



Assisted Suicide (Scotland) Bill – call for evidence

Response from the J Kenyon Mason Institute for Medicine, Life Sciences and Law University of Edinburgh

The J Kenyon Mason Institute for Medicine, Life Sciences and Law is an interdisciplinary research network based at the University of Edinburgh. Located within the School of Law, the Mason Institute aims to investigate the interface between medicine, life sciences and the law in relation to technical, social and ethico-legal issues.

The Mason Institute welcomes the opportunity to submit evidence to the Stage 1 consideration of the Assisted Suicide (Scotland) Bill. In doing so we draw on the outcomes a symposium co-hosted with Ampersand Advocates in April 2014 on the principles, practicalities, palliative care, and policing aspects of the proposed Bill. The event brought together lawyers, healthcare professionals, and other practitioners to explore the implications of the Bill. It is important to note, however, this response does not purport to reflect the views of any of the speakers or attendees at the symposium; nor does it represent a summary of the diverse views shared during the event: this information can be found on the website of the Mason Institute. Rather, this contribution is the consensus view of the Executive Committee of the Mason Institute, informed by its interactions with a wide range of parties, including but not restricted to, those involved in the April 2014 symposium.

Consultation Question 3: The Bill precludes any criminal and civil liability for those providing assistance, providing the processes and requirements set out in the Bill have been adhered to. Do you wish to make any comment on this?

Implementation of the Bill in its current iteration may prove challenging. There is scope for clarification of terms within the Bill, notably the use of a reformulated definition of ‘capacity’ in s.12 rather than the more settled definition of incapacity provided under s.1(6) of the Adults with Incapacity (Scotland) Act 2000. A clearer explanation on capacity within any future iteration is warranted as this determination has important implications for the liability of all parties involved in the process.

Also, further explanation of what is precisely meant by ‘assistance’ (versus prohibited acts such as euthanasia), would be imperative to assess any potential liability arising out of actions of individuals who are permitted to assist in the procedure under the proposed law (see for example, s.4 ‘Assistance in Dying’ in Lord Falconer’s Assisted Dying Bill for England and Wales). Further to this, it is unclear how liability is affected in the event of procedural

error. On this basis it is important to provide guidance to the police and public prosecutors regarding the extent to which individuals would be held liable within the Bill's provisions.

More generally, the relationship between the text of any future Act, Explanatory Notes, and professional guidance should be explored fully. At present, and as the above examples illustrate, it is too often the case that important detail is left to ancillary instruments. This will not provide the clarity or reassurance to professionals that are crucial to the success of legislation like this, nor, most importantly, the fundamental protection to citizens seeking to avail themselves of the provisions of any Act.

Consultation Question 4: The Bill outlines a three stage declaration and request process that would be required to be followed by an individual seeking assisted suicide. Do you have any comment on the process being proposed?

It is important to establish robust criteria as to which illnesses or conditions qualify individuals to avail themselves of the provisions of the proposed Bill. At present the Bill is too vague on decisional processes. Additionally, and vitally, the Bill exhibits insufficient safeguards to protect patients from coercion or undue influence in making decisions. Particular care must be taken to protect individuals from interested parties that are explicitly disqualified from the decisional process, including the person's family, anyone who will gain financially in the event of the person's death, and those medical practitioners who have provided treatment or care. This protection could take the form of specified criminal offences in cases where excluded parties are found to have coerced or unduly influenced an individual seeking assisted suicide. Furthermore, this highlights the need for robust oversight bodies to ensure all procedures are adequately monitored to ensure the safety and overall protection of the individuals involved in making such decisions.

We have a serious concern that (a) the tight timescale involved, and (b) the requirement to return drugs if not used within a specified timeframe, might conspire to coerce citizens to commit suicide before they are ready to do so. We suggest that useful lessons could be learned from the experience in Oregon, both with respect to timescales and from the evidence that suggests the facility to hold on to drugs provides reassurance and a degree of continuing control (and autonomy) for citizens. For example, between 1998 and 2002, although there were 198 prescriptions there were only 38 deaths. After 1 July 2016, prescribing in Oregon will be overseen by professional practice standards, which suggests a lighter-touch regulatory approach in light of the lack of evidence of abuse. We are not persuaded by arguments that the failure to remove prescriptions will mean that lethal drugs are free to circulate. There are many legal and dangerous substances in free circulation in society. Nefarious uses of these are already well covered by the criminal law.

Consultation Question 5: Do you have any comment on the provisions requiring that the person seeking assisted suicide must have a terminal or life-shortening illness, or a progressive condition which is either terminal or life-shortening?

