Development Pharmacist, Community Pharmacy Scotland;

Theresa Fyffe, Director, Royal College of Nursing;

James Anderson, Clinical Psychologist, Scottish National Spinal Injuries Unit, and member of the Special Interest Group on Spinal Injuries, British Psychological Society in Scotland;
Detective Superintendent Brian Yule, Adult Support and Protection Working Group, Association of Chief Police Officers in Scotland;
Ruth Stark, Scottish Manager, British Association of Social Workers;
Kirsty Freeland, Senior Social Worker/Bereavement Service Coordinator, Scottish Regional Group, Association of Palliative Care Social Workers.

7th Meeting, 2010 (Session 3)
Tuesday 21 September 2010

End of Life Assistance (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Paul Philip, Director of Standards and Fitness to Practise, General Medical Council;
Professor Tony Hazell, Chair, Nursing and Midwifery Council;
Reverend Dr Donald MacDonald, Retired Professor of Practical Theology, Free Church of Scotland;
Major Alan Dixon, Assistant to the Scotland Secretary, Salvation Army;
Reverend Ian Galloway, Convener of Church and Society Council, Church of Scotland;
Dr Bill Reid, Connexional Liaison Officer, Methodist Church in Scotland;
Dr Salah Beltagui, Convener, Muslim Council of Scotland;
Leah Granat, Public Affairs Officer, Scottish Council of Jewish Communities;
John Bishop, Secretary, Humanist Society of Scotland.

8th Meeting, 2010 (Session 3)
Tuesday 28 September 2010

End of Life Assistance (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Frank Mulholland QC, Solicitor General;
John Logue, Head of Policy Division, Crown Office and Procurator Fiscal Service;
Pam Duncan, Board Member, Inclusion Scotland;
Johanna McCulloch, Policy Information and Parliamentary Officer, Scottish Disability Equality Forum;
Sarah Wootton, Chief Executive, Dignity in Dying;
Gordon MacDonald, Public Policy Officer, Care Not Killing Scotland;
David Manion, Chief Executive, Age Scotland;
Chris Docker, Director, EXIT;
Jan Killeen, Director of Policy, Alzheimer Scotland;
Tanith Muller, Parliamentary and Campaigns Officer, Scotland, Parkinson’s UK;
Sheila Duffy, Member, Friends at the End;
John Deighan, Parliamentary Officer, Catholic Bishop’s Conference of Scotland.

9th Meeting, 2010 (Session 3)

Tuesday 5 October 2010

End of Life Assistance (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—
Margo MacDonald MSP, member in charge of the Bill;
David Cullum, Head, Non-Executive Bills Unit, Scottish Parliament;
Peter Warren, researcher to the member in charge.

End of Life Assistance (Scotland) Bill (in private): The Committee considered its draft Stage 1 report.

10th Meeting, 2010 (Session 3)

Tuesday 26 October 2010

End of Life Assistance (Scotland) Bill (in private): The Committee considered a draft Stage 1 report. Various changes were agreed and the Committee agreed to consider a revised draft at its next meeting.

11th Meeting, 2010 (Session 3)

Tuesday 2 November 2010

End of Life Assistance (Scotland) Bill (in private): The Committee considered a revised draft Stage 1 report. Various changes were agreed and the Committee agreed to consider a further revised draft at its next meeting.

12th Meeting, 2010 (Session 3)

Tuesday 9 November 2010
End of Life Assistance (Scotland) Bill (in private): The Committee considered a revised draft Stage 1 report. Various changes were agreed and the Committee agreed to consider a further revised draft at its next meeting.

13th Meeting, 2010 (Session 3)
Tuesday 16 November 2010

End of Life Assistance (Scotland) Bill (in private): The Committee considered a revised draft Stage 1 report. Subject to a number of changes, the report was agreed to.

