

Submission to the End of Life Assistance (Scotland) Bill Committee by Christian Concern for our Nation and the Christian Legal Centre¹

Background

The End of Life Assistance (Scotland) Bill² was introduced in the Scottish Parliament on 20th January 2010 as a Members' Bill on behalf of Margo MacDonald MSP.³ The Lead Committee for Stage 1 of this Bill is the End of Life Assistance (Scotland) Bill Committee.⁴ This submission is our response to a call for written evidence of that Committee and answers the questions raised therein.⁵

1. Do you agree a person should be able to request end of life assistance from a registered medical practitioner?

No, we strongly disagree that a person should be able to request end of life assistance from a registered medical practitioner or from anyone else. We support the preservation of life, as reflected in Article 2 of the European Convention on Human Rights, which states: "Everyone's right to life shall be protected by law."⁶

We also do not accept the premise in the Policy Memorandum that people will find ways to kill themselves anyway. The experience of enacting the Abortion Act 1967 shows that many more women decide to have an abortion today than they did in the years prior to 1967 (14,600 per year up to 1966,⁷ compared with 195,296 in 2008⁸). Such permissive enactments do not merely improve outcomes for those who would like to end lives anyway (either at the start or the end of life); instead, they positively encourage the taking of life.

In Scotland, euthanasia is a crime punishable as a homicide.⁹ It should continue to be classed as murder.¹⁰ In our opinion, rather than legalising assisted suicide and voluntary euthanasia, Scotland should stand firm and retain its current criminal laws, which protect the ill, elderly and vulnerable.

The stated policy objectives and the purpose of this Bill put forward by Margo MacDonald in the Policy Memorandum accompanying the Bill are unconvincing.¹¹ For example, the purpose of the Bill¹²—to legalise assistance to end life—is intended to:

- Be available to a person where ***Life has become intolerable***.¹³ What "intolerable" means is not defined in the Bill, but the Explanatory Notes envisage a "subjective" self-assessment.¹⁴ Surely everyone feels that way sometimes and this Bill opens up the possibility that the depressed may be killed rather than treated. Research in Oregon has found that "the current practice of the Death with Dignity Act 1997 may fail to protect some patients whose choices are influenced by depression from receiving a prescription for a lethal drug."¹⁵ The Bill as drafted would not necessarily protect people who

are suffering from depression, because “mental disorder” is defined as including only “mental illness”, “personality disorder”, and “learning disability” and the assessment of mental disorder is only conducted for the purposes of ascertaining the patient’s capacity to make such a request. In any event, all people, regardless of any mental disorder, should be protected from any thought that they should end their lives.

- Provide **persons with a choice at the end of life... [so] they can have [a] dignified death.**^{16, 17} It is a myth that euthanasia, once legalised, can be adequately controlled. Once it becomes legalised it changes the culture of society and killing even becomes acceptable as a cheaper treatment option.¹⁸ The Dutch experience shows that around 1,000 patients are killed every year against their wishes or without consent by their doctors.¹⁹

Hence, the emphasis placed by euthanasia advocates on autonomy, or the right to control one’s own death, is misplaced. Evidence from the Dutch experience shows that “assisted dying” leads to the killing of defenceless people who have not expressed a wish to die—the worst possible denial of autonomy. It is claimed that euthanasia is about the “right to die” a “good death”. However, euthanasia is not about the “right to die”; it could lead to doctors having the right to kill their patients when treatment becomes too costly or burdensome in the view of doctors or in the perceived view of society.

The Bill contains no conscientious objection section to ensure that a person does not have to facilitate, participate in or assist with a requested killing. It is also a myth that euthanasia is a “good” or “dignified” death. Research in the Netherlands has shown that there are clinical problems with euthanasia and physician assisted suicide (PAS). For example, whilst patients are expected to die soon after taking the lethal drugs in PAS, 19% of patients took 45 minutes to seven days to die²⁰. In Oregon in 2009, the time from ingestion until death ranged from 2 minutes to 4½ days.

- **Good quality palliative care ensures a dignified and peaceful death, but for a small minority, this is not so.**²¹

No explanation is given as to why pain relief and good palliative care cannot apply to all.²²

The Bill and Policy Memorandum assume a rationalistic worldview that takes no account of the possibility of sudden, unexpected recovery, healing after treatment or prayer, or a consideration of the afterlife. A philosophy that gives people the choice to die creates moral relativism and grey areas in the law. The primary purpose of the law must always be to protect the weak and vulnerable not to provide an option for a few strong-minded individuals at the expense of the majority in need of the law’s proper protection.

2. Are you satisfied with the requirements for age and connection with Scotland as set out in the Bill?

No.²³ There is nothing to stop “doctor shopping”,²⁴ because section 4(3) allows the “requesting person” to register with different medical practices for any reason during the 18 months prior to their request. Therefore, it would be possible for a patient to register with a pro-euthanasia Scottish doctor who has little or no knowledge of their history or circumstances a week before the patient makes the first formal request for end of life assistance. This is an even greater danger, both because there is nothing to stop the two witnesses from being the doctor’s assistants/employees and because the Bill does not give either the designated practitioner or the psychiatrist any right to refuse a request for end of life assistance. The Bill should require registration with the same doctor for the duration of the 18 months in order to reduce the number of cases in which a doctor’s lack of knowledge of the patient could result in abuses of the system.

