END OF LIFE ASSISTANCE (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the End of Life Assistance (Scotland) Bill introduced in the Scottish Parliament on 20 January 2010. It has been prepared by the Non Executive Bills Unit on behalf of Margo Macdonald, the member in charge of the Bill to satisfy Rule 9.3.3(A) of the Parliament's Standing Orders. The contents are entirely the responsibility of the Member and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 38–EN.

POLICY OBJECTIVES OF THE BILL

> "There is no right way to die, and there should be no schism between advocates for better palliative care and advocates for making it possible to hasten death with a physician's help. Good palliative care and the right to make this choice are no more mutually exclusive than good cardiologic care and the availability of heart transplantation. To require dying patients to endure unbelievable suffering, regardless of their wishes is callous and unseemly. Death is hard enough without being bullied. Like the relief of pain, this too is a matter of mercy..."[1]

2. 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.

3. The Bill is concerned with providing persons with a choice at the end of life. It is about ensuring that persons who find their lives intolerable can have the dignified death they desire.

4. The Bill details those persons eligible to apply and specifies the criteria to be met.

5. For most people nearing the end of life, good quality palliative care ensures a dignified and peaceful death, but for a small minority, this is not so. It is the needs of these persons the Bill seeks to meet.

[1] Marcia Angell, MD, Senior Lecturer in the Department of Social Medicine at Harvard Medical School, "The Quality of Mercy," published in the *Willits News*, July 11, 2006

6. For some people, death is not only painful, but entails loss of dignity. To avoid this experience at the end of life, some resort to methods of suicide that can be violent, or unsuccessful or both. Some others refuse food or water in an effort to control the time and manner of their death.

7. The Bill recognises that autonomy and the right of the person to seek assistance to die. It will not be a criminal offence or a delict for another person to give assistance if it is requested and there is adherence to the requirements and provisions of the Bill.

8. At present the only way for a person seeking end of life assistance to receive such assistance is to travel abroad to a jurisdiction in which assisted dying is legal, such as Dignitas in Switzerland.

9. The Member believes this to be unsatisfactory in every respect. The person concerned may have to end their life before it becomes intolerable, to comply with Swiss law. The ability of a person to access the Dignitas facilities in Switzerland depends on financial means rather than personal or medical considerations.

10. The quality of a person's death is indivisible from their quality of life, as death is simply the last part of life. It therefore follows that the person concerned should have the same right to attempt to ensure for themselves a peaceful and dignified death.

SUPPORT FOR ASSISTED DYING

11. It is generally accepted that support for assisted dying appears to be growing in Scotland and across the United Kingdom.

12. The existence of assisted dying can be traced back to ancient Greece and Rome when many people preferred to die by their own will than to live in pain. The focus in these societies was on meeting death with peace of mind and minimal pain. To ensure such a death it was permissable to arrange the circumstances of one's death including measures that would shorten one's life.[2] In the sixteenth century, Thomas More, in describing a utopian community, envisaged such a community as one that would facilitate the death of those whose lives had become burdensome to them as a result of 'torturing and lingering pain'. In the 1600s, Francis Bacon stated he thought it part of a physician's duty to alleviate pain, even if that means death.

13. In the Mail on Sunday, Terry Pratchett expressed his support for assisted dying.

> "But for me, the scandal has not been solely that innocent people have had the threat of murder hanging over their heads for committing a clear act of mercy. It is that people are having to go to another country to die; it should be possible to die with benign assistance here."[3]

[2] Euthanasia and physician-assisted suicide: Killing or Caring – Michael Manning, Paulist Press International, 2003
[3] http://www.dailymail.co.uk/news/article-1203622/Ill-die-endgame-says-Terry-Pratchett-law-allow-assisted-suicides-UK.html#ixzz0NtRFo2R9

14. Support for dying with assistance has been registered in surveys of public opinion for more than 30 years. National Opinion Poll (NOP) polls commissioned by the Voluntary Euthanasia Society (VES) in 1976, 1985, 1989 and 1993 saw three quarters of those surveyed support the proposition that adults should be allowed "to receive medical help to an immediate peaceful death if they suffer from an incurable physical illness that is intolerable to them".[4]

15. Similar NOP polls commissioned by the VES in 2002 and 2004 showed that more than 80% of those surveyed supported the proposition that "a person who is suffering unbearably from a terminal illness should be allowed by law to receive medical help to die, if that is what they want".[5]

16. Recent polls commissioned by the Times and Metro also reflect the support in the United Kingdom for assisted dying. Both The Times and Metro polls found that 74% of people want doctors to be allowed to help terminally ill patients to end their lives.[6] [7]

17. In Scotland, a poll conducted by STV in 2009 found that 75% of those surveyed supported assisted dying and a further 78% expressed support for the proposition that persons should not be prosecuted for assisting a close friend or family member to die. In the same poll, 61% of respondents supported the proposition that doctors should be legally able to prescribe a fatal does of medication on the request of a person wishing assistance to end their life.[8]

18. Most recently, the Sunday Times commissioned a poll by Cello MRUK which surveyed Scots on the proposed Bill. In particular, it asked whether the law should be changed in Scotland to allow doctors to help people with chronic illness who want to die to end their lives: 68% agreed, 8% said no and 24% did not know.[9]

BACKGROUND

19. Suicide is not a crime in Scotland. Assisting in another's suicide is a matter that is not specifically covered by statute law. According to *Scots Criminal Law (1997)*:

> "Suicide is not a crime in Scots Law and it is therefore not a criminal offence to attempt suicide. Encouraging or assisting another to take his own life is another matter, as the sympathy which the law has for the suicide does not necessarily extend to those who facilitate suicide. There is no Scottish authority on this issue; in other jurisdictions it is not unusual to find statutory provisions which penalise the provision of any assistance to the would-be suicide." [10]

20. On 11 November 2004, the Deputy Minister for Health and Community Care indicated that:

[4] http://www.euthanasia.cc/stats.htm
[5] http://www.parliament.the-stationery-office.com/pa/ld200405/ldselect/ldasdy/86/8609.htm
[6] http://www.timesonline.co.uk/tol/life_and_style/health/article6726928.ece
[7] http://www.metro.co.uk/news/article.html?Half_of_us_back_right_to_die_law&in_article_id=709629&in_page_id=34
[8] http://news.stv.tv/home/83990-lead-story-assisted-suicide/
[9] http://www.timesonline.co.uk/tol/news/uk/scotland/article6908055.ece
[10] http://www.schb.org.uk/publications/position%2002%20-%20assisted%20suicide.htm

> "Under Scots law, an act of euthanasia by a third party, including physician-assisted suicide, is regarded as the deliberate killing of another and would be dealt with under the criminal law relating to homicide. The consent of the victim would not be a defence and no degree of compassion on the part of the person who carried out the act would amount to a legal justification." [11]

21. It is commonly understood that an assisted death is one that is brought about before the point at which death would occur naturally and for which the person has received assistance. This assistance need not involve an active involvement at the point of death, but the act of providing the person with the required means to undertake an assisted death or influencing them to do so.