This Bill collapses the distinction between terminal and incurable illnesses, as well as between terminal or life-shortening conditions, and therefore has a wider scope than Lord Falconer's Assisted Dying Bill, s.2 of which only applies to individuals who are "terminally ill". The collapsing of distinctions may be perceived as enhancing personal autonomy by

allowing the affected individual to make a choice based on subjective interpretation of their situation. We recognise, however, that use of undefined terms such as ‘life-shortening conditions’ might suggest a wider scope of application than is intended (echoing the concerns and suggestion made under Question 4 for more robust criteria in precisely what conditions or illnesses are within the scope of the Bill). Conversely, individuals suffering from extreme or incurable pain which do not meet the criteria of this Bill would be excluded from seeking assistance to die. A robust commitment to respect for autonomy would suggest that these citizens also be included, even if this only occurs after some future review (see further below).

Given that the stated underlying principle of this proposal is to recognise and promote autonomy, we endorse the attempt to provide a definition of eligible citizens that is broad and inclusive of all who can exercise their own autonomy. However, as the Oregon experience indicates, there is a potential disjunct between theoretical inclusion and practicability if a citizen’s particular medical condition precludes them from performing the final act of suicide. We would therefore welcome greater clarity on what qualifies as the ‘final act’ for citizens who are physically incapable.

Consultation Question 6: Are you satisfied with the eligibility requirements as regards age, capacity, and connection with Scotland as set out in the Bill?

While we fully acknowledge the importance of political expediency in setting up eligibility thresholds and exclusions at this stage, a commitment to genuine respect for citizens’ autonomy would require the eligibility requirements to be kept under constant consideration. Thus, for example, while the age limit of 16 might be appropriate now, future reviews of the legislation should consider whether those under 16 who can exercise their autonomy should also be allowed to make use of the law. If it is accepted that the so-called ‘mature minor’ is able both to consent and refuse care under s.2(4) of the Age of Legal Capacity (Scotland) Act 1991, then legal consistency would expect this to be extended to assisted suicide.

Consultation Question 7: Do you have any comment on the roles of medical practitioners and pharmacists as provided for in the Bill?

Evidence from jurisdictions where assisted suicide has been legalised indicates that demand is typically low. While the underlying principle of the Bill is the autonomy of the citizen, the reality is that the acceptance of processes and procedures for assisted suicide morally implicates all those involved in all stages of the process. Thus, while the role of facilitators may be welcome with respect to the later stages, the law and Scottish society must acknowledge fully the moral impact for medical practitioners and pharmacists, respectively, in assessing capacity to commit suicide and of dispensing the medicaments to do so. Respect for autonomy does not mean that individuals are fully entitled to do as they wish. A more accurate sense of what is involved is to consider the notion of “relational autonomy” – i.e. all of our requests, actions, and omissions impact on those around us.

The acceptance by a doctor that an individual’s quality of life is sufficiently poor to merit assisted suicide may be construed by others as a judgement upon similarly-situated individuals. This could affect societal perceptions of vulnerable groups, and considerably alter the dynamic between doctors and patients. For this reason and those above, doctors

would need to establish whether participation at any point in assisted suicide could be reconciled with professional ethics and their personal perception of their role. A recent UK-wide consultation undertaken by RCGP reaffirmed the organisation's opposition to legal change. In light of this, the absence of a specific conscience clause within the proposed Bill is a critical oversight despite the fact that directorial power over medical services is reserved to Westminster. In the absence of inclusion in the Bill, we strongly support a conscience clause in relevant professional guidance, if the Bill were to proceed. Any guidance should be accompanied by an obligation to refer the citizen to another professional or support service willing to engage with the process.

Consultation Question 11: Do you have any comment to make about the Bill not already covered in your answers to the questions above?

From a policing perspective, it may be appropriate to include protocols that facilitate assessment of the three stage process. This would involve an independent regulatory body taking an oversight and assessment role, while also providing for appropriate response by enforcement bodies. Assessments would be important, in particular, at the time of the first and second requests, ensuring independence of the decision made by the individual.

This relates to the omission from the Bill of an independent regulatory body. If the practice of assisted suicide in Scotland is intended to be subject to close scrutiny; under the control of a relevant public authority; and responsive to reliable practice and treatment data for future assessment, then close regulatory scrutiny combined with regular review will be vital. This is particularly so in practice areas such as this which are socially contested.

Finally, we strongly endorse explicit inclusion, in any proposed Bill, of a review period, for example, of three years. An example of this is the May 2013 legislative provision in Vermont where the process set forth in the Act will 'sunset' and be up for review, while maintaining immunity for individuals who wish to continue to avail themselves of the Act. Note, once again, that a review could either tighten legislative provisions or make them more inclusive, in light of experience. As well as examples given above, this might include an extension of the category of person acting as facilitator to include family members (where no reason to believe ulterior motive or coercion).

Finally, we would raise an important question: what will be recorded on the death certificate in cases of lawful assisted suicide?

The response has been prepared for, and on behalf of, the Mason Institute Executive by:

Cameron Kennedy
Leslie Stevens
Professor Graeme Laurie
Professor J Kenyon Mason
Nayha Sethi
Dr Shawn Harmon
Dr Gill Haddow
Dr Cate Heeney