Young people aged 16 may still be living with, and dependent upon, their parents. Teenagers often suffer from depression, because it is a time of hormonal change and they are thus particularly vulnerable and require protection. The law should protect people of all ages, but particularly the young and the vulnerable. In fact, one of the reasons for the tightening up of the law on assisted suicide in the Coroners and Justice Act 2009 in England and Wales, was due to an outcry over teenage suicides because of suicide promotion websites and to protect them from harm.²⁵ This Bill does the opposite of providing protection and clearly puts young people at risk. No-one who has or is contemplating suicide should be helped or encouraged, especially not if they have their whole life ahead of them. The tragic consequences of creating grey areas in the law are all too evident. For example, in England and Wales, the “Living Wills” law (which was not meant to allow assisted suicide by the back door), may be revisited after a young woman of 26 was left to die because of an advance directive she had made. Her parents subsequently considered suing the hospital for allowing her to commit suicide in this way.²⁶

3. Are you satisfied with the two categories of people who would qualify to be assisted under the terms of the Bill?

No. Please see our comments in answer to question 2 on finding life intolerable.

The scope of the two eligible categories of those who may request end of life assistance is incredibly broad. Many thousands of seriously ill and disabled people in Scotland would fall within its remit.

The Bill states that the two categories of people who may request assistance are:

1. Those who have been diagnosed as terminally ill (if death within 6 months of that condition can be reasonably expected) and who find life intolerable, and
2. Those who are permanently incapacitated to such an extent as not to be able to live independently and who find life intolerable.

They include life-threatening illnesses and non-life-threatening disabilities.

In the first category, (section 4(2)(a)) “terminally ill” may well cover a substantial proportion of the causes of death in Scotland from 1986 to 2008, including Malignant Neoplasms (cancer), Ischaemic Heart Disease, Cerebrovascular Disease and Respiratory Disease.²⁷ Those four causes accounted for 36,920 (66.3% of the 55,700 total), for deaths in Scotland in 2008. The category is so wide that it could include conditions ranging from end-stage heart disease, to neurological diseases such as end-stage Parkinson’s or dementia, “co-morbidity” (deterioration due to damage to more than one system), and the elderly frail.

The length of time for determining whether an illness is “terminal” is six months, both in this Bill (section 4(4)) and in the Oregon Death with Dignity Act 1997. However, the Bill does not suggest any need for a recent medical prognosis or confirmatory prognosis for the patient’s life expectancy. Someone can live with cancer for a decade or more and in any event, exact diagnosis is likely to be very difficult and there are many examples of people who have lived many months or years beyond their life expectancy, such as in the case of breast cancer: “Overall, the 15-year survival rate for England, Wales and Northern Ireland is at 86 per cent for invasive cancers which have spread beyond the breast.”²⁸

According to doctors, predicting life expectancy is a bit like forecasting the weather in Britain—one can often be right, but often hopelessly wrong. Again, some life expectancy predictions prove to be self-fulfilling prophecies because of the low quality of care patients are given, whilst in other cases, patients manage to defy the odds because of their will to live. Such people should not be allowed to condemn themselves to death prematurely.

The Policy Memorandum accompanying the Bill, prepared on behalf of Margo Macdonald, argues that concern for the elderly evidenced in this Bill is misplaced because “Old age is not a qualifying condition to receive an assisted death.”²⁹ However, even if no age limit is ultimately inscribed in the Bill, it is likely to have serious implications for the elderly, lonely and vulnerable, because many elderly people could be described as “terminally ill”. In Scotland, the average age of death from all causes in 2008 including cancer, Ischaemic Heart Disease and stroke was 75.3 years.³⁰

In the second category, many disabled people could be seen as “permanently...incapacitated” (section 4(2)(b)) to such an extent as not to be able to live independently. Many disabled and elderly people need some form of

assistance and cannot live independently for many reasons, whether physical or psychological. Those with arthritis may experience such pain and stiffness as to need the help of a hoist, whilst those with heart disease may be too breathless to rise from a chair unaided. Such people should be encouraged to undergo treatment and be provided with help, support, care and assistance rather than be encouraged to end their lives. How is the term “to such an extent” to be interpreted or measured?

For example, a blind person may have difficulty in living independently without adaptations or aids and if none were to be provided or the patient were to be assessed before such aids were provided, the patient would be likely to fit within the Bill’s definition. In short, this Bill devalues dependent human life by implying that dependence is a ground for wishing oneself dead. By definition, disabled people require assistance and often live dependent lives. That is no reason for allowing them to request assistance to kill themselves.

4. The Bill outlines a several stage consent and verification process that would be required to be followed for an eligible person to receive end of life assistance. Are you satisfied with this process?