22. In April 1996 Lord Cameron of Lochbroom ruled in the Court of Session that life-sustaining treatment could be withdrawn from a woman who had been in a persistent vegetative state for some years. The case was brought by her Health Board, seeking assurance that the withdrawal of feeding would not result in civil or criminal action against medical staff.[12]

23. The Lord Advocate, at that time Lord Mackay of Clashfern, issued a statement that he would not authorise the prosecution of a doctor if acting in good faith, with the authority of the Court of Session, they withdrew life sustaining treatment from a patient in a persistently vegetative state with the result that the patient died. [13]

24. Commenting on the case, Professor Sheila McLean of Glasgow University's Institute of Law and Ethics in Medicine said:

> "What our law does, therefore, is to endorse decisions which will result in the deaths of certain patients (most notably those who cannot express a preference) but not those who are competent to ask for aid in dying."[14]

25. This Bill addresses this anomaly by ensuring that it will only be those persons who are deemed capable of making an autonomous decision about their death who will be able to receive an assisted death. It will continue to protect those vulnerable people unable to express their wishes.

26. Professor McLean further stated that people ought to be able to expect "certainty, cogency and clarity" from the law on assisted dying.

27. In 2005 Jeremy Purvis MSP sought to provide this "certainty, cogency and clarity" by lodging a draft proposal for a bill in the Scottish Parliament to allow capable adults with a terminal illness to access the means to die with dignity.

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[11] Scottish Parliament, Official Report, 11 November 2004, Col. 11891
[12] http://www.schb.org.uk/publications/position%2003%20-%20euthanasia.htm
[13] http://www.schb.org.uk/publications/position%2003%20-%20euthanasia.htm
[14] http://www.scottish.parliament.uk/business/officialreports/meetingsparliament/or-08/sor0326-02.htm

28. The proposal would have given a competent adult suffering from a terminal illness, who made persistent and considered requests to die, the right to receive medical help to bring about death.

29. 616 responses were received to the consultation exercise carried out to inform the bill. Of which, 56% were in support of the proposal, and 33% expressed opposition.[15]

30. However, while there was strong public support, there was not sufficient political support for a final proposal to proceed.

LEGISLATIVE APPROACHES IN OTHER JURISDICTIONS

31. There have been several attempts to legalise assisted dying in various parts of the United Kingdom. Proposals to legalise assisted dying have been considered in the House of Lords and in the Guernsey and Isle of Man legislatures.

32. Most recently, in the House of Lords, Lord Falconer lodged amendments to the Coroners and Justice Bill (2009) that would have exempted from prosecution persons giving assistance to those who travel abroad for the purpose of assisted suicide. Whilst appreciating Lord Falconer's humane intention, the Member rejects this approach because of its inequity and willingness to prolong the practice of making use of another legal jurisdiction whilst avoiding responsibility for having ours exercise the same responsibility for end of life issues.

33. There are now several European countries whose legal systems provide for assisted dying, as do the American states of Oregon, Washington and Montana. The jurisdictions are all distinctive in their application of the principle, but in each case the numbers of people receiving assisted death is small. In Washington State for example since assisted dying became legal in November 2008 only one person has received an assisted death.[16] In Oregon, which has had assisted dying since 1997, 401 people have received assisted deaths, representing 0.001% of all deaths.

34. More detailed information on the countries and states that permit assisted dying can be found at Annex A.

ARTICLE 8 OF ECHR – THE RIGHT TO CHOOSE

35. In England and Wales the criminality of assisting a person to die has been challenged in court.

36. In 2001 in one such case, after the Director of Public Prosecutions (DPP) had refused to guarantee her husband freedom from prosecution should he assist her to die, the late Diane Pretty successfully petitioned the High Court to permit her to appeal against this, arguing that it was a denial of her human rights.

[15] http://www.scottish.parliament.uk/business/bills/membersBillsS2-0407.htm
[16] http://www.nytimes.com/2009/05/23/us/23suicide.html

37. The appeal was rejected by 3 High Court judges, on the grounds that the UK was not ready to sanction assisted suicide. After this judgement was confirmed by 5 Law Lords, in 2002 Diane Pretty took her case to the European Court of Human Rights. It too rejected her case and that same year she died. [17]

38. In 2009, commenting on the case brought by Debbie Purdy, seeking the same protection for her husband as Diane Pretty, 5 Law Lords ruled that under Article 8 of ECHR, a person has the right to die as they choose. Explaining their decision they stated:

> "Everyone has the right to respect for their private life and the way that Ms Purdy determines to spend the closing moments of her life is part of the act of living...Ms Purdy wishes to avoid an undignified and distressing end to her life. She is entitled to ask that this too must be respected."

39. In addition, the Law Lords ruled that the DPP must specify the circumstances in which a person might be prosecuted. The DPP issued an interim policy in September 2009 in which he confirmed that the law would not change and that every case where assisted suicide was suspected would continue to be investigated. He explained:

> "There are no guarantees against prosecution and it is my job to ensure that the most vulnerable people are protected while at the same time giving enough information to those people like Ms Purdy who want to be able to make informed decisions about what actions they choose to take."

40. The DPP set out 16 public interest factors in favour of prosecution. These factors covered the age of the person who had received an assisted death, whether they had expressed a wish to die, the condition from which they suffered, their relationship with the person who had assisted them and the motivation of the person who had assisted them.[18]

41. Furthermore, the DPP set out 13 public interest factors against prosecution. These factors cover:

- the expressed desire of the person to commit suicide;
- a request from the person for assistance;
- the physical condition of the person;
- the relationship with the person who assisted them and the motivation of that person;
- that the person was physically unable to take their own life;
- that alternative medical options had been explored;
- that the person who assisted in the death was reluctant to do so; and
- was willing to assist with police inquiries.[19]

42. Whilst recognising that the DPP's guidance applies to England and Wales only, it should be noted that the intentions of this Bill satisfy much of the criteria defined by the DPP. The

[17] http://www.dignityindying.org.uk/personal-stories/uk/greater-london/luton/diane-pretty-story-8.html
[18] http://www.cps.gov.uk/news/press_releases/144_09/
[19] http://www.cps.gov.uk/news/press_releases/144_09/

principal exception being that the Member has not incorporated assistance from family in the Bill. The Member believes this should act as a further safeguard against the coercion or pressure from relatives that emerged as a fear amongst some respondents to the consultation.