Footnotes:

1 End of Life Assistance (Scotland) Bill. Available at: http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/b38s3-introd.pdf [Accessed 17 November 2010]


3 End of Life Assistance (Scotland) Bill. Policy Memorandum. Available at: http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/b38s3-introd-pm.pdf [Accessed 17 November 2010]


7 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 21 September 2010, Col 191

8 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 20 September 2010, Cols 149

9 West Dunbartonshire Council, written submission


32 Laurie Prof G and Mason Prof JK, written submission

33 The Rt Hon Lord Mackay of Clashfern KT, written submission

34 Hutchison Dr S et al, written submission

35 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Col 87

36 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Col 87

37 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Cols 86-88

38 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 7 September 2010, Cols 54-55

39 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 5 October 2010, Col 300

40 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 5 October 2010, Col 283

41 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 5 October 2010, Col 286

42 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 5 October 2010, Col 283

43 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 5 October 2010, Col 283

44 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 5 October 2010, Col 283

45 Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 5 October 2010, Col 285
Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 5 October 2010, Col 286*


Policy Memorandum, paragraph 68


Dr Iain Brassington, written evidence

Dr Iain Brassington, written evidence

Dr Iain Brassington, written evidence

Dr Iain Brassington, written evidence

Dr Iain Brassington, written evidence
Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 28 September 2010, Col 260

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 28 September 2010, Col 244

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 28 September 2010, Col 245

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 28 September 2010, Col 250

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 28 September 2010, Col 251

EXIT, written submission

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 7 September 2010, Col 53-4

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 5 October 2010, Col 286

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 5 October 2010, Col 283

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Col 81

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Col 81-2

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Col 82

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Col 82-3

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Col 83

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Col 83-4

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 14 September 2010, Col 84

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 21 September 2010, Col 210

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 21 September 2010, Col 210

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 21 September 2010, Col 210-11

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. Official Report, 21 September 2010, Col 211
Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 21 September 2010, Col 211-12*

Royal College of Psychiatrists, written submission

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 40*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 41*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 20 September 2010, Col 139*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 19*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 28 September 2010, Col 225-6*

Royal College of Psychiatrists, written submission

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 20 September 2010, Col 138*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 14 September 2010, Col 103*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 14 September 2010, Col 103-4*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 22*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 22*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 21-2*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 36-7*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 36*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 21*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 22*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 28 September 2010, Col 260-1*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 14 September 2010, Col 94*


Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010*, Col 63-4


Policy Memorandum

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 14 September 2010*, Col 100


Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 14 September 2010*, Col 100


Explanatory Notes

Policy Memorandum


Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 7 September 2010, Col 60*

Scottish Disability Equality Forum, written submission

Inclusion Scotland, written submission

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 28 September 2010, Col 264*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 20 September 2010, Col 130-1*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 20 September 2010, Col 133*

Royal College of Physicians and Surgeons of Glasgow, written submission

Royal College of Psychiatrists, written submission

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 20 September 2010, Col 131*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 5 October 2010, Col 300-1*

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 14 September 2010, Col 78*

Brassington, Dr I, written submission

Laurie, Professor GT, and Mason, Professor JK, written submission

Laurie, Professor GT, and Mason, Professor JK, written submission

Royal College of Psychiatrists, written submission

Royal College of Psychiatrists, written submission

Scottish Parliament End of Life Assistance (Scotland) Bill Committee. *Official Report, 20 September 2010, Col 164*


Laurie, Professor GT, and Mason, Professor JK, written submission

Centre for Applied Ethics and Legal Philosophy, University of Glasgow, written submission

M Branthwaite, written submission; Parkinson’s UK, written submission; Dignity in Dying, written submission


Deputy First Minister and Cabinet Secretary for Health and Wellbeing, written submission

Jeffery Dr D, written submission

Dignity in Dying, written submission

Royal College of Physicians and Surgeons of Glasgow, written submission

Royal College of Physicians of Edinburgh, written submission

Community Pharmacy Scotland, written submission

Royal College of Nursing Scotland, written submission

Scottish Partnership for Palliative Care, written submission

Association of Chief Police Officers in Scotland, written submission

Dignity in Dying, written submission