No, it is entirely unsatisfactory. “Assisted suicide” is defined as a person killing him or herself with the assistance of another person who may provide the means to do so, such as the tablets. “Voluntary euthanasia” entails the killing of a person by another (e.g. a doctor) with his or her consent, for example, the doctor putting the lethal drugs in the person’s mouth with their consent. “Non-voluntary euthanasia” involves the killing of a person who is unable to give consent (i.e. a person in a persistent vegetative state). “Involuntary euthanasia” ends the life of a person who has not been asked for consent and therefore without that person’s consent.

The definition of “end of life assistance” (in section 1(2)) does not refer to any of these terms, but “administration of appropriate means” is so broad that it could include not only assisted suicide/PAS but also voluntary euthanasia. The Bill does not state who is to provide the end of life assistance, which means that it could be the requesting person themselves or someone else (section 10(1)(c)). If someone else does so, then the act becomes euthanasia rather than assisted suicide. In Oregon, the Dying with Dignity Act does not allow euthanasia.³¹ Active euthanasia, such as injecting a person with drugs in order to make them die, is also still illegal in Sweden.³²

In England and Wales, assisted suicide is a crime punishable by up to 14 years imprisonment under the Suicide Act 1961 (as amended by the Coroners and Justice Act 2009)³³ and so-called “mercy killing” where someone takes the life of another is liable to a charge of murder or manslaughter. The Crown Prosecution guidance on Homicide states that:

148. *Murder is so serious that a prosecution is almost certainly required even in cases such as “mercy killing” of a sick relative.*³⁴

The verification process of the Bill is entirely unsatisfactory:

- The process requires the same doctor’s approval at both stages, which creates the risk of cases like those of Dr. Harold Shipman.
- The same or a different psychiatrist can provide a positive report at both stages, creating an analogous danger.
- Less than a handful of people can arrange for a person’s death (one doctor, one psychiatrist and two witnesses—one of whom could be responsible for the day-to-day care of the patient in a care home) with a complete lack of provision for independent monitoring, reporting or review. Even where independent measures (such as a review committee) have been used in the Netherlands, they have proven to be ineffective as a safeguard once the law allows end of life assistance.³⁵ This is particularly true, because such measures are not required on the face of the Bill.
- The drafting of the Bill is vague and full of euphemisms and ambiguities. It has many loopholes and there is nothing to prevent single-doctor-led private assisted suicide/euthanasia practices from opening up in every town and city in Scotland. This is because according to sections 2 and 12, any “registered medical practitioner” (as defined by section 2 of the Medical Act 1983³⁶) could play the role of the “designated practitioner” and be paid “reasonable fees” for doing so. The same applies to psychiatrists (section 5(2)(b)). It could also allow local GPs’ surgeries to terminate patients’ lives provided the public does not have access at the time when the end of life assistance is being provided (section 11(5)). The Explanatory Notes to the Bill³⁷ envisage that the bulk of the work will fall on general practitioners.
- The submission by the Scottish Government to this Bill’s Committee on 20th April 2010 states that “NHS hospitals are currently open to the public and in certain circumstances this is on a 24 hour basis”.³⁸ It is difficult to see how end of life assistance could be provided in an NHS hospital given that they are open to the public, in contrast with the requirements of section 11(5). The idea behind section 11(5) is that the death should take place behind closed doors. In Oregon the law was changed to require patients to be counselled on not taking the medication in a public place.³⁹
- There are no advertising or internet restrictions in the Bill. Advertising assisted suicide/euthanasia/death clinics is seen as a crime in England and Wales, but would be allowed in Scotland.⁴⁰ The Bill could lead to a culture of death in Scotland that normalises such advertising, leaving the young, vulnerable, depressed and elderly at great risk of undue influence. For

example, it has been reported that as a result of euthanasia laws in Holland and Belgium “please do not kill me” cards are in demand.⁴¹

- Because the two witnesses are not permitted to be relatives of the patient and are not required to be the same witnesses each time, (section 8(4)), their certification of the requests could be achieved without any knowledge of the person making each request and they might therefore be unable to determine or might not care enough to find out whether the request is being made voluntarily, is understood and has not been prompted by undue influence (section 6(2)(c)).
- Whilst no financial connection between the doctor and the psychiatrist is permitted (section 9(5)(b)), a local network referral system could easily operate.
- There is nothing to prevent a patient’s former spouse or former civil partner from being the designated practitioner, since the list of relatives is limited (section 12).
- There is nothing in the Bill to prevent a private medical clinic from taking commission from a local undertaker to dispose of the bodies after end of life assistance has been given.
- There are no independent monitoring, reporting or review requirements for the doctor, which is a serious oversight. However, even such safeguards are ultimately illusory, since the Dutch experience shows that death certificates for assisted suicides can be falsified as natural deaths to avoid additional paperwork and scrutiny.⁴²
- A superficial, “tick-box” approach to form filling, witness signing, consultations and report writing could easily achieve many of the processes described in the Bill and it could all be over within less than a month. Perfunctory questioning on matters such as the alternatives to end of life assistance would be sufficient to fulfil the Bill’s requirements. There is no need to refer the person for hospice and/or palliative care, only to discuss it (section 7(1)(b)).
- All of the safeguards proposed are procedural ones,⁴³ which could easily be circumvented despite their robust appearance. They would not prevent ideologically-driven doctors from putting patients on a “conveyor belt” to death.
- The primary decision-maker in this process is the person who makes the end of life request. The doctor and psychiatrist(s) are not able to refuse the patient’s request for end of life assistance if he or she is not suffering from any mental disorder that would affect the making of such a request and

meets the other eligibility criteria. Care not killing of patients should always be the primary motive in a civilised society.