Differences between approach of the DPP in England and Wales and the Lord Advocate in Scotland

43. Whilst the DPP has produced some clarification of the situation exemplified by Diane Pretty and Debbie Purdy in England and Wales, the Member believes the final resolution of whether assisting a person to die should remain a crime subject to possible prosecution, can only be achieved by legislation.

44. The First Minister has endorsed this view[20], and the Lord Advocate has indicated that the position adopted by the DPP in England and Wales will not be replicated in Scotland. For the latter to be possible, there would require to be a specific crime in Scots Law of assisting a person to commit suicide. There is not, and the few prosecutions that have resulted from this action have been for other crimes, such as Culpable Homicide. It must be inferred from the Lord Advocate's position that any decisions by the DPP in England and Wales on whether to prosecute persons assisting another to commit suicide would have no bearing on decisions made in Scotland in relation to similar cases.

POLICY CONSIDERATIONS

Public policy and private fears

45. This Bill is positioned at the interface of privacy, individual morality and belief and public policy. It addresses a sensitive issue, and seeks to establish the legal perimeters inside which a person will not be committing an offence in giving end of life assistance to a person who has requested such assistance.

46. Contrary to criticisms made before the Bill was introduced, the proposal is in no way an alternative to palliative care. This Bill is primarily about giving an **option** of requesting an assisted death if suffering becomes intolerable. Its intention is to provide peace of mind and, if required, a truncated end of life experience, should that be the wish of what is likely to be a consistently small percentage of people dying each year. There is no reason to assume that Scotland will produce very different numbers of people, who wish to choose the time of their death, because life is no longer tolerable, and palliative care does not meet their needs, than in other territories.

47. Hospices have refined and improved palliative care, particularly for cancer patients, and palliative services delivered at home are becoming more common. However, for a small number of people, perhaps suffering from Huntingdon's, or virulent MS or Parkinson's, for example, palliative care at the end of life does not accomplish a dignified death.

[20] Scottish Parliament, Official Report 24 September 2009, Col. 19969

48. These are the people for whom this Bill would enable a peaceful, dignified end of life rather than a prolonged period of misery as they approach death.

49. It should also be noted that, judging from the Oregon, Dutch and Dignitas experience, a sizable minority of those making a choice in favour of assisted death do not eventually exercise that choice. This has been described to the Member as an "insurance policy" by sufferers of progressive, incurable conditions who believe that the approach to the end of their lives would be more tolerable if they knew they had the ability to end it should it become intolerable.

50. Marcia Angell's opinion quoted on page 1 is amplified by a report produced by a House of Lords' Select Committee that investigated the issue:

> "There was a general consensus among our witnesses as regards the limitations of palliative care in relieving patient suffering. The Voluntary Euthanasia Society took the view that "no amount of palliative care can address some patients' concerns regarding their loss of autonomy, loss of control of bodily functions and loss of dignity. An ability to meet these needs arises not because of a failure of palliative care but because these are person-centred issues. These issues most frequently lie at the heart of a request for help to die". Dr David Cole, a consultant oncologist at the Oxford Radcliffe Trust, took the same view. "There is a group of patients," he told us, "who continue to have intractable distress despite the input from expert palliative medicine, expert general practitioners, etc. That small group of patients who continue to suffer intractable distress may express a wish to choose the time at which they want to die". The BMA echoed this view, observing that "there are patients for whom even the best palliative care is not dealing with their pain", adding that "in spite of excellent palliative care, the position is not necessarily one which those patients regard as beneficial to them… the loss of autonomy"."[21]

51. Belgium demonstrates how palliative care and assisted death can compliment one another. A study carried out by the Vrije Universiteit Brussel in Belgium concluded that the use of specialist multidisciplinary palliative care was often associated with medical decisions to end a patient's suffering. There was no evidence that patients who don't use palliative care services are more likely to choose euthanasia.[22]

The Slippery Slope And Pressurised Old People

52. Before the Bill's introduction, and therefore in advance of knowing its precise provisions, critics expressed fear about so-called "legislative drift" in relation to this Bill as had been seen in relation to the Abortion Act 1967 (c.87). As the Member also wishes to avoid "drift" a considerable effort has gone into providing a tightly defined and clear process and into incorporating detailed protections.

53. Another concern about the Bill before its publication was that it would encourage relatives to put pressure on older people to request assisted death, or, that elderly, perhaps

[21] Select Committee on the Assisted Dying for the Terminally Ill Bill, First Report, 3 March 2005
[22] http://www.dentalplans.com/articles/44066/euthanasia-palliative-care-work-in-unison-in-belgium.html

vulnerable and lonely people, would feel that they had lived their life and had a duty to stop being a burden on their family.

54. Such people do not come within the Bill's scope. Old age is not a qualifying condition to receive an assisted death. The Bill also protects the elderly and vulnerable from being coerced into requesting an assisted death. In the course of the process, there are 5 separate checks by medical practitioners as to whether the person is being coerced into making the request. In addition, both requests for end of life assistance require to be signed by 2 witnesses who attest to the fact that the person is under no coercion.

55. It is possible that some people may attempt to access assistance and in so doing, access support and care, palliative or otherwise, that they were not aware of being available or entitled to.

Dignity

56. At present, people wishing to receive an assisted death in Switzerland have to be healthy enough to travel and physically capable enough to take the medication that brings about the end of life. This means that people are dying earlier than they would otherwise choose if the law in Scotland was more compassionate.

57. When Dr Anne Turner travelled to Switzerland in January 2006, she had relatively few of the symptoms of progressive supranuclear palsy that had been diagnosed the previous summer. At the time, Dying in Dignity, a group campaigning for choice at the end of life, argued that this was evidence of how the law on assisted dying was shortening rather than prolonging lives. A spokesperson stated:

> "Anne Turner would not have been forced out of Britain to go to Zurich whilst she was still able to travel for help to die. She would be alive today."[23]

58. It is the Member's view that forcing people into a position where they feel they have to end their lives prematurely to satisfy that the law is not humane. The interim policy produced by the DPP in England and Wales still requires a person to travel at a relatively early stage in the development of their condition.

59. Some respondents to the consultation argued that the provision of assisted dying would lead to people taking their lives early on in the development of their conditions. It is one of the key aims of this Bill to ensure that people are not forced into a situation where, in order to receive an assisted death, they have to pursue it before their life becomes intolerable.

60. This Bill will for some persons prolong life. It allows persons requesting an assisted death to seek it only when they have reached the point at which they find life intolerable. They will not be forced into requesting an assisted death at an earlier date simply because of the need to travel and the ability to take the medication themselves.