- The doctor merely has to discuss the patient's medical condition based on the patient's own subjective assessment that they find life intolerable.
- The Bill provides no details as to the forms this end of life assistance may take, leaving open the possibility of assisted suicide and voluntary euthanasia by lethal drugs, gas poisoning, suffocation by pillow, electrocution, strangulation etc. This is a particular danger, because the Bill only requires the agreement between doctor and patient as to the means of death to be complied with "so far as reasonably practicable" (section 11(1)). In our view, therefore, the Bill should require exact compliance with the agreement between the doctor and patient.
- The diagnosis of terminal illness need only have been made at some point; it could be out of date (section 4(2)(a)).
- It is very regrettable that there is to be a longer "cooling off" period of fifteen days (section 8(1)(c)) after the approval of the first request, but a remarkably short cooling off period of only two days following the patient-doctor agreement as to how the patient's life is to be terminated. This appears to be the wrong way around, because the patient will have been put at ease by the doctor's assurance that the first request is revocable and by the fact that the death is not imminent, whereas the death must follow soon after the agreement is made. The two days between the making of the agreement to put the patient to death and its becoming effective is derisory in comparison with the cooling-off period available to consumers in connection with a simple hire purchase transaction.⁴⁴ There is no requirement that the doctor should reiterate the revocability of the second request, or to state that the agreement and request to die can be cancelled. There is not even a requirement that the doctor should remind the patient of the finality of his or her decision to die at any stage of the process. Whilst this may seem obvious, it is often difficult for people to grasp the finality of death, as the widespread provision of bereavement counselling shows.
- There is no requirement to report either of the requests for end of life assistance to the patient's relatives prior to the death. The patient's nearest and dearest may not find out until it is too late.⁴⁵
- Many of the terms in the Bill are not defined and clearly open to abuse. For example, even the definition of "end of life assistance" does not specify what constitutes "appropriate means" for the termination of life (see section 1(2)).
- The requirement that the designated practitioner (doctor) has to be present at the time of the death (section 11) seems to be included merely to give the

macabre process an air of respectability, since the doctor's role is not to prevent death.

- In the Netherlands, two thirds of the requests for euthanasia that are put to doctors are refused.⁴⁶ This Bill has an approval, not a refusal mechanism, which sends entirely the wrong signal to vulnerable people.
- The withdrawal of the request is dependent on only informal notice being given to the designated practitioner (section 3(1)). An unscrupulous doctor such as Dr Shipman could well ignore such a request.⁴⁷ The Bill's provisions are wholly inadequate in failing to provide a mechanism for reporting, monitoring or review.

5. Do you consider the level and nature of safeguards as set out in the Bill to be appropriate?

No, please see answer to question 4. There are absolutely no foolproof safeguards in this type of legislation that could ever properly protect the vulnerable from death. In Oregon, the evidence strongly suggests that safeguards there are circumvented in ways that are harmful to patients.⁴⁸ If a State disapproves of the death penalty because an innocent person could be killed, then they must also vote against this Bill, which could easily have the same outcome. It should not even be entertained. The European Court of Human Rights made the following statement in the case of *Pretty v United Kingdom* regarding the English and Welsh prohibition on assisting a suicide:

*...The law in issue in this case, section 2 of the 1961 Act, was designed to safeguard life by protecting the weak and vulnerable and especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life. Doubtless the condition of terminally ill individuals will vary. But many will be vulnerable and it is the vulnerability of the class which provides the rationale for the law in question. It is primarily for States to assess the risk and the likely incidence of abuse if the general prohibition on assisted suicides were relaxed or if exceptions were to be created. **Clear risks of abuse do exist...** (Our emphasis)⁴⁹*

6. Do you have any other considerations on the Bill not included in answers to the above questions?

- The safeguards are seriously defective. Evidence from countries that have brought in laws that are more stringent than this Bill shows that it is impossible to prevent abuses of such legislation. The evidence shows that it is equally impossible to prevent attitudes towards treatment decisions from changing; for example, euthanasia was even discussed in relation to conditions such as gastrointestinal obstruction.⁵⁰