[23] http://news.bbc.co.uk/1/hi/health/4625538.stm

61. This Bill allows death at home if that is what is desired. It provides the freedom to choose where to die, to choose a comfortable private place which contributes to the sense of a dignified death and to be supported by friends and family if desired.

Suffering

62. It is cruel to force a dying person suffering uncontrollable pain who wishes to die to continue living. Some terminally ill patients die in terrible pain. A study found that 50% of conscious patients who died in hospital experienced moderate to severe pain in the final 3 days of life. [24]

63. Similar sentiments were expressed in many of those responses to the consultation supporting the proposal:

> "Dying is bad enough; why should a person have to die in pain? We do not allow dying animals to suffer; we put them out of their misery. Why not do the same for people?"

64. Gloria Thomson suffers from Huntingdon's disease. She watched her father die from the disease and is watching as another sister suffers severely from the disease. She was also forced to watch her other sister die from cancer:

> "My other sister died from cancer and I was with her in her last few days. It was terrible that no-one could help her - she just had to lie there in pain waiting to die."[25]

65. A connected and recurring feature in consultation responses was concern that developments in medical science had led to some lives being prolonged, but not necessarily improved. It was suggested that some people are living longer, but without quality of life, plagued by pain.

66. One of the key reasons for the Member pursuing this proposal is to ensure that a person meeting the criteria contained in the Bill should have the option of requesting an assisted death and they should not have to continue to suffer.

Autonomy

67. Although suffering is a prominent justification given for legalising assisted dying, findings from Oregon would suggest it is not only or even primarily physical pain that leads patients to request it. The Fifth Annual Report on Oregon's Death with Dignity Act noted: "... patient requests for lethal medications stemmed from multiple concerns related to autonomy and control at the end of life. The 3 most commonly mentioned end-of-life concerns during 2002 were: loss of autonomy, a decreasing ability to participate in activities that made life enjoyable, and losing control of bodily functions."

[24] http://jme.bmj.com/cgi/content/full/31/4/235
[25] http://www.dignityindying.org.uk/personal-stories/uk/scotland/gloria-thomson-story-12.html

68. 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"[26]. 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". [27]

69. The view that autonomy related concerns were more prominent than fears of pain among Oregonians requesting assisted dying was supported by a study published in the *Journal of Palliative Medicine* in June 2003. "Being in control and not dependent on other people is the most important thing for them in their dying days,"[28] said Dr Linda Ganzini, a psychiatrist at Oregon Health & Science University who led the study. This was exemplified by one patient quoted by her doctor as saying: "I want to do it on my terms. I want to choose the place and time. I want my friends to be there. And I don't want to linger and dwindle and rot in front of myself".

70. It was argued by some consultation responses that this Bill was promoting "unrestricted" personal autonomy. As explored in the following section, this Bill puts in place a series of checks to ensure that all those considering entering into the process are protected.

Safeguards

71. It is widely known that assisted deaths are taking place in secret without safeguards to protect vulnerable persons. This Bill incorporates many protective measures to ensure that the vulnerable are not put at risk and deaths are conducted transparently and humanely.

72. Helene Starks from the University of Washington highlighted the dangers associated with not legalising assisted dying:

> "I believe that physician-assisted suicide should be legalized because that allows for more scrutiny and application of the safeguards. The practice is happening regardless of the legal status; keeping it illegal has the potential to cause more harm than good as it restricts access to knowledgeable social services and health care providers who may help patients and families explore other options to achieving a good death, leaving PAS [physician-assisted suicide] as truly an option of last resort."[29]

73. An article in the Guardian, suggested that legalising assisted dying had actually resulted in a reduced rate of assisted deaths in Oregon:

> "…10 years after an assisted dying law was passed, there is no evidence of abuse. On the contrary, there are now 4 times fewer cases than in states where it's illegal: once people

[26] Assisted Suicide: The Philosophers' Brief, By Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, T.M. Scanlon, Judith Jarvis Thomson
[27] Assisted Suicide: The Philosophers' Brief, By Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, T.M. Scanlon, Judith Jarvis Thomson
[28] http://www.liebertpub.com/products/product.aspx?pid=41
[29] http://aclu.procon.org/viewanswers.asp?questionID=000752

know they can die whenever their illness becomes unbearable, they don't need to make the choice early out of fear of losing control."[30]

74. The specific detail of the protections contained within the Bill is explored at greater length later in the next section of the memorandum. In general terms, however, there are 6 levels of protection, within which there are a number of other checks:

- Firstly, the eligibility criteria, requires persons to be 16, to have been registered with a medical practice in Scotland for 18 months, to be mentally capable of making the request and to be in one of 2 categories of person prescribed in the Bill.

- The second level is provided by the need for the person to make 2 separate requests for assistance. Ensuring that it is clear that the person is making the request themselves. Moreover, these requests must be witnessed again, providing another check on the process.

- The third level of protection is provided by the medical scrutiny of the requests. The person requesting an assisted death is required to make 2 requests and at both stages the person is examined by both a registered medical practitioner and a psychiatrist. The registered medical practitioner is also required to be satisfied that the person continues to meet the criteria at the point at which end of life assistance is to be provided.

- Fourthly, there are time constraints within the process. These constraints, do however, provide sufficient time for the person to give due consideration to the enormity of the decision.

- Fifthly, there are constraints upon the nature of the assistance used to end life. The assistance must be such that it enables the requesting person to die with dignity and a minimum of distress.

- Finally, under the terms of the Crown Office and Procurator Fiscal Service guidance[31] on the reporting of sudden deaths, each death must be reported to the Procurator Fiscal. It is anticipated that each death will be investigated by the Procurator Fiscal to ensure all the safeguards and protections have been met.

CONSULTATION

75. The consultation document accompanying the draft proposal for the End of Life Choices (Scotland) Bill was issued on 8 December 2008 and ran until 9 March 2009.

76. It was issued to 139 organisations and individuals with an interest in the issue. The consultation document was also made available from a link on the Proposals for Members' Bills webpage on the Scottish Parliament Website. The Scottish Parliament: - Bills - Proposals for Members' Bills

[30] http://www.guardian.co.uk/commentisfree/2008/dec/13/assisted-suicide-law-polly-toynbee
[31] http://www.crownoffice.gov.uk/Publications/1998/11/DeathandthePF

77. In addition, the Member answered in excess of 250 requests for copies of the consultation.

78. In total 405 formal responses were received.

79. In advance of the launch of the consultation, the Member received 127 informal responses. Of these, 94 offered support with 7 opposed.

80. Responses to the formal consultation were drawn from a wide spectrum of society. They can be grouped into 6 distinct groups:

- Personal Experience
- Moral Conviction
- Religious Faith
- Professional Medical Background
- Campaigning Group
- Other

81. Of particular interest in the responses was the strong support for the proposal amongst those people who had a personal experience of a progressive and degenerative condition. This varied from those who themselves had a progressive and degenerative condition to those who had seen or were seeing close friends and family suffer. This group of people indicated that there were cases where palliative care had been unable to offer relief and in these instances they argued that having the option to request an assisted death would be welcome.

82. Some concern was expressed about increasing numbers of people seeking assisted deaths. There is no expectation that numbers of people receiving assisted deaths will increase significantly in the years following the implementation of the Bill. Responses to the consultation document raised concerns about this Bill being the beginning of a "slippery slope" toward non-voluntary euthanasia as well as ever increasing numbers of people receiving assisted deaths. The Bill, however, has been drafted in such a way that its purpose is clear and that it is about giving people freedom of choice to end their life in a dignified way. Given that its focus is personal freedom, it is not a Bill that could be used to implement non-voluntary euthanasia. Nor, is there any evidence to suggest that when assisted dying has been introduced elsewhere, numbers receiving assistance have increased year on year. During the debate on Lord Falconer's amendment to the Coroners and Justice Bill, Lord Joffe highlighted the stability in the numbers requesting assisted deaths in Oregon and the general compliance with the ethos of the legislation there:

> "In 2008 there were 50 assisted deaths in Oregon…. The previous year there were 49 death, and 48 the year before. The year before that there were 47 – hardly a slippery slope. The report also states that the Oregon medical board found no violation of good faith compliance with the Act."[32]

[32] http://www.publications.parliament.uk/pa/ld200809/ldhansrd/text/90707-0008.htm

ALTERNATIVE APPROACHES

83. In the consultation document, it was proposed that there be 3 eligibility grounds, the final one of which was expressed in the following terms:

> "And thirdly persons who are not terminally ill, suffering from a degenerative condition, or unexpectedly incapacitated but who find their life to be intolerable."

84. Much of the concern amongst the medical profession in the responses related to this. It was argued that it was too permissive and would place vulnerable people at risk. Based on these concerns, the Member removed it.

85. In the consultation document, provision for the involvement of psychiatrists was only made in relation to those requesting an assisted death who fell into the third category of person in the consultation document as described above. It was argued by respondents that this provided an insufficient safeguard and risked doctors missing co-morbidity. Given these concerns, the Member deemed it appropriate to extend the involvement of psychiatrists to all requests. This has the additional benefit of imposing another check on the work of registered medical practitioners.

86. In addition to seeking general views on the proposal, the Member asked a series of questions in the consultation document in order to inform her policy. The Member gave serious consideration to these and has drawn on them in forming the policy. Reference to issues raised in responses and the approach taken can be found throughout this memorandum.

HOW THE BILL WORKS

Request for end of life assistance

87. The Bill enables a person to request end of life assistance and establishes that the provision of end life assistance is not a criminal offence.

Eligibility conditions

88. Only capable adults, registered with a medical practice in Scotland for at least 18 months will be eligible to request an assisted death.

89. The Bill defines an adult as a person who is 16 years old or over on the date of making the first documented request to a registered medical practitioner.

90. It is not necessary for the person to be registered with the same practice in Scotland for 18 months nor is it necessary for them to be registered with the same medical practitioner. It is increasingly improbable that a person would see the same general practitioner at a practice. The management and operation of medical practices is such that when making an appointment, it is more common to see the first available general practitioner than to see the same general practitioner time and time again. It is equally possible that a general practitioner might move

away from the person's surgery or retire or that the person may themselves move, perhaps at the onset of their condition in order to be closer to friends and family.

91. The purpose of the registration provision is to prohibit so-called 'suicide tourism'. It is understood from the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004 (S.S.I. 2004/115) that while you are not required to be in the practice area to register with that practice, a practice can reject a request to be registered on the grounds that the person is not resident in the practice area. People who have emigrated from the UK, but return sometimes for visits would not normally be entitled to free NHS treatment from a practice. Any person who leaves the UK to live abroad will be removed from his or her practice's list after 3 months.

92. The Bill requires persons to be mentally capable in order to make a request and uses a similar definition of incapable to that within the Adults with Incapacity (Scotland) Act 2000 (asp 4).

93. To address concerns raised in the consultation responses and to increase the protections contained within the Bill, the Bill also requires a psychiatrist to assess each person making a request and to do so after both the first and second request have been made. This approach provides a degree of certainty around diagnosis of capacity and added protection for persons who may be vulnerable or depressed. This is discussed further at paragraph 112.

94. Further to the above eligibility requirements, the Bill details the medical conditions that a person must suffer from in order to be eligible to request end of life assistance. In this regard, there are 2 categories of person who will qualify for an assisted death under the terms of the Bill.

95. Firstly, persons who have been diagnosed as terminally ill and find their life intolerable. The phrase 'terminally ill' is defined and follows the general understanding of members of the medical profession to relate to a life expectancy of approximately 6 months.

96. The second category applies to persons who are permanently physically incapacitated to such an extent as not to be able to live independently and as a result find life intolerable. This category incorporates persons who either suffer from a progressive condition and have become permanently physically incapacitated as a result of it, or to persons who have been involved in a trauma which has resulted in them being permanently physically incapacitated. This permanent physical incapacity in itself is not enough to qualify for an assisted death, it is necessary that as a result of the incapacity they are unable to live independently and that they find life intolerable.

97. The Bill does not define "intolerable". It will be for the person requesting an assisted death to determine that they find their life intolerable. The registered medical practitioner will assess the person and require to be satisfied that the person does indeed find their situation as a result of that condition intolerable.

Process

98. The Bill provides a clear and linear process to be followed by a person requesting an assisted death and the registered medical practitioner considering it. The process includes a series of checks and safeguards to ensure that the conditions are met. The process also requires detailed written evidence of the requests and the medical determinations. The process has been designed to ensure that to receive such assistance a person's eligibility, capability and desire to receive an assisted death is thoroughly tested and that all alternative options are fully explored. All other alternatives should have been explored before an assisted death is agreed.

First request

99. To initiate the process the person seeking an assisted death must make a request to any registered medical practitioner.

100. All requests require to be attested to by at least 2 witnesses. Amongst other things, they will be required to attest that the person has not come under any undue influence in making the request.

101. Restrictions are placed on who can be a witness to ensure independence and impartiality. For example, exclusions are made for persons who may benefit financially from the death.

102. Should care home residents seek assistance to die, a responsible individual should be nominated by the management as a witness. This person should be in a position to judge whether the requesting person was influenced or coerced into seeking help to die. If, however, the care home service does not designate a witness then this should not frustrate the process and if no one is identified in a reasonable period of time then this requirement is removed. There would, however, still be a need for 2 witnesses.