- The Explanatory Notes assume that the NHS⁵¹ will be involved and that the number of deaths will be low.⁵² These assumptions are not borne out by this submission.
- The “right to die” can become a “duty to die”.⁵³ There was even a recent Dutch campaign in which training of non-medical staff to administer a lethal injection to healthy people over the age of 70 who "consider their lives complete" and want to die was proposed.⁵⁴ This is evidence of the validity of the “slippery slope” argument that warns against what happens when laws allow a culture of death to become acceptable in society.
- That a culture of death results in a more casual attitude to life and death as it becomes more socially acceptable, can be illustrated by the fact that in Oregon between 1998 and 2008 9.6% of PAS cases were referred for psychiatric evaluation, whereas zero percent were referred in 2008.⁵⁵
- The Bill gives the wrong message to the vulnerable, the ill and the elderly that they should request assistance to kill themselves to avoid being a burden. More than a third of end of life patients in Oregon between 1998 and 2008 gave that concern as a factor in their decision to seek end of life treatment.⁵⁶
- The vast majority of medical practitioners,⁵⁷ the BMA⁵⁸ and the Royal College of Physicians⁵⁹ do not support assisted suicide. “The BMA remains opposed to doctors taking a role in any form of assisted dying.”⁶⁰
- For Scotland to legalise assisted suicide or euthanasia would mean that the lives of the terminally ill, elderly, disabled, lonely, mentally-ill and depressed are seen to be of no value because they are not useful or lack meaning. Such a subjective utilitarian judgement should not be forced on the population of Scotland.
- Parliament in England and Wales has continued to vote against legalising assisted suicide,⁶¹ and the Scottish Parliament has rejected it twice.
- In Oregon, one survey showed that 45% of patients who were given good palliative care changed their minds about requesting euthanasia.⁶² We are pleased to note the Scottish Government’s support for palliative care.⁶³
- Palliative care and pain relief before death are rated poorly in Oregon where this type of law is allowed.⁶⁴ Even the architect of the Dutch law admits she may have made a mistake because of its impact on services for the elderly.⁶⁵
- Characteristics of elderly suicides and cases of deliberate self-harm in the United Kingdom suggest that depression, social isolation and loss, and

physical illness all are risk factors.⁶⁶ Hence, this Bill will put the most vulnerable lives at risk.

- In our opinion, the Scottish Government should directly oppose this Bill instead of allowing a free vote.⁶⁷ We note that Canada has recently voted against a Bill on PAS⁶⁸ and we would strongly urge the Scottish Government to do likewise.

Andrea Minichiello Williams, Barrister
Director
Christian Concern For Our Nation and the Christian Legal Centre
3rd May 2010

E-mail: info@ccfon.org

Tel: (07712) 591164 or (020) 7935 1488

¹ About Us

Christian Concern for Our Nation (CCFON) is a policy and legal resource centre that identifies changes in policy and law that may affect the Judeo-Christian heritage of this nation. The team of lawyers and advisers at CCFON conduct research into, and campaign on, legislation and policy changes that may affect Christian Freedoms or the moral values of the UK. CCFON reaches a mailing list of 25,000 supporters: <http://www.ccfon.org>. CCFON is linked to a sister and separate organisation, the Christian Legal Centre, which takes up cases affecting Christian freedoms: <http://www.christianlegalcentre.com>

²² See the Bill at: <http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/b38s3-introd.pdf>. The Bill, Explanatory Notes and Policy Memorandum can be found at this link: <http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/index.htm>

³ See the guidance on the Stages of a Bill:

<http://www.scottish.parliament.uk/business/bills/documents/AmendmentstoExecutiveBillsguidanceWebAugust08.pdf>

⁴ See: <http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/index.htm>

⁵ See the details of how to submit evidence:

<http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/currentInquiries.htm#evidence>

⁶ See: <http://www.echr.coe.int/nr/rdonlyres/d5cc24a7-dc13-4318-b457-5c9014916d7a/0/englishanglais.pdf>

⁷ Whilst it is extremely difficult to ascertain how many abortions were performed each year prior to the passing of the Abortion Act 1967 because they were illegal, the rise in the number of abortions in the years following the Act is instructive: from 23,641 in 1968 to 54,819 in 1969, some 126,000 in 1971 and 195,296 in 2008, see table 1 in the abortion statistics for England and Wales, 2008:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099714.pdf. Ann Farmer states in her authoritative work, *By Their Fruits: Eugenics, Population Control, and the Abortion Campaign*, that the Royal College of Obstetricians and Gynaecologists estimate that 14,600 illegal abortions were performed each year prior to 1967.

⁸ See the Department of Health's abortion statistics at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_099285.

⁹ See the Scottish Parliament's Official Report of 11.11.04 at:

<http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-04/sor1111-02.htm#Col11876>

¹⁰ See: <http://www.law.ed.ac.uk/sln/blogentry.aspx?blogentryref=7908>

¹¹ See pages 1 and 2 of the Policy Memorandum on the Policy Objectives of the Bill:

<http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/b38s3-introd-pm.pdf>

¹² Some of the main purposes of the Bill mentioned under "Policy Objectives" on pages 1 and 2 in the Policy Memorandum are quoted in bold italics to enable discussion of them in this response. For the Policy Memorandum, see the following link: <http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/b38s3-introd-pm.pdf>

¹³ See point 2 on page 1 of the Policy Memorandum which states: "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." *Ibid.*

¹⁴ See the Explanatory Notes to the Bill at point 21, which indicates that the assessment includes a psychiatric assessment, yet there is no need for any medical assessment to be made—only a requirement for the medical condition to be discussed. For the Explanatory Notes, see the following link: <http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/b38s3-introd-en.pdf>. The medical condition could be discussed from the starting point of the patient's subjective assessment; (see clause 9(2)(a)).