103. The registered medical practitioner will consider the request along with a psychiatrist not related or financially connected in any way to the registered medical practitioner. They will confirm eligibility, discuss the medical condition, discuss alternatives and determine whether the person is mentally capable of making such a request.

Second request and end of life process

104. In order to qualify for an assisted death, a second written request must be made to the registered medical practitioner who approved the first request. Such a second request, can only be made after a waiting period of 15 days from the date on which the requesting person was informed of the approval, but no later than 30 days after that date.

105. The delay is designed to provide the person a reasonable time to consider whether they wish to continue. Equally, it limits the time the approval is valid.

106. If the registered medical practitioner and psychiatrist agree to the second request then the requesting person and registered medical practitioner will agree how and where the assisted death is to take place. They will also agree who will bring about the end of life. This agreement

will be recorded in writing. The recording of this information provides a further safeguard and clarity to the process.

107. The means of death must be humane and minimise the distress to the person receiving end of life assistance. The Bill aims to provide a good death with dignity at the end of life.

108. The means required to provide end of life assistance can only be administered by persons who are not a relative of the requesting person, not a person who would benefit from the requesting person's estate on the requesting person's death or would have another interest in that death. Regardless of who provides end of life assistance, the registered medical practitioner must be present at the end of the requesting person's life.

109. The means to be used and the method of delivery is not specified in the Bill. This reflects an individual's choice, acknowledges medical development and accepts expertise is best left to registered medical practitioners.

110. The place where an assisted death is to take place must be private and not one to which the public would have access at the relevant time. While the general public would be precluded from being present in the place where the end of life assistance is to take place, the friends and family of that person or any such person that the requesting person should wish may be present.

111. After the agreement has been reached there is a period of 2 clear days in which assistance cannot be provided. This is to allow the requesting person a final opportunity to consider whether or not they wish to continue. The agreement can only apply during a period of 28 days from the date the person was advised that the second formal request had been approved, after which the authorisation is no longer valid.

Role of medical practitioner and psychiatrist

112. The registered medical practitioner's role is to consider eligibility, to explain the process, to discuss alternatives and to consider whether the request is made voluntarily. The psychiatrist's role is primarily to consider capability and whether the requesting person has come under any undue influence in making the request. There is no limit on how much time or how many consultation sessions a registered medical practitioner or psychiatrist dedicate to considering the requests. It is key to the process that a correct determination is made about the person's capability to make the request. It should not, however, be forgotten that the person is making the request because they find their life intolerable and as such the process should not be unnecessarily prolonged.

Objections

113. 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.

114. 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.[33]

115. 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.[34]

Crown Office and Procurator Fiscal Service

116. The legislation ensures that provided the specified processes have been properly followed, a person providing end of life assistance to a person who has requested such assistance will not be committing an offence.

117. It is the Member's understanding that any assisted death under this Act will have to be reported to the Procurator Fiscal.

118. The Procurator Fiscal is a lawyer employed within the Crown Office and Procurator Fiscal Service. The Procurator Fiscal's best known role is as the local public prosecutor but they have a separate duty to investigate all sudden, suspicious, accidental, unexpected and unexplained deaths and any deaths occurring in circumstances causing serious public concern. The Procurator Fiscal's powers to investigate such deaths are se out in the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

119. It is the Member's understanding registered medical practitioners would be required to report assisted deaths to the Procurator Fiscal.

120. Guidance prepared by the Crown Office sets out what information the Procurator Fiscal will require:

> "…what is required is sufficient information to enable the Procurator Fiscal to decide whether it is appropriate to accept any death certificate which may be offered or whether to initiate further action, for example by instructing the police to investigate and report. The

[33] http://www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs.asp
[34] http://www.gmc-uk.org/guidance/ethical_guidance/personal_beliefs.asp

history will also assist the Procurator Fiscal to decide whether to instruct a post mortem examination."[35]

121. The information that a registered medical practitioner is required to record in the course of this process should be ample to meet these demands.

122. It is anticipated that a procurator fiscal will most likely pursue one of 3 courses of action on receiving a report:

- Take no further action. This is the usual decision if the doctor reporting the death is prepared to issue a Death Certificate and the Procurator Fiscal is satisfied from the history reported that the death does not require further investigation.

- Request a police report. The requesting of a police report does not mean that the Procurator Fiscal regards the matter as criminal. In such a situation the police are acting as the agents of the Procurator Fiscal and gathering information on his or her behalf. The Procurator Fiscal will almost always instruct a police report in a case where instructing a post mortem examination is anticipated. It can be anticipated that, at least in the early years, this is the likely course of action when an assisted death is reported.

- Consent to a hospital (non-PF) post mortem examination. Occasionally where the cause of death has not been certified, a hospital doctor will inform the Procurator Fiscal that the hospital has received permission from the relatives to carry out a post mortem examination. If the death does not otherwise require investigation the Procurator Fiscal will normally permit the hospital post mortem to proceed, subject to being advised of the cause of death.

123. It is not anticipated that this Bill will increase the work load on Crown Office Procurator Fiscal Service (COPFS). 13,500 deaths are currently annually reported to the COPFS. The addition of an extra 50 deaths is unlikely to have a significant impact on the working of the service. Indeed, the volume of documentary evidence required by the Bill and the transparency of the process should assist the work of the Procurator Fiscal.

124. The consultation document proposed that a specific review committee be established to assess whether the process prescribed in the Bill had been adhered to by the registered medical practitioner. Following discussion with members of the medical profession and consideration of COPFS guidance it is considered that it would be incumbent upon registered medical practitioners to report assisted deaths to the procurator fiscal. If a review committee had been established it would be performing the same role as a procurator fiscal in assessing whether the process detailed in the Bill had been adhered to. If, the review committee had had any concerns, they would then have drawn the case to the attention of a procurator fiscal. It was therefore clear that a review committee would be a costly and unnecessary inclusion in the Bill adding nothing to the protections already incorporated.

[35] www.copfs.gov.uk › Publications › 1998 › November

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

Equal opportunities

125. The Bill will have a positive impact on issues of equality.

126. The Bill provides options for an assisted death to those meeting the criteria prescribed in the Bill who express a clear and consistent desire to end their lives. The categories of person to whom the Bill applies is clear and requests will be thoroughly scrutinised.

127. It is interesting to note the comments of the MS Society in the aftermath of the publication of the DPP's interim policy on assisted dying:

> "People have been given the green light to explore assisted suicide, but without the support of medical professionals their only likely resource is Google.
>
> Whether society is ready to accept assisted suicide is too big a question for the DPP, for the courts, or for people with a long-term condition to decide.
>
> That's why the MS Society is calling for a Royal Commission to advise the government on whether legislation for assisted suicide is now needed."[36]

128. For those seeking an assisted death, the only viable option has been to travel to Switzerland. For many, however, it has 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.

129. The Bill equally has in place a series of stringent protections, to ensure that those seeking an assisted death are resolute in their request, are not being coerced and are mentally capable of making the request. 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.

Human rights

130. It is considered that the provisions in the Bill are compatible with the European Convention Rights. The most relevant Convention rights for the purposes of the provisions of the Bill are Articles 2 (right to life) and 8 (right to respect for private and family life), and they are considered further here.

[36] http://www.mssociety.org.uk/news_events/news/press_releases/dpp_guidance.html

Article 2

131. Article 2(1) provides:

> "*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.*"

132. Paragraph 2 of Article 2 sets out some limited exceptions to that provision's prohibition on the deprivation of life in relation to the use of force where absolutely necessary: in defence of any person from unlawful violence; in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; or in action lawfully taken for the purpose of quelling a riot or insurrection.

133. There are 2 aspects of Article 2 which are particularly relevant to the provisions in the Bill. These are the general prohibition in Article 2 on the deprivation of life, and the corresponding obligation on the state to ensure that everyone's right to life is protected by law.

134. The Bill creates an exemption from existing Scots criminal law where a person provides a requesting person with end of life assistance in accordance with the requirements set out in the Bill. Consideration has been given as to how the legislative framework established by the Bill, under which end of life assistance may be provided, sits against Article 2.

135. In the case of *R Pretty v DPP [2002] 1 AC 800* the House of Lords held that a right to die could not be read into the right to life protected by Article 2. Mrs Pretty took her case to the European Court of Human Rights in Strasbourg *(Pretty v UK (2002) 35 EHRR 1)* which confirmed the decision of the House of Lords on the point that Article 2 did not encompass a positive right to die.

136. The Member considers that Article 2 would not preclude legislation which permits assisted dying where accompanied by adequate safeguards to protect life. The *Pretty* case simply established that there was no negative aspect to Article 2 which conferred a right to die. Indeed, the decision of the Strasbourg court in *Pretty v UK* left open the question of whether legislation on assisted dying would be permissible under Article 2, and indicated that its determination of any such question would require regard to the circumstances of individual legislation. The Court noted (at paragraph 41 of its decision):

"The applicant has argued that a failure to acknowledge a right to die under the Convention would place those countries which do permit assisted suicide in breach of the Convention. It is not for the Court in this case to attempt to assess whether or not the state of law in any other country fails to protect the right to life. As is recognised in the case of Keenan, the measures which may reasonably be taken to protect a prisoner from self-harm will be subject to the restraints imposed by other provisions of the Convention, such as Articles 5 and 8 of the Convention, as well as more general principles of personal autonomy. Similarly, the extent to which a State permits, or seeks to regulate, the possibility for the infliction of harm on individuals at liberty, by their own or another's hand, may raise conflicting considerations of

personal freedom and the public interest that can only be resolved on examination of the concrete circumstances of the case."

137. Since the matter was left open in *Pretty v UK*, the question of the compatibility of national legislation on assisted dying with Article 2 has yet to be addressed by the European Court of Human Rights, or the UK domestic courts. The paragraph from the *Pretty* case quoted above could be read to suggest that, in assessing the reasonableness of national legislation and safeguards to protect life, the Strasbourg court may have regard to notions of personal autonomy protected by other Convention rights, such as Article 8, and elsewhere. Therefore, the recent decision of the House of Lords in *R (Purdy) v Director of Public Prosecutions [2009] 3 W.L.R.* that the manner in which an individual chooses to die falls within the ambit of Article 8, would likely have some bearing on any assessment of measures on assisted dying in the UK (such as this Bill) against Article 2.

138. It is considered that the provisions in this Bill would not amount to a deprivation of life or failure to protect life adequately within the meaning of Article 2. Article 2 imposes an obligation on State Parties to protect life, but it does not prescribe the detailed criminal or civil legislation which a state must put in place to give effect to that obligation; such matters are left to the discretion of the state at the national level. The detailed provisions of the Bill are regarded as sufficient to give effect to that obligation.

139. Section 1(1) of the Bill creates an exemption from the criminal law, and delictual liability, where a person gives end of life assistance. That exemption is closely confined, however, by a number of requirements set out in the Bill in order to protect life. In the first instance, there are certain eligibility criteria with regard to requesting end of life assistance. Safeguards are incorporated into the Bill's processes for the consideration and approval of requests for end of life assistance. Among other things these include witnessing, and the close involvement of a registered medical practitioner and a psychiatrist throughout the process. Any end of life assistance must be such that enables the requesting person to die with dignity and a minimum of distress. A registered medical practitioner will remain present throughout the actual provision of assistance until death, and it is intended that all deaths under the Bill be reported to the Crown Office and Procurator Fiscal Service and be subject to further investigation where considered necessary.

Lord Joffe's Assisted Dying for the Terminally Ill Bill – consideration of Article 2 by the UK Parliament's Joint Committee on Human Rights

140. By way of further background in relation to Article 2, it is interesting to note the consideration given to that article by the UK Parliament's Joint Committee on Human Rights the Assisted Dying for the Terminally Ill Bill, a Member's Bill introduced by Lord Joffe in the House of Lords. The scheme of that Bill was broadly similarly to this Bill, although the substantive detail of its provisions differed. The Joint Committee commented on that Bill as follows,

> *". . . we cannot state categorically that a Bill to allow assisted dying would be compatible with Article 2. Nevertheless, we find the following propositions persuasive—*
>
> - *The State usually has a duty not to deprive people of life intentionally.*

- *It also has a positive obligation to take appropriate steps to protect the lives of people whom it knows to be at risk of being intentionally deprived of life.*
- *The State's positive obligations are not absolute. They depend on what is reasonable and practicable in the circumstances of each case. When considering this matter, the State has a margin of appreciation (or, in domestic courts, a discretionary area of judgment) in which the courts must, within limits, respect a properly made assessment by the primary decision-maker.*
- *When deciding what positive steps are appropriate to protect life within its area of judgment, it is legitimate for the State to take account of other rights and the circumstances of individual cases.*
- *Patients have other rights, beside the right to life. As established in Pretty v. United Kingdom, competent patients have a right to self-determination and personal autonomy under Article 8.1. The State may, if it sees fit, interfere with this right in order to protect the rights of vulnerable patients, and does not thereby violate either Article 8 or Article 14. However, the State may equally come to the conclusion that there are good reasons for not interfering with decisions of particular patients and with the acts of professionals pursuant to those decisions. In other words, within its area of discretion it would be legitimate for a State to decide that it would be inappropriate to take State action through the criminal law to interfere with personal autonomy so as to give positive protection to life, if the circumstances are right.*
- *Those circumstances include, crucially, the adequacy of safeguards to ensure that vulnerable patients are not subjected to assisted dying against their wills."* [37]

Article 8

141. Consideration has also been given to the compatibility of the Bill's provisions with Article 8 of the European Convention on Human Rights. Article 8(1) provides,

"Everyone has the right to respect for his private and family life, his home and his correspondence."