¹⁵ See: http://www.bmj.com/cgi/content/abstract/337/oct07_2/a1682?ijkey=bc7d37e92efbfea7ce03a2d59bfd0c8b4623fa04

¹⁶ See point 3 on page 1 of the Policy Memorandum, which states that: "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." See above, note 12.

¹⁷ See the account of the Lumberjack who took a lethal dose and woke up after 3 days:

<http://www.dailymail.co.uk/debate/article-1205138/The-chilling-truth-city-pay-people-die.html>

¹⁸ See: <http://www.telegraph.co.uk/comment/personal-view/4736927/Right-to-die-can-become-a-duty-to-die.html>

Barbara Wagner had recurrent lung cancer and Randy Stroup had prostate cancer. Both were on Medicaid, the state's health insurance plan for the poor that, like some NHS services, is rationed. The state denied both treatment, but told them it would pay for their assisted suicide. "It dropped my chin to the floor," Stroup told the media. "[How could they] not pay for medication that would help my life, and yet offer to pay to end my life?" (Wagner eventually received free medication from the drug manufacturer. She has since died. The denial of chemotherapy to Stroup was reversed on appeal after his story hit the media.) Despite Wagner and Stroup's cases, advocates continue to insist that Oregon proves assisted suicide can be legalised with no abuses. But the more one learns about the actual experience, the shakier such assurances become.

¹⁹ See Van der Maas PJ et al.: "Euthanasia and other medical decisions concerning the end of life", *The Lancet* 1991; 338: 669-74. Van der Maas PJ et al.: "Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands", 1990-1995. *NEJM* 1996; 335: 1699-705. Onwuteaka-Philipsen BJ et al.: "Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001", *The Lancet* online 17th June 2003, at <http://image.thelancet.com/extras/03art3297web.pdf>.

Three surveys done over a 10-year period by Dutch researchers show that in Holland, where euthanasia has been legalised, at least 1,000 patients are killed every year through euthanasia without consent or without request. This constitutes murder. The first report, published in 1991 showed that in 1,000 cases (equivalent to 0.8% of all deaths) physicians administered a drug with the explicit purpose of hastening the end of life without an explicit request by the patient. Two further reports from 1996 and 2001 confirm these findings. In 2001, still 1,000 deaths (0.7% of total) were due to patients killed against their wishes or without explicit consent.

²⁰ See Groenewoud JH et al. "Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands", *New England Journal of Medicine* 2000; 342: at 551-6.)

²¹ See point 5 on page 1 of the Policy Memorandum (cited above, note 12), which states that:

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.

²² See the Position Statement of the Scottish Council on Bioethics: "Palliative care can address the suffering of a terminally ill person", at: <http://www.schb.org.uk/publications/position%2002%20-%20assisted%20suicide.htm>

²³ The Bill states that in order to be eligible for end of life assistance, a person must be aged 16 or over and must be registered with a Scottish medical practice for a minimum of 18 months.

²⁴ The experience of Kate Cheney, 85, whose case was described in *The Oregonian* in October 1999 shows how despite the fact that doctors are not permitted to write a lethal prescription under inappropriate conditions, so-called "doctor shopping" occurred and her assertive daughter was able to see to it that she died. The experience of Kate Cheney demonstrates that Oregon's so-called safeguards offer scant protection to the vulnerable. At least five of the fifteen deaths in the first year of the law's operation were those of people who had first been turned down by at least one doctor, according to official reports. For further details, please see: <http://www.nrlc.org/news/1999/NRL1199/kate.html>

²⁵ See the comments by Mr. Straw in the Hansard report for 26th January 2009:

<http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090126/debtext/90126-0006.htm#0901264000672>

Both the Law Commission and an independent review identified confusion about the scope of the law on assisted suicide. I have also received strong representations on the issue from my hon. Friend the Member for Bridgend (Mrs. Moon), whose constituency has suffered the terrible tragedy of a series of suicides. Part 2 does not substantively change the law, but it does simplify and modernise the language of section 2 of the Suicide Act 1961 to increase public understanding and to reassure people that the provision applies as much to actions on the internet as to actions offline.

<http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090126/debtext/90126-0006.htm#0901264000672>

²⁶ See: <http://www.telegraph.co.uk/health/healthnews/6259181/Living-wills-law-could-be-revisited-after-Kerrie-Wooltorton-suicide-case-Andy-Burnham.html>

²⁷ See table 6.5 "Deaths by frequency of cause by sex, numbers and percentages, Scotland, 1986 to 2008", General Register Office for Scotland, 2009, at: <http://www.gro-scotland.gov.uk/files2/stats/vital-events-ref-tables-2008/ve-2008-t6-5.pdf>

²⁸ See "Women with breast cancer can have unaffected life expectancy", *The Daily Telegraph*, 11th June 2008 at:

<http://www.telegraph.co.uk/news/2107992/Women-with-breast-cancer-can-have-unaffected-life-expectancy.html>

²⁹ See points 53 and 54 in the Policy Memorandum under the heading "The slippery slope and pressurised elderly people", cited above, note 12.