142. The Bill does not give rise to any significant issues under this Article. The recent decision of the House of Lords in *R(Purdy) v DPP* is a pertinent one in that the House of Lords affirmed the position that end of life decisions could engage the right to respect for private and family life as set out in Article 8. This confirmed earlier suggestions to that effect by the European Court of Human Rights in its decision in the *Pretty* case.

Island communities

143. 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.

[37] http://www.publications.parliament.uk/pa/jt200203/jtselect/jtrights/74/7409.htm

Local government

144. There will be minimal if any direct impact on local government. The financial and resource impact of this Bill will be minimal.

ANNEX

LEGISLATIVE APPROACHES IN OTHER JURISDICTIONS

Legalised assisted dying is available in a number of countries and territories throughout the world. The Member has drawn on the experience of other systems and applied lessons in formulating her Bill.

European experience

In France, Finland, Germany and Sweden assistance in the suicide of another is not illegal. However, in these countries, in cases of assisted suicide a person could still be charged with failure to assist a person in danger. In other countries, there is a lesser charge associated with assisted suicide (Poland, Demark) or killing in response to "the person's earnest and insistent demand" or "out of compassion" for a "hopelessly ill person" (Austria, Denmark, Norway, Portugal and Spain). Spain amended its Penal Code in 1995 to recognise that active co-operation in the assistance of another person's death at the "express desire of the patient who is suffering from a terminal disease or a disease which produces serious and permanent suffering", will be punished with a lesser penalty.[38]

Four European countries have a legalised system of assisted dying.

Netherlands

In the Netherlands, voluntary euthanasia and physician assisted suicide has been permitted by the courts since 1984 with legislation in force since 2002. The physician ensures that the request for termination of life or assistance with suicide is made voluntarily by the patient, and establishes that the patient's situation entails unbearable suffering with no prospect of improvement.

The procedural requirements include that:

- the termination of life be performed by a physician
- before assisting the patient, the physician must consult a second physician, and
- the death must be reported as a case of euthanasia or physician-assisted suicide.[39]

Belgium

Belgium legalised euthanasia in 2002. The Belgian Act does not regulate assisted suicide. Euthanasia is defined as an act of a third party that intentionally ends the life of another person at that person's request. Persons must be over 18, resident in Belgium and suffering unbearably either physically or psychologically. The process is reviewed by a Commission whose role is to determine whether the euthanasia was performed in accordance with the legislation. The Commission can refer the case to the public prosecutor.[40]

[38] http://news.bbc.co.uk/1/hi/world/europe/7322520.stm
[39] http://www.euthanasia.cc/dutch.html
[40] http://www.assistedsuicide.org/suicide_laws.html

Switzerland

The Swiss Penal Code prohibits voluntary euthanasia (ending a person's life at his or her request), although it has a lesser sentence than other acts deemed homicide. The Penal Code does, however, provide that assisted suicide is permitted if the person assisting the suicide does so for unselfish reasons. Unlike in other countries the person assisting need not be a physician.[41]

The primary destination for those seeking an assisted death abroad has been Dignitas in Switzerland. Dignitas is an assisted dying group that helps those with terminal illness and severe physical and mental illnesses to die assisted by qualified doctors and nurses.

According to figures produced by Dignity in Dying, since 2002, 115 Britons are known to have travelled abroad to receive an assisted death, while others are preparing to travel.

Luxembourg

Luxembourg is the most recent country to have passed a law legalising euthanasia and assisted suicide in February 2008. Some conditions apply:

- The patient must be suffering from a terminal or incurable illness.
- The request must be made repeatedly.
- The consent of 2 doctors and a panel of experts is required. [42]

Outwith Europe

A growing number of territories outside of Europe have adopted assisted suicide.

The growth in legalising assisted dying is perhaps most marked in the United States. So far, 3 states have legalised assisted dying.

Oregon

In November 1994, Oregon legislated to allow terminally ill adult residents of Oregon, with a prognosis of less than 6 months to live, to obtain a prescription for medication for the purpose of committing suicide. Before a physician could issue such a prescription, certain conditions require to be met. These are:

- The patient has to make 2 oral requests and one written request for medication.
- A second medical opinion is required.
- At least 15 days has to have elapsed since the initial request for a prescription.
- The patient has to be capable, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist.

[41] http://news.bbc.co.uk/1/hi/world/europe/2676837.stm
[42] http://www.assistedsuicide.org/suicide_laws.html

- If the physician is of the opinion that a patient's judgment may be impaired by a psychiatric or psychological disorder or depression, the physician must refer the patient for counselling.
- The physician must verify that the patient is making an informed decision, and has been fully informed by the attending physician of:
    - his or her medical diagnosis
    - the potential risks associated with taking the medication to be prescribed
    - the probable result of taking the medication to be prescribed
    - the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

Since the law came into force in 1997 401 patients have received assisted suicide. During 2008, 88 prescriptions for lethal medications were written compared to 85 during 2007. Of these, 54 patients took the medication. 6 patients with earlier prescriptions died as a result of prescribed medication as well, resulting in a total of 60 assisted deaths during 2008. This corresponds to an estimated 19.4 assisted deaths per 10,000 total deaths. [43]

Washington State

In 2008 Washington State gave terminally ill people the option of medically assisted suicide.

Patients must be at least 18, competent and a resident of Washington State.

The patient makes 2 oral requests, 15 days apart, and submits a written request witnessed by 2 people, including one person who is not a relative, heir, attending doctor, or connected with a health facility where the requester lives.

2 doctors certify that the patient has a terminal condition and 6 months or less to live.[44]

Montana

In December 2008, Montana became the third US state to allow assisted suicide although the judicial decision is currently under appeal. [45]

[43] http://egov.oregon.gov/DHS/ph/pas/ar-index.shtml
[44] http://www.usatoday.com/news/nation/2009-03-01-washington-assisted_N.htm
[45] www.nytimes.com/2008/12/07/health/07montana.html

This document relates to the End of Life Assistance (Scotland) Bill (SP Bill 38) as introduced in the Scottish Parliament on 20 January 2010

END OF LIFE ASSISTANCE (SCOTLAND) BILL

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