³⁰ See Table 6.14, "Average age of death, selected causes, Scotland, 1977 to 2008",

General Register Office for Scotland, 2009, at: <http://www.gro-scotland.gov.uk/files2/stats/vital-events-ref-tables-2008/ve-2008-t6-14.pdf>

- ³¹ See "Death with Dignity Act Information", at: <http://www.oregon.gov/DHS/ph/pas/fags.shtml>
- ³² See: <http://www.health24.com/news/Other/1-934.56073.asp>
- ³³ See the Suicide Act 1961 version (not updated by the Coroners and Justice Act 2009), at: <http://www.statutelaw.gov.uk/content.aspx?activeTextDocId=1132509>. See also sections 59 to 61 and Schedule 12 of the Coroners and Justice Act 2009, which amended the Suicide Act 1961, at: http://www.opsi.gov.uk/acts/acts2009/ukpga_20090025_en_5#pt2-ch1-pb4-l1g59
- ³⁴ See http://www.timesonline.co.uk/tol/comment/columnists/guest_contributors/article7039977.ece and http://www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/index.html#ASSISTING_OR_ENCOURAGING
- ³⁵ See the United Nations' Report "Concluding observations of the Human Rights Committee: Netherlands. 27/08/2001. CCPR/CO/72/NET". The Concluding Observations/Comments state:

The Committee learnt with unease that under the present legal system more than 2,000 cases of euthanasia and assisted suicide (or a combination of both) were reported to the review committee in the year 2000 and that the review committee came to a negative assessment only in three cases.

<http://www.unhchr.ch/tbs/doc.nsf/385c2add1632f4a8c12565a9004dc311/dbab71d01e02db11c1256a950041d732?OpenDocument&Highlight=0.euthanasia>

- ³⁶ See section 2 of the Medical Act 1983 at: http://www.gmc-uk.org/about/legislation/medical_act.asp#1
- ³⁷ See point 98 of the Explanatory Notes to the Bill at: <http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/b38s3-introd-en.pdf>
- ³⁸ See Note 10 of the Scottish Government's Memorandum at: <http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/papers-10/elap10-02.pdf>
- ³⁹ See Physician-Assisted Suicide, SB 491 (Or Laws Chapter 423), **which amends** ORS 127.800 to 127.897. SB 491 amends the Death with Dignity Act 1997, requiring the physician to counsel the patient about the importance of having another person present when the patient takes the medication and about the importance **of not taking the medication in a public place**, at: <http://www.dhs.state.or.us/policy/spd/transmit/im/1999/im-99-72.pdf>
- ⁴⁰ See sections 59 to 61 and Schedule 12 of the Coroners and Justice Act 2009, which amend the Suicide Act 1961 in England and Wales and relevant Criminal Justice Acts in Northern Ireland, at: http://www.opsi.gov.uk/acts/acts2009/ukpga_20090025_en_1
- ⁴¹ See "Physician Assisted Suicide" and "Do not Kill me" Cards: 1/04/09, at: http://www.realclearreligion.com/index_files/category-death-0026-unnatural-death.html
- ⁴² See the "Falsified Death Certificates" paragraph at the following link: <http://www.internationaltaskforce.org/fcthall.htm>
- ⁴³ See the flow-chart that shows the process for the provision of "end of life assistance" in Appendix 1 of the Briefing Paper by the Scottish Partnership for Palliative Care, at: <http://www.palliativecarescotland.org.uk/assets/files/News/Key%20Features%20-%20End%20of%20Life%20Assistance%20Bill%2011.pdf>
- ⁴⁴ Except in the particular circumstances of sections 63(2) and 64(1)(b), when it is slightly less. See the Consumer Credit Act 1974, section 68. See also: <http://whatconsumer.co.uk/cooling-off-and-cancellations>
- ⁴⁵ See: <http://www.telegraph.co.uk/health/healthnews/7578591/Police-investigating-death-at-Dignitas-of-wealthy-British-widow.html>
- ⁴⁶ See the BBC's Ethics arguments against Euthanasia, under "The Dutch approach" near the bottom of the following page: http://www.bbc.co.uk/ethics/euthanasia/against/against_1.shtml
- ⁴⁷ See: <http://news.bbc.co.uk/1/hi/uk/3391897.stm>
- ⁴⁸ See Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective", at: http://www.spiorg.org/publications/HendinFoley_MichiganLawReview.pdf
- ⁴⁹ See *Pretty v UK* (Application No. 2346/02), at paragraph 74: <http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=698325&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649>
- ⁵⁰ A euthanasia doctor in *The Netherlands* described a request for a consultation from a physician whose patient had gastrointestinal obstruction. The requesting doctor told him that "in the past in this situation, I solved it by euthanasia. Now this patient doesn't want it, and I do not know what to do". The consulting doctor stated: "This is my biggest concern in providing euthanasia and setting a norm of euthanasia in medicine: that it will inhibit the development of our learning from patients, because we will solve everything with euthanasia."
- Dr. Zyllicz, Q1533, in Select Committee on the Assisted Dying for the Terminally Ill Bill. *Assisted Dying for the Terminally Ill Bill, HL, Vol. II, Evidence*, London, The Stationery Office Limited, April 4, 2005, at <http://www.doctorsforlife.org/articles/art42UofO.htm>
- ⁵¹ See page 13 of the Explanatory Notes to the Bill, at: <http://www.scottish.parliament.uk/s3/bills/38-EndLifeAssist/b38s3-introd-en.pdf>
- ⁵² Up to 2,500 euthanasia cases were reported in Holland in 2009, up nearly 10 per cent. <http://www.telegraph.co.uk/news/worldnews/europe/france/7414590/Dutch-plan-to-let-healthy-elderly-people-commit-suicide.html>
- ⁵³ See: <http://www.telegraph.co.uk/news/worldnews/europe/france/7414590/Dutch-plan-to-let-healthy-elderly-people-commit-suicide.html>
- ⁵⁴ See: <http://www.telegraph.co.uk/news/worldnews/europe/france/7414590/Dutch-plan-to-let-healthy-elderly-people-commit-suicide.html>
- ⁵⁵ See the 12th Assisted Suicide Report for Oregon 2010, at: <http://www.oregon.gov/DHS/ph/pas/docs/yr12-tbl-1.pdf>
- ⁵⁶ See the articles on euthanasia in Oregon at: <http://www.euthanasia.com/page8.html> and the 12th Assisted Suicide Report for Oregon 2010 cited above.

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- ⁵⁷ See “Doctors want nothing to do with assisted suicide”, comments on Lord Falconer’s amendment, which was unsuccessful, at: <http://www.telegraph.co.uk/comment/personal-view/5759447/Doctors-want-nothing-to-do-with-assisted-suicide.html>
- ⁵⁸ See “Assisted Dying—a summary of the BMA’s position”, 20th February 2009, at: http://www.bma.org.uk/ethics/end_life_issues/Assisdyingsum.jsp. See also the “BMA comment on Director of Public Prosecutions’ final guidance on assisted dying”, 1st March 2010: “The BMA has long advised doctors—for moral as well as legal reasons—to avoid actions that might be interpreted as assisting, facilitating or encouraging a suicide attempt**The BMA remains opposed to doctors taking a role in any form of assisted dying**”, available at: http://www.bma.org.uk/ethics/end_life_issues/dppassisteddying.jsp
- ⁵⁹ See: <http://www.telegraph.co.uk/news/newstoppers/politics/lawandorder/7029204/Royal-College-of-Physicians-warns-that-proposed-guidance-could-open-door-to-doctor-assisted-suicide.html>
- ⁶⁰ See the BMA’s comment on the Director of Public Prosecutions’ final guidance on assisted dying, quoted above.
- ⁶¹ The Policy Memorandum fails to state this important point, see points 31 and 32. Lord Falconer’s amendment 173, which was designed to legalise assisted suicide was soundly defeated by a majority of 53 at Committee Stage in the House of Lords on 7th July 2009; see the Hansard reports at: <http://www.publications.parliament.uk/pa/ld200809/ldhansrd/text/90707-0006.htm>—start of debate. <http://www.publications.parliament.uk/pa/ld200809/ldhansrd/text/90707-0011.htm>—vote.
- ⁶² See the BBC Ethics arguments against euthanasia under “The Oregon approach”, at: http://www.bbc.co.uk/ethics/euthanasia/against/against_1.shtml
- ⁶³ See: <http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/papers-10/elap10-02.pdf>
- ⁶⁴ See the “Oregon Palliative Care Study Article”, at: <http://www.vcil.org/news/main/oregon-palliative-care.html> and “The Consequences of Physician-Assisted Suicide Legalization”, at: <http://www.doctorsforlife.org/articles/art42UofO.htm>
- ⁶⁵ See: <http://www.dailymail.co.uk/news/article-1234295/Now-Dutch-turn-legalised-mercy-killing.html>
- ⁶⁶ See the following abstract for further information: <http://journals.cambridge.org/action/displayAbstract.jsessionid=041DAFF86B28866A4B762CA2E3342B13.tomcat1?fromPage=online&aid=274342>
- ⁶⁷ See note 17 in the Scottish Government’s Memorandum to the Committee dated 20th April 2010: “..and the Scottish Government has indicated that this will be a matter of conscience and members, including Ministers, should be given the right to vote as such.” <http://www.scottish.parliament.uk/s3/committees/endLifeAsstBill/papers-10/elap10-02.pdf>
- ⁶⁸ See “Assisted Suicide Voted Down by MPs” 21st April 2010, available at: <http://www.cbc.ca/canada/story/2010/04/21/parliament-euthanasia-bill-vote.html